research
in practice
for adults

Safety Matters:

Practitioners' Handbook

Developing practice in safeguarding adults

Revised Third edition

Dartington

www.ripfa.org.uk

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Introduction

Safeguarding adults means protecting a person's right to live in safety, free from abuse, neglect, violence and exploitation. It is about promoting individuals' wellbeing and preventing both the risk of, and the experience of, abuse and neglect. The *Care Act* guidance (DHSC, 2018) explains that being (and feeling) safe is only one element of wellbeing, and this means that practitioners need to be able to work in a person-centred and outcomes-focused way.

This handbook came out of a Change Project called *Safety Matters*, which took place in 2009 and brought research and practice together to identify what works best in safeguarding. The handbook was updated in 2013, and this is the third edition. The focus is on developing practice in safeguarding by highlighting research messages and good working practices, and is intended to promote reflection and discussion among practitioners. This third edition takes account of recent policy and culture changes in safeguarding adults under the *Care Act 2014* and following the national implementation of Making Safeguarding Personal (MSP).

The handbook is aimed at anyone who is involved practically with safeguarding adults. It will:

- Provide practical advice.
- Set out relevant legal structures and national policies.
- Disseminate key research messages.
- Promote and develop good practice.
- Prompt individual and organisational reflection.
- Enhance professional judgment and defensible decision-making.

It will **not**:

- Replace your own local policy and procedures.
- Address strategic level concerns.
- Provide a process for managing safeguarding enquiries.
- Provide a substitute for legal advice in difficult cases.
- Seek to provide 'all the answers'.

This handbook uses generally accepted terminology and safeguarding practices described in the *Care Act 2014* and subsequent Care and Support Statutory Guidance (*Care Act* guidance: DHSC, 2018, updated 12 February).

Safeguarding: Definitions and legal framework

Safeguarding adults was first introduced into policy through the *No Secrets* (DH, 2000) statutory guidance, which led to the development of multi-agency POVA (protection of vulnerable adults) procedures. Since then, terminology and focus has changed within safeguarding adults; the emphasis has widened to include empowerment as well as protection.

Under the *Care Act 2014* some (limited) statutory duties have been introduced for local authorities; these include a duty to:

- Make or cause to be made an enquiry (a 'Section 42') where an adult with care and support needs may be experiencing, or at risk of, abuse or neglect.
- Arrange for an advocate to represent and support the individual through the safeguarding enquiry if they might experience difficulty being involved.
- Establish a Safeguarding Adults Board (SAB).
- Establish a Safeguarding Adults Board that will carry out Safeguarding Adults Reviews if there is concern over how the safeguarding system acted in a particular safeguarding case, and an adult has either died, or experienced, abuse.

The number of referrals made to safeguarding teams is increasing. NHS Digital (2017) reports that 151,160 Section 42 and other safeguarding enquiries were started in 2016-17, resulting from an average of around 1,000 concerns per day being recorded by local authorities.

The table below shows the data for England for the last two years.

	2016-17	**2015-16**
Safeguarding concerns	364,605	184,860*
Section 42 enquiries	133,265	102,970
Other enquiries	17,895	8,365**
Total enquiries	151,160	151,160

Annual data showing change in number of safeguarding concerns and enquiries over time (NHS Digital, 2016, 2017).

*Data collected voluntarily – 110 councils submitted data.

**Data collected voluntarily – 67 councils submitted data.

While this increase in activity does not necessarily mean there is more abuse or risk occurring than previous years (in fact, it can be seen as positive in that more abuse is being identified), higher numbers of enquiries put safeguarding systems under increased pressure.

The working principles in safeguarding, as outlined in the *Care Act* guidance (DHSC, 2018) are empowerment, protection, prevention, proportionality, partnership and accountability. This handbook aims to help practitioners use these principles in practice.

Empowerment
Promoting person-led decisions and informed consent.

Protection
Support and protection for those in greatest need.

Proportionality
Proportionate and least intrusive response appropriate to the risk presented.

Partnership
Providing local solutions through services working with communities.

Accountability
Accountability and transparency in delivering safeguarding.

Prevention
It is better to take action before harm occurs.

Reflective point

How do you ensure the principles outlined above are reflected in your work in safeguarding adults?

Who do adult safeguarding duties apply to?

In the context of the legislation, specific adult safeguarding duties apply to any adult who:

> has care and support needs

> is experiencing, or is at risk of, abuse or neglect

> is unable to protect themselves from either the risk of, or the experience of abuse or neglect, because of those care and support needs.

Within the scope of this definition are:

> All adults who meet the above criteria, regardless of their mental capacity to make decisions about their own safety or other decisions relating to safeguarding.

> Adults who manage their own care and support through personal or health budgets.

> Adults whose needs for care and support have not been assessed as eligible or which have been assessed as below the level of eligibility for support.

> Adults who fund their own care and support.

> Young people receiving a service from children's services if they are aged 18 years or over.

(London ADASS, 2016)

Adults in custodial settings (prisons and approved premises) are outside the scope of this handbook. Prison governors and National Offender Management Services have responsibility for these arrangements, although the Safeguarding Adults Board has a duty to assist prison governors on safeguarding adult matters. Local authorities are required to assess prisoners' care and support needs, taking into account their wellbeing. Equally, NHS England has a responsibility to commission health services delivered through offender health teams, which contributes towards safeguarding offenders. For further information on adult safeguarding in prisons, see: **www.justiceinspectorates.gov.uk**

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a sector-led initiative, supported by the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA), which emphasises that safeguarding practice should be person-centred and outcomes-focused. It represents a shift in social work practice in relation to safeguarding, with a focus on the person not the process, and sits within the Government's Care and Support Statutory Guidance (DHSC, 2018).

MSP marks a shift from care management to person-centred relational practice. It aims to engage people in a conversation about how best to respond to their safeguarding situation and, through this involvement, enable them to exercise choice and control over how their needs are identified and met.

MSP outlines that safeguarding adults should:

- Be led by and centred on the person.
- Engage the person from the start, throughout and at the point of the enquiry being closed to address their needs.
- Focus on the outcomes the person or their advocate wants to achieve, and check at the end of the enquiry whether they were achieved.

Romeo (2015) argues that this requires practice and organisational culture change, and an evaluation of MSP in 2015 supports this. It noted several challenges in using the MSP approach related to the need for changes in culture, practices and approaches to safeguarding (Pike and Walsh, 2015). The report made recommendations related to promoting good outcomes for people, improving practice locally and partnership working. A 'temperature check' carried out in 2016 (Cooper et al, 2016) builds on these findings; both are incorporated throughout this guide.

Principles for person-centred safeguarding include:

- Focusing on the empowerment and wellbeing of the person.
- Listening to the person, asking for their views and seeking their consent, while ensuring they understand the risks and benefits throughout.
- Respecting the right of people with capacity to make unwise choices (with the caveat of being alert to people being subject to coercion or undue influence – see page 40 et seq for more details).
- Providing information and advice in accessible formats.
- Offering advocacy and support to enable people to have choice and control.
- Supporting best interest decisions based on section 4 of the *Mental Capacity Act 2005* (see section on MCA, page 40).

Types of abuse

The *Care Act* guidance (DHSC, 2018) notes that abuse and neglect may take many forms. It lists ten types of abuse:

- Physical abuse
- Domestic violence
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect

Importantly, the guidance cautions against practitioners being constrained by categories and practitioners should not overly compartmentalise their understanding of abuse. Types of abuse and neglect may overlap or co-exist; situations that meet the criteria for safeguarding should be brought to the attention of the local authority regardless of the ability, or not, to precisely define the type of abuse.

Organisational abuse (previously known as institutional abuse) is a complex umbrella term and can encompass many of the other types of abuse on the list. It is defined as:

> *'Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.'*
>
> **(DHSC, 2018: 14.17)**

Research and practice knowledge is continually contributing to fuller and more diverse understandings of abuse dynamics and to identification of further specific types of abuse. These might be termed 'emergent categories'.

Disability hate crime

There is no specific offence of 'hate crime'. However, the term is commonly used to cover a range of criminal behaviour where the perpetrator is either motivated by or demonstrates hostility towards the victim's disability, race, religion, sexual orientation or transgender identity'. These aspects of a person's identity are known as 'protected characteristics'.

A hate crime can include verbal abuse, intimidation, threats, harassment, assault and bullying, as well as damage to property. The perpetrator can also be a friend, carer or acquaintance who exploits their relationship with the victim for financial gain or some other criminal purpose. (For more information see the Crown Prosecution Service website: **www.cps.gov.uk/hate-crime**)

While there is no specific offence of 'hate crime', a judge must treat hostility towards a protected characteristic as an aggravating factor that will increase a person's sentence for any crime they did commit.

Coercive control

Coercive control is recognised as the behaviour that underpins domestic abuse. According to the *Serious Crime Act 2015*, Section 76, coercive control is behaviour used 'repeatedly or continuously' that has had a 'serious effect' on the person, causing them to fear that violence would be used against them on 'at least two occasions' *or* with a 'substantial adverse effect on their day to day activities' (Section 76 applies only to: (i) people who are intimate partners, or (ii) people who live together and are former intimate partners or are members of the same family.). In addition, the alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she 'ought to have known' it would have that effect.

An open access resource details the role of health and social care professionals in working with people experiencing coercive control - **www.coercivecontrol.ripfa.org.uk**

Female genital mutilation (FGM)

FGM is a harmful traditional practice with no health benefits that intentionally alters or injures female genital organs for non-medical reasons. The Female Genital Mutilation Act 2003 (as amended by the Serious Crime Act 2015) makes it illegal to perform FGM in the UK, or to help, encourage or pay anyone to perform it on a UK national abroad. Safeguarding policies should be followed where adults with care needs are identified as having had, or being at risk of, FGM.

The Act also places a duty on regulated health or social care professionals to notify the police if, in the course of their work, they 'discover' (either because the girl tells them, or there are physical signs) that FGM has been performed on a girl under the age of 18. Where a professional suspects that an under 18-year-old is at risk of FGM, this should be treated in the same way as any other serious issue of child abuse; in practice, this will usually mean making a referral to Children's Services or the local safeguarding hub (see Department of Health, 2016: 3). In urgent cases, a local authority can apply directly to the court for an FGM Protection Order (under Schedule 2 of the Act) to protect a girl at risk of FGM.

Further reading

Department of Health (2016)
Female Genital Mutilation Risk and Safeguarding: Guidance for professionals

Forced marriage

This is a marriage when one or both parties do not, or cannot, consent and pressure, coercion or abuse is used to obtain cooperation with the marriage. Forcing someone to marry in such circumstances is a criminal offence under Section 121 of the Anti-social Behaviour, Crime and Policing Act 2014.

Ten per cent of the total cases recorded by the UK Forced Marriage Unit in 2016 concerned people with learning disabilities (140 people) – although research indicates that the incidence of forced marriage of children and adults with learning disabilities is likely to be vastly underreported. There is some concern around this issue specifically for people with learning disabilities from South Asian communities (although there have also been cases from other communities too). Human trafficking and domestic abuse may also be related issues.

Further reading

HM Government (2014) *The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage*

‘Honour’ based violence

‘Honour’ based violence or ‘honour’-based abuse is a form of domestic abuse. It is defined by the Forced Marriage Unit at the Home Office as ‘a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community’. Women and girls who have been judged to have ‘shamed’ their community or family are most commonly the victims of honour based violence, but men may also be at risk. Adult safeguarding concerns that include domestic violence, concerns about forced marriage, enforced house arrest and missing person’s reports may indicate honour based violence.

Human trafficking and modern slavery

Both human trafficking and modern slavery are offences under the *Modern Slavery Act 2015*. Modern slavery includes slavery, servitude and forced or compulsory labour. Botting et al (2017) outline examples of signs that may indicate that a person is subject to modern slavery, which include:

- removal or confiscation of passport and other travel or ID documents
- confiscation of mobile phones, deprivation of money or resources
- restricted communication with family or friends
- being accompanied at all times.

The Pan London Multi-agency Safeguarding Procedures (London ADASS, 2016) have highlighted recent modern slavery court cases. Crown v Moloney (2016) found homeless adults had been promised paid work opportunities, and were then enslaved and forced to work and live in dehumanised conditions. Crown v Rooke (2014) found adults with learning disabilities worked for no gains, had their movements restricted, were threatened with physical violence, were starved, and were subject to continued acts of abuse.

Practitioners must report any cases of suspected modern slavery to the Modern Slavery Human Trafficking Unit (MSHTU). Where people consent, refer via the National Referral Mechanism; where they do not, use the MS1 Duty to Notify form.

Further reading

Botting A, Elliott T and Oliver S (2017) ‘Palermo to Croydon: Modern Slavery and Human Trafficking – Seeking best practice on a new frontier of safeguarding’ in Cooper A and White E (eds) (2017) *Safeguarding Adults Under the Care Act 2014: Understanding Good Practice.* London: Jessica Kingsley Publishers.

The Salvation Army website offers useful data, as well as signs and indicators for practitioners to be aware of:

www.salvationarmy.org.uk/humantrafficking

Mate crime

Mate crime refers to calculated actions against disabled people by people they consider to be their friends or that they have a mutual relationship with. Mate crime may include acts of cruelty, humiliation, servitude, exploitation and theft. Projects to tackle mate crime, such as Safety Net Friend or Fake (see below) have focused on raising awareness of the issue, specifically in people with a learning disability.

Mate crime can also be part of the practice of organised crime networks. Such exploitation is a common feature of county lines drugs supply, for example, which can include ‘cuckooing’ (ie, the use of someone’s home for the storage or supply of drugs in a rural marketplace) (NCA, 2017).

Further reading

Safety Net Project

http://arcuk.org.uk/safetynet

Video about mate crime from Camden People First (useful for people with learning disabilities)

www.youtube.com/watch?v=0Q-2QmIRV4w

Financial scamming

Financial scams are one form of financial abuse. They are illegal, and may include targeting individuals with letters and phone calls asking them to send money to win prizes. If people reply, they are put on a list and targeted further. Scams are different to cold calling or charities seeking financial support (although legitimate charities and businesses can also behave unscrupulously). People may be targeted due to their circumstances – for instance, if someone is lonely or socially isolated – or because of specific attributes such as cognitive impairment or poor financial literacy. Practitioners have a role in ensuring that individuals, carers and communities are alert to scams and empowered to protect themselves. Lee et al (2017) outline some practical steps to discuss with people:

> Not to send advanced payments, banking details or PIN numbers to anyone unknown.

> Ask Royal Mail not to deliver any leaflets or promotional material that is not personally addressed. You can do this by filling in a door to door opt out form available from the Royal Mail's website at **www.royalmail.com**.

> Register with the Telephone Preference Service to stop nuisance calls.

> Check credentials of unknown callers and thoroughly research any offer.

Further reading

Bournemouth University have produced resources on financial scamming, available at:

www.ncpqsw.com/financial-scamming

Self-neglect

Self-neglect is widely understood to relate to a lack of self-care (eg, personal hygiene, nutrition and hydration) and/or a lack of care for the domestic environment (eg, hoarding or squalor), and/or a refusal of services that might mediate risks to safety or wellbeing (Braye et al, 2015a). A multi-agency approach is needed to enable effective working with people who self-neglect – it is not solely the responsibility of adult social care.

Self-neglect can sometimes bring into focus an apparent tension between respect for a person's autonomy and duty of care. The law is quite clear, however. If a person has mental capacity, there is no statutory basis for any actions they do not consent to (although professionals can, of course, seek to persuade the person to act in a way consistent with their care and best interests).

If the person does not have capacity, then a decision in their best interests may be made, but it is essential both to take into account the person's wishes and feelings and to enable and encourage their participation.

If it is believed that someone with mental capacity is self-neglecting due to the 'undue influence' of another person, then an application can be made to the High Court under the inherent jurisdiction[1] (see page 22).

Professionals should try to make what the person wants happen, if that can be done in a way that serves their best interests (see Briggs v Briggs [2016] EWCOP 53, paragraph 59[2]). In cases of severe self-neglect in which the person without capacity resists assistance, overriding their wishes in their best interests remains possible.

The *Care Act* guidance advises that self-neglect may come within the statutory definition of abuse or neglect, if the individual concerned has care and support needs and is unable to protect him or herself 'by controlling their own behaviour' (DHSC, 2018: 14.17). People may self-neglect for many and multiple reasons, including physical or mental health conditions or disabilities, substance use, impaired cognitive functioning and emotional influences.

In cases of self-neglect, it is essential that a capacity assessment is made early on and reviewed as necessary. Effective practice with people who self-neglect is supported by:

> Building trust, showing empathy, respect and 'concerned curiosity'.

> Understanding the significance of the self-neglect in the context of the person's life.

> Working patiently, but being able to spot moments where change might be possible.

> Revisiting the question of the person's capacity to make decisions about self-care.

> Open communication about risk and interventions.

> Good understanding of the legal framework and powers.

> Coordination of a multi-agency response.

(Braye et al, 2015a)

Hoarding may be addressed through safeguarding where appropriate, or through the support of adult social care or mental health services. Like self-neglect, a multiagency response is likely to be most effective.

Further reading

Braye S and Orr D, Preston-Shoot M (2015a) *Working with people who self-neglect.* Dartington: Research in Practice for Adults

Orr D, Braye S and Preston-Shoot M (2017) *Working with people who hoard.* Dartington: Research in Practice for Adults.

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[1] See Southend-on-Sea Borough Council v Meyers [2019] EWHC 399 (Fam): **www.39essex.com/cop_cases/southend-on-sea-borough-council-v-meyers**

[2] **www.familylawweek.co.uk/site.aspx?i=ed175387**

The impact of abuse and neglect

Abuse and neglect can lead to negative outcomes – loss of dignity, negative effects on health, wellbeing and confidence, isolation, substance misuse, emotional trauma, injury and even premature death. Safeguarding interventions need to take into account the complexities of people's situations.

It is important to understand the psychological impact that abuse may have on a person's thinking and behaviour. People may live in fear of abuse but be unwilling to report it, and there can be many complex and interrelated reasons for this. Some people might feel ties of loyalty to an abuser, might stay in an abusive situation because of threats (eg, in situations of modern-day slavery or domestic abuse) or fear consequences such as the loss of home or relationships. Some people may be afraid of not being believed, or fear pressure from their wider family or community.

People want to be safe but for some their only human contact is with the abuser. Self-esteem, self-confidence and mental health all may be undermined by long-term effects of abuse, intimidation and/or coercion. As a result, the victim may lack self-worth, feel ashamed or blame themselves.

Lack of knowledge or lack of trust in services can make people unwilling to seek help. Disabled or older adults may be more physically vulnerable and unable to escape. Sometimes the victim is the carer of the abuser and feels a sense of obligation to carry on and put up with the abuse. People may be afraid of what will happen if they report abuse: for instance, being put in a care home, or losing contact with relatives. Adults living in residential care, or their relatives, may be reluctant to complain about the conditions or lack of dignity due to fear of repercussions or a shortage of alternatives (Preston-Shoot, 2017).

Adults who have experienced abuse and neglect may need support to build up their resilience and develop coping mechanisms. This is a process whereby people use their own strengths and abilities to overcome what has happened, learn from the experience and develop an awareness that may prevent a reoccurrence (or at least, enable people to recognise the signs and risks of abuse and neglect, and know who to contact for help and how). Resilience is supported by recovery actions, which include adults identifying actions that they would like to see to prevent abusive situations from recurring.

Case study

‘Susi had a moderate learning disability. She lived in supported living. Historically there was acceptance by Susi of unwanted sexual relationships and tolerance of violence. There had been a number of safeguarding referrals alleging sexual abuse of Susi by her boyfriend. No police action had been taken and the situation remained unresolved. Susi had been assessed as having capacity to make decisions about her relationship.

‘Susi initially wanted to remain with her boyfriend. She wanted him to treat her differently and for professionals to help change his behaviour. Professionals at that point wanted to put in a range of protective measures to prevent the sexual relationship whilst the risk remained significant.

‘Rather than take control, professionals were able gradually to involve Susi in considering the potential benefits and harms of pursuing a range of outcomes. They supported her to have greater insight into the risks alongside what was to be gained from remaining in the relationship. Her preferred outcomes were represented at all safeguarding meetings and reviewed at every stage.

‘Through this approach Susi began to realise the extent and nature of the risk and that her initial preferred outcomes were not achievable. She realised that her boyfriend’s behaviour towards her would not change. Susi adapted the outcomes she wanted as she began to understand what was necessary to enable her to feel safe. She weighed up the risks and took the decision to leave her boyfriend and set in place a long-term plan to live in a new environment away from him.’

(Laswon, 2017a: 34)

Policy and law

Legal literacy is important in social care. Primary and secondary legislation, central government guidance and judicial decisions impact on the commissioning and provision of social care, and these legal rules are often applied in complex and shifting situations. Practitioners who carry out 'public functions', such as in health, social care and related sectors must:

> Act lawfully – have a good understanding of the law and their own professional standards, regulations, codes of practice and other guidance.

> Act reasonably – not make decisions that are 'so absurd that no sensible person would ever dream that it lay within the powers of the authority'. They must be honest, act in good faith, and approach their duties in a proportionate way.

> Act fairly – ensure that decisions are without bias, give individuals or groups who will be affected by decisions the opportunity to participate in decision-making processes, and avoid possible abuses of power.

(Bateman, 2017)

This section outlines key legislation as related to safeguarding adults.

Care Act 2014

The *Care Act 2014* consolidates good practice in statute as well as bringing in new reforms. It embeds and extends personalisation in social care into the realm of safeguarding adults, increasing the focus on wellbeing and prevention. It also enables local authorities and partners to have a wider focus on the whole population in need of care. The Act clarifies and enhances the duties, roles and responsibilities of multi-agency partners in safeguarding, and strengthens the collaborative approach that should be taken (Preston-Shoot, 2015).

Enhancing and promoting wellbeing is at the heart of effective safeguarding. Section 1 of the *Care Act 2014* places a duty on local authorities to promote a person's wellbeing when carrying out any of their care and support functions. This includes all activity relevant to safeguarding adults, from prevention to responding to concerns.

Wellbeing is a broad concept, and it is described in the Act as relating to the following areas:

- Personal dignity (including treatment of the individual with respect).
- Physical and mental health and emotional wellbeing.
- **Protection from abuse and neglect.**
- Control by the individual over day-to-day life (including over care and support provided and the way it is provided).
- Participation in work, education, training or recreation.
- Social and economic wellbeing.
- Domestic, family and personal.
- Suitability of accommodation.
- The individual's contribution to society.

Human Rights Act 1998

> *'Human rights approaches can provide the basis for ensuring and driving up quality, as well as a tool to change the culture of services towards one that supports person centred approaches, co-production, safeguarding and personalisation. Making this shift requires increased understanding - particularly among those using and delivering services - of how human rights can be put into practice.'*
>
> **(British Institute of Human Rights, 2013)**

Upholding human rights is the foundation of safeguarding adults. Any 'public authority' with existing powers to intervene in a person's life must, under Section 6 of the *Human Rights Act 1998* (which incorporates the European Convention on Human Rights into domestic British law), respect that person's human rights. It is unlawful for the authority to 'act in a way which is incompatible with a Convention right'.

Section 73 of the *Care Act 2014* extended the definition of 'public authority' to include also voluntary and private providers of state-funded adult social care.

Broach (2018), a barrister specialising in public law, explains that Section 73 means a resident of a care home can bring a claim against that home if their human rights have been violated.

Key Articles in relation to safeguarding adults include:

Article 2: Right to life

Article 3: No torture, inhuman or degrading treatment

Article 5: Right to liberty

Article 8: Right to a private and family life.

Elliott (2017) argues that Article 10 – the right to freedom of expression – underpins guidance on Making Safeguarding Personal.

Articles 2 and 3 should be considered especially in relation to duty of care, when people who may be experiencing abuse (especially self-neglect) may be unwilling to accept interventions. See later sections (eg, page 25) for more detail.

Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS)

The *Mental Capacity Act 2005* (MCA) provides a legal framework for acting and making best interest decisions on behalf of people who lack capacity to make particular decisions. Section 44 of the MCA created a criminal offence of wilfully ill-treating or neglecting a person who lacks capacity.

The Deprivation of Liberty Safeguards (DoLS), which which came into force in 2009, form part of the MCA. The safeguards are used to protect the rights of people who lack the ability to make decisions about their current residence and so ensure their freedom is not restricted inappropriately.

Mental Health Act 1983

The *Mental Health Act 1983* (MHA) is used to ensure that people who need treatment for a serious 'mental disorder' receive this treatment, even against their wishes, if there are sufficient risks to their own health or safety or risks to the safety of other people.

The revised Code of Practice (Department of Health, 2015) includes five guiding principles:

1. Least restrictive option and maximising independence: Where it is possible to treat a patient safely and lawfully without detaining them, the patient should not be detained. Wherever possible, patients' independence should be encouraged and supported with a focus on promoting recovery.
2. Empowerment and involvement: Patients should be fully involved in decisions about care, support and treatment.
3. Respect and dignity: Patients, their families and carers should be treated with respect and dignity and listened to by professionals.
4. Purpose and effectiveness: Decisions about care and treatment should be appropriate to the patient, have clear therapeutic aims, promote recovery, and accord with national and/or best practice guidelines.
5. Efficiency and equity: Providers, commissioners should work together to ensure mental healthcare services are of high quality and given equal priority to physical health and social care services. All services should work together to facilitate timely, safe and supportive discharge from detention.

Section 127 of the MHA made ill-treatment of patients, or wilful neglect of a patient's welfare and dignity, a specific offence for staff employed in hospitals or mental health nursing homes.

In October 2017 the Prime Minister announced an independent review of the *Mental Health Act 1983*. The Review submitted its report and recommendations in December 2018 (IRMHA, 2018).

Sexual Offences Act 2003

The *Sexual Offences Act 2003* highlights the issue of consent, and was introduced to protect everyone from abuse and exploitation. It gives a comprehensive list of sex offences and provisions to protect individuals from abuse and exploitation.

Among other things, the Act makes it an offence to engage in sexual activity without the other person's consent, an offence to engage in sexual activity with a person who lacks the mental capacity to consent to it, and an offence for care workers to engage in sexual activity with any person with a mental disorder, even when the person has mental capacity.

Part 2 of the Act sets out the notification requirements for offenders, with an emphasis on the protection of vulnerable individuals.'

Domestic Violence, Crime and Victims Act 2004

The *Domestic Violence, Crime and Victims Act 2004* includes provisions related to abuse by partners or family members and created an offence of causing or allowing a child or vulnerable adult to die or suffer serious physical harm. This was introduced to cover situations where it was clear that someone in a household was responsible for harming a child or vulnerable adult, but it could not be proved who.

Serious Crime Act 2015

The *Serious Crime Act 2015* created a new offence of controlling or coercive behaviour in intimate or familial relationships (Section 76). The new offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members.

Modern Slavery Act 2015

This Act was designed to tackle slavery, servitude, forced or compulsory labour and human trafficking. It also provides guidance for identifying and supporting victims, including children.

Equality Act 2010

The principle of equality for all citizens, and the right of everyone to live free of abuse and discrimination, is explicit in human rights legislation. The Human Rights Act 1998, which incorporates into British law the rights set out in the European Convention on Human Rights (ECHR), sets out the fundamental rights and freedoms that everyone in the UK is entitled to.

Article 14 of the ECHR states that rights and freedoms shall be secured without discrimination on any ground such as sex, race, colour, religion, or national origin, for example, ‘or other status’. The courts have made clear that disability is a relevant ‘other status’.

The Equality Act 2010 places a duty on public bodies to take positive action to avoid discrimination in relation to specified ‘protected characteristics’. These are: ‘age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation’.

Inherent jurisdiction

England and Wales is a common law jurisdiction, so there is relevant law that is not found in any Act of Parliament. The most relevant here is ‘the inherent jurisdiction of the High Court’. If a ‘vulnerable’ adult is ‘under constraint’, ‘subject to coercion or undue influence’, or ‘for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent’ then, in exceptional circumstances, the High Court can make injunctions restraining the person who is coercing them. See DL v A Local Authority [2012] EWCA Civ 253.

Data Protection Act 2018/General Data Protection Regulation (GDPR)

Organisations that process personal data (this includes organisations within health and social care) must comply with the General Data Protection Regulation (GDPR), which came into force on 25 May 2018. Together with the *Data Protection Act 2018*, the GDPR forms part of the data protection regime in the UK. Data protection principles under the GDPR are similar to those that applied under the *Data Protection Act 1998*. Personal data must be:

- Processed fairly, lawfully and in a transparent manner.
- Used for specific, explicit and legitimate purposes.
- Adequate, relevant and limited to what is necessary for the purpose they are being processed.
- Accurate and (where necessary) kept up to date.
- Kept in a form that allows identification of individuals no longer than is absolutely necessary.
- Processed in an appropriately secure way.

Organisations must be able to demonstrate compliance with the key principles of the GDPR (ICO, 2018).

The Information Commissioner's Office has published a comprehensive guide to the GDPR (although the guidance is not specific to the care sector). Go to: **www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation**

The following websites have detailed up-to-date information:

NHS Digital:
https://digital.nhs.uk/information-governance-alliance/General-Data-Protection-Regulation-guidance

Information Commissioner's Office:
https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

Reflective points

How confident do you feel in your knowledge of the legislation listed above?

Can you discuss the implications of human rights, mental capacity and equalities legislation in relation to your practice in safeguarding adults?

Further reading

Elliott T (2017) *Embedding human rights in adult social care: Leaders' Briefing*. Dartington: Research in Practice for Adults

Bateman F (2017) 'Using the law to support adult safeguarding interventions' in Cooper A and White E (eds) (2017) *Safeguarding Adults under the Care Act 2014: Understanding good practice*. London: Jessica Kingsley Publishers

Braye S and Preston-Shoot M (2016) *Legal literacy: Practice tool*. Dartington: Research in Practice for Adults

Strengths-based practice and safeguarding adults

What do people want from safeguarding?

Pike's (2015) review of research looked at the evidence around what people want from safeguarding adults enquiries. Some key themes emerged:

- People value rights and independence as well as support, and want to be involved in their safeguarding.
- People want their need for and contribution to relationships to be recognised.
- Not to be judged (some people fear losing their independence if they are judged not to be coping).
- To be heard, and have options and flexible ways of working presented to them.
- Clarity over the scope, limits and processes of safeguarding.
- Support to prepare for safeguarding meetings.

(Pike, 2015)

Research on the outcomes that people want from safeguarding has also been carried out. Timson et al (2015) and Hopkinson et al (2015) looked at the outcomes that people wanted from Making Safeguarding Personal. They found that the most common outcomes that people wanted included:

- Being safe from continuing harm or abuse.
- To have their views and wishes taken seriously.
- To maintain important relationships without compromising safety.
- To be aware of what support is available to meet their needs.
- To feel in control of the situation.
- To remain independent.
- To know why they were harmed, and what would be done to prevent the same thing happening again to themselves or others.

Another study (Montgomery et al, 2017) piloted a method to gather feedback about safeguarding adults from individuals who had experienced safeguarding in Northern Ireland: the '10,000 voices' survey tool. (Although Northern Ireland has a separate policy context, the direction of practice is moving in a similar direction to Making Safeguarding Personal in England.)

The project aimed to find out how safeguarding could be improved to be more 'rights based, empowering, consent-driven and person-centred'. Questions were co-developed with people who use services and with carers, and can be seen as indicative of what people want from safeguarding:

'1. To what extent did you feel listened to during meetings and conversations?

2. To what extent did you feel satisfied with how the safeguarding investigation was carried out?

3. To what extent were you able to understand the information given to you during the safeguarding investigation?

4. To what extent were you given the information you needed at the right time during the safeguarding investigation?

5. To what extent were you satisfied with the outcome of the investigation?'

(Montgomery et al, 2017: Table 1).

The researchers were able to analyse people's responses to gauge the overall experience of safeguarding, and identify areas for improvement.

However, the question of 'what people want' can be too simplistic in some cases. Braye et al (2015a) outline this with particular reference to people who self-neglect: professionals must work within the legal framework, asking questions about choices, and making sure the person understands the implications of their actions. In the context of self-neglect, if an admission under the Mental Health Act 1983 is appropriate (and often it will not be), the Mental Capacity Act 2005 is legally binding and a capacity assessment is essential (see page 15). If the person has the relevant care and residence capacities, then action in their best interests is not permissible. However, Making Safeguarding Personal does not mean simply 'abandoning' people to their choices. Professionals can attempt to persuade and reason with them. In a briefing for managers, Braye et al (2015b) suggest 'concerned curiosity and honesty-based authority' as an effective approach – this principle can apply to situations other than self-neglect, too.

Key message

People value independence, control and their relationships. Practitioners should do all they can to find out what is important to individuals and work accordingly.

Involving people in their safeguarding

The *Care Act* guidance lays out clear expectations around involving people in their safeguarding enquiry, stating:

'14.79 What happens as a result of an enquiry [s.42] should reflect the adults' wishes wherever possible, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision, and be proportionate to the level of concern.'

'14.93 [In relation to a safeguarding enquiry] ... it will usually start with asking the adult their view and wishes which will often determine what next steps to take...'

(DHSC, 2018)

Factors to consider when supporting people through the safeguarding process include:

Capacity: Has the person been provided with appropriate information about safeguarding? Can they understand it? Can they retain, use or weigh it up (with support if necessary) as part of the process of being involved? Can they communicate their preferences – again, with support (s.67 *Care Act 2014*)?

Might the person 'experience substantial difficulty' with understanding, retaining, using, and weighing the information, or with communicating their 'views, wishes or feelings' (s.68 *Care Act 2014*)? If so, is there an 'appropriate person to represent and support the adult for the purpose of facilitating the adult's involvement'? (This cannot be anyone in a paid care position.) If not, the local authority is legally bound to appoint an independent advocate.

Existing strengths and networks: Adults should be involved in their own safeguarding as much as they want and are able to be. The strengths of the adult should always be considered. Identifying their strengths and that of their personal network may reduce risks sufficiently so that people feel safe without the need to take matters further. The MSP temperature check (Cooper et al, 2016) found that for some councils, concerns less often resulted in enquiries because a proper conversation with the person at the beginning could lead to alternative solutions and resolution.

Support: Where planning or other safeguarding meetings may be held, the adult should always be given an opportunity to attend if they would like to. Meaningful involvement of adults and/or their representatives in safeguarding meetings requires professionals to think in a person-centred way. This involves reflecting on several key issues.

- How would the adult like to be involved?
- Where is the best place to hold the meeting?
- How long should the meeting last?
- What time is best for the adult?
- Do they need time to go through the agenda with their advocate?
- What support might they need to fully participate in the meeting?
- Do they want to develop or add to the agenda?

- Who should chair the meeting?
- Does the adult have particular needs for support in the meeting? (Loop systems, interpreters etc.)
- How can issues relating to confidentiality be addressed?

Considerations during the meeting:

- Language and terminology: keep jargon free, avoid abbreviations, explain acronyms, and regularly check that the person understands what is happening.
- Recording the meeting: how will it happen? How will it be shared with the person whether they have attended the meeting or not?

Adults should be supported to identify:

- The decisions that are important to them relating to the Section 42 enquiry.
- How they will be involved in the enquiry.
- Which decisions will be outside of their control.
- Why and what information they can expect and at what stage.
- What they want to achieve from the Section 42 enquiry.

Information: Whether the adult chooses to be involved with the enquiry or not, it is essential that they understand the implications of the plan and how it relates to their desired outcome. Clarity is also needed over what information is shared with whom, and the adult should consent to this wherever possible. Please see detail about the new General Data Protection Requirement (GDPR) on page 23.

Organisational culture: Safeguarding is a multiagency responsibility, but agencies will have different approaches to involvement. Successful involvement requires clarity for all professionals involved about how and why involvement is being facilitated, at every stage.

The adult's views, wishes and desired outcomes may change throughout the course of the enquiry process. There should be an ongoing dialogue and conversation with the adult to ensure their views and wishes are gained as the process continues, and enquiries re-planned should the adult change their views.

Reflective points

How do you currently ensure meaningful involvement from adults in their safeguarding?

Is there an inter-agency agreement about involving adults in their safeguarding in your local area?

Involving people from specific cultural communities and social groups

Although mistreatment and abuse of adults at risk exist in all cultures, definitions of and responses to abuse may vary from one cultural context to another. Structural disadvantage and/or community expectations may also affect people's decisions to disclose abuse: for example, involvement of 'outsiders' may be seen in some communities with strong family ideologies as bringing dishonour to the family, and therefore unacceptable. People from minority communities might hesitate to contact services for many reasons – for example, there is evidence that trans people who experience domestic abuse can find it difficult to access support, though they experience domestic abuse in at least the same levels as the general population (Rogers, 2016). People experiencing modern slavery may be wary about cooperating with the authorities due to previous treatment, pre-existing vulnerabilities and anxiety about their immigration status (Botting et al, 2017). Cultural differences, however, should not be presumed. In-group variability and the interplay between ethnicity, race, gender, age, disability and other factors should be taken into account when considering both people's susceptibility to abuse and their perceptions and responses to it.

Opportunities to discuss cultural differences in perspectives of 'abuse' should be created to enable effective collaboration and responses. Practitioners should also familiarise themselves with specialist services in their area and signpost people appropriately.

Looking for solutions within the family or community, or to seek the support of local BAME organisations, may be preferable to involvement in safeguarding. However, careful consideration, including risk assessment, should be given to this, especially in cases of 'honour' based violence, FGM or forced marriage, as family or community members may pose part of the risk to the person. Research emphasises the importance of:

- Developing culturally sensitive practices for dealing with adult abuse.
- Having good knowledge of the specific cultural context.
- Using an ecological approach that takes into account the socio-cultural context in which the individual is immersed.
- Listening to the service users, providing support and information while at the same time respecting their perspective and choices.

People from minority communities may also face a range of barriers. These include: language barriers; lack of information about their rights and the available services and a lack of services that are able to meet their needs in a sensitive way (or a lack of confidence in existing services). Inaccessible or inadequate services were also shown to put additional pressure on carers from minority communities, thus increasing the risk of abuse and neglect.

Racism and discrimination are often experienced by people from minority ethnic communities in their interaction with social and health care institutions and need to be addressed.

Close collaboration between local authorities and local community groups is required to overcome such barriers and to develop culturally competent services and awareness-raising initiatives. Involvement of community groups in the local Safeguarding Adults Board is one way to address this. For example, Greenwich did some specific work with the dDeaf community to find out about their specific needs and views around safeguarding adults issues. (dDeaf is a term used to describe people who are Deaf (users of sign language) and deaf (who are hard of hearing but use English, and may lipread rather than signing.)

Agencies should monitor the extent to which the demographics of their staff reflect the composition of the population they serve, and the impact this may have on the uptake of services by different groups.

Further reading

Pike L (2016a) *Involving people in safeguarding adults: Leaders' briefing.* Dartington: Research in Practice for Adults

Pike L (2016b) *Case studies: Involving people in safeguarding adults.* Dartington: Research in Practice for Adults
www.ripfa.org.uk/IPISA-case-studies

Wallcraft J (2011) *User involvement in adult safeguarding.* SCIE report 47. London: SCIE

Consent in relation to safeguarding

Some people may choose not to engage with professionals. Additionally, practitioners may not share views about risk with individuals. It can be quite difficult for practitioners to accept that the adult does not want any intervention; if there are no concerns about the adult's mental capacity and the relevant sections of the *Mental Health Act 1983* do not apply, then the practitioner should respect the right of the adult to decline support.

If it is believed that a vulnerable adult with mental capacity is only refusing support because someone else is influencing them to do so, then it might be appropriate to apply to the High Court for an order under the inherent jurisdiction (see page 22).

Practitioners should however take steps to be assured that the adult is making an informed choice by:

- Supporting the adult to weigh up the risks and benefits of different options.
- Ensuring the adult is aware of the level of risk and possible outcomes.
- Offering to arrange for an advocate or peer supporter.
- Offering support to build confidence and self-esteem if necessary.
- Providing information or education for the individual about abuse and neglect, and available support.
- Agreeing on and recording the level of risk the adult is prepared to take.
- Providing information and contact details of your own and other agencies.
- Recording the reasons for not intervening or sharing information with other agencies.
- Regularly reviewing the situation.
- Trying to build trust to enable the adult to better protect themselves.

It is important to see the adult in circumstances that best enable them to share information freely and ensure that they are not subject to coercion or control by other people.

Practitioners bringing concerns to the attention of the local authority are expected to discuss their concerns with the person and seek their agreement to share information. However, they can refer concerns without consent where there is reasonable cause to suspect abuse or neglect (Bateman, 2017).

Making safe enquiries

If you believe for any reason that the person may not be able to disclose or discuss their situation due to coercive control – for example, if you think someone may be experiencing domestic abuse – you should ensure the enquiries you make are safe enquiries. Guidance from the Local Government Association and the Association of Directors of Adult Social Services (2015) outlines the principles of safe enquiries:

'To ensure safety and confidentiality:

> *always ensure you are alone with the person before enquiring into possible abuse — never ask in front of a partner, friend or child*

> *make sure that you can't be interrupted, and that you – and the person – have sufficient time*

> *only use professional interpreters*

> *do not pursue an enquiry if the person lacks capacity to consent to the interview unless you have already arranged an advocate*

> *document the person's response (but not in client/patient held records or organisational systems to which the perpetrator may have access).*

Explain your reasons for enquiring into domestic violence or abuse, for example:

> *as we know domestic abuse is common and affects many people; we ask everyone about it when we observe possible indicators of abuse*

> *domestic abuse isn't just about physical violence. It can be financial, sexual or emotional, and includes forced marriage*

Explain the limits of your confidentiality, for example:

> *the only time I would tell anyone anything you told me would be if a child was in danger, if another adult was in serious danger or if a crime may have been committed. Even then, I would discuss it with you first if I could and I would do everything I could to support you.*

Ask direct questions about their circumstances, for example:

> *has anyone close to you ever made you feel frightened?*

> *does anyone close to you bully you, control you or force you to do things?'*

(LGA and ADASS, 2015: 38-39)

Reflective points

- Do you use team meetings as an opportunity to discuss anonymised cases? This can help you share good practice in making safe enquiries.
- Consider the guidance on coercive control. Supervision is an opportunity to discuss this complex issue in relation to specific cases.

Further reading

LGA and ADASS (2015) *Adult safeguarding and domestic abuse.* London: ADASS

See Research in Practice for Adults' dedicated website to help social workers and other practitioners develop their knowledge and skills in working with situations of coercive control: **www.coercivecontrol.ripfa.org.uk**

Risk enablement in partnership with adults

Safeguarding is fundamentally about practitioners enabling adults with care and support needs to identify, manage and review risk so that they are safe from abuse and neglect and can prevent abuse and neglect as much as possible.

The right to take risks can be considered part of citizenship, and good decisions about risk are made with the involvement of the people affected (Duffy and Sutton, 2018). In their chapter on working with risk, Duffy and Sutton (2018: 65) explain 'risk enablement doesn't mean risk promotion... any harm from risk is not positive, but navigating the decision-making processes of risk taking can be'. Other authors have argued that supporting people to take everyday risks is important for learning and developing a sense of identity and worth; for instance McNamara and Morgan (2016) pay particular attention to positive risk-taking as a person-centred approach that supports enablement and wellbeing.

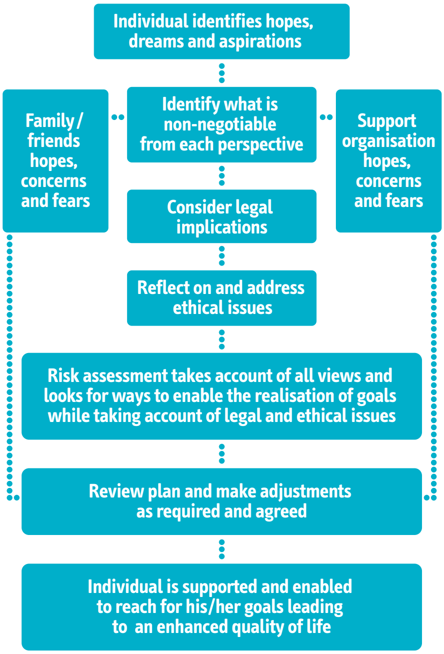
Discussions about risk with the person can help them – and also help practitioners – to balance the risks of different options, deciding on a course of action that is best for the person's wellbeing. For example, a person who is being financially abused by 'friends' who insist he buys all their drinks in the pub can have the idea of 'buying a round' explained to them, and be supported to develop their assertiveness.

This approach addresses the risk of financial abuse, without denying the person a social life (by recommending they are 'protected' from seeing their friends), which would increase the risk of loneliness and social isolation.

Parley (2011) points out that risk assessment and risk management can be done from a service or professional perspective or from a person-centred perspective, and the two approaches can result in a very different risk management plan.

She outlines an alternative framework for risk management in safeguarding in the form of safety planning. This is illustrated in the diagram below.

Safety Plan Based On Inclusive Risk Assessment



Making Safeguarding Personal reinforces that the adult is best placed to identify risks, provide details of the impact and say whether or not they find mitigations acceptable. Working with the adult to lead and manage the level of risk that they identify as acceptable creates a culture where:

- Adults feel more in control.
- Adults are empowered and have ownership of the risk.
- There is improved effectiveness and resilience in dealing with a situation.
- There are better relationships with professionals.
- There is good information sharing to manage risk, involving all the key stakeholders.
- Key elements of the person's quality of life and wellbeing can be safeguarded.

Family group conferences and mediation (see page 63 for more detail) have also been suggested as methods that could be used in adult safeguarding. Both aim to empower people and their families or carers to come to an agreement about an area of difficulty or dispute. This could be used to discuss risk and risk management.

Risk should be considered throughout the safeguarding experience. The McNamara and Morgan briefing (2016) discusses risk in more detail, with a focus on what we know from research about good practice and factors to consider.

A person who is encouraged to understand the nature of risk will be in a better position to manage it independently in the future. As a person-centred approach to risk, positive risk-taking aims to enable people to weigh up the risks and benefits of different options. It is a way of working with risk that supports the outcomes-led safeguarding of Making Safeguarding Personal, and is a major change to safeguarding from a process-driven response that relied upon risk management plans that prioritised safety above everything else.

McNamara and Morgan (2016) explain that the following conditions, taken from Morgan (2010), can help individual practitioners, teams and organisations to develop a balanced view of the possible outcomes of taking risks:

1. Define the risks according to the specific situations.
2. Take into account different perspectives on the meaning and daily impact of risks for people accessing services, carers and practitioners.
3. Identify the potential gains and consequences of the risks.
4. Work with the individual's strengths when assessing the risks.
5. Focus discussions of risk on original causes to ensure they do not reoccur.
6. Help to draw up plans to avoid risk safely.
7. Provide responsive support when needed.
8. Ensure there is reasoned and collaborative decision-making.
9. Ensure that teams and organisations are consistent in their understanding of positive risk-taking.
10. Develop a true culture of learning, not blame.

Safeguarding, risk and self-directed support

Direct Payments, and the wider personalisation agenda, offer good examples of balancing choice and control, risk enablement and appropriate safeguards. Research carried out among Adult Safeguarding Coordinators (ASCs) (Manthorpe et al, 2009, 2011; Manthorpe and Samsi 2013) showed that although at the outset ASCs could see the potential benefits for increased choice, they had a number of concerns that personal budgets and Direct Payments could lead to increased financial abuse. However, the pilots did not appear to show increased safeguarding referrals resulting from increased use of Direct Payments.

Some ASCs stated that since Direct Payments are only permitted after careful scrutiny, this can prompt useful open discussion of risks. In addition, the police and the Court of Protection provide safeguards, and the Department for Work and Pensions is able to stop unsuitable people having access to the benefits or pensions of people considered to be at risk. ASCs argue, however, that they should have a key role in personalisation to ensure their concerns about potential financial abuse are taken on board, and risks minimised by sufficient monitoring.

In 2011, the government produced, in collaboration with other partners, a framework for supporting personal assistants working in care (DH, 2011). This provides useful guidance for an otherwise unregulated section of the workforce.

Schwehr (2010) argues that the crucial link between safeguarding and personalisation is mental capacity. The processes for personalisation are broadly similar to the current care management cycle. At each stage, mental capacity is a key consideration affecting initial referral, assessment, care planning and support. Schwehr outlines the responsibilities that councils have, which include:

- A duty to monitor and review that extends to direct payments, and can place conditions on how need is met.
- Ensuring that people who access services understand their duties as employers.
- Advising on regulations and checks for employees.
- Providing clarity about what direct payments can and cannot be used for.

She concludes that preventative safeguarding is merely assertive care planning that is conducted within the legal framework. In this way, risk assessment becomes a vital part of the self-assessment process and an opportunity for practitioners and people seeking support to discuss risk, and how to mitigate or work with it.

Structures to support working with risk

A positive approach to risk enablement in partnership with the person should be used wherever possible. However, when there are high levels of risk, formal structures can support effective resolution of issues, ensure consistency of practice and facilitate multiagency working.

Risk enablement protocols such as this example from Cumbria Council can be helpful in agreeing the approach, roles and responsibilities in working with risk.

Cumbria Council (2015) *Risk taking for positive outcomes.*

www.cumbria.gov.uk/elibrary/Content/Internet/327/6904/40591114541.pdf

Established formal partnership structures to manage high-level risk such as the Multi-Agency Risk Assessment Conference (MARAC), and Multi-Agency Public Protection Arrangements (MAPPA) have been adopted in most local areas. However, research has found that adults whose information has been shared at a MARAC generally did not feel involved and did not understand the process of it (McLaughlin et al, 2014). This is at odds with the principles of Making Safeguarding Personal.

Relevant approaches are described below, but practitioners are encouraged to think about creative ways to ensure the person is actively involved in meetings and agreeing ways to manage risk - eg, by inviting professionals to meet at a location convenient for the adult, rather than expect that person to slot in to a predetermined MARAC or MAPPA process and location.

Multi-Agency Risk Assessment Conference (MARAC)

The MARAC is the multi-agency forum of organisations that manages cases identified as 'high risk' by use of the Domestic Abuse, Stalking and Harassment and 'Honour'-based Violence (DASH) risk identification checklist, and develops a coordinated safety plan to protect each victim. This might include actions agreed for any children, adults and perpetrators.

The primary focus of the MARAC is to safeguard the adult. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture, but all may have insights that are crucial to safeguarding as part of the coordinated community response to domestic violence. A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about an adult at risk, the representatives discuss options for increasing the adult's safety and turn these into a coordinated action plan.

The LGA and ADASS (2015) guide on adult safeguarding and domestic abuse highlights that councils should ensure there are clear local arrangements between safeguarding services and MARACs so that there are a range of social work and legal options with which to work with people.

The following case study draws out the links between domestic abuse and adult safeguarding that with the benefit of hindsight might have been presented to the MARAC.

Case study

The death of an 81-year-old woman following an alleged assault by her 88-year-old husband of 56 years triggered a Safeguarding Adults Review in Essex, which raises questions about how the largely hidden issue of domestic abuse among older people is addressed. Mrs A died of a bleed to the brain following a 'domestic related' incident at her home in Leigh-on-Sea Essex in October 2010. Mrs A had had considerable contact with Southend agencies, including Essex Police, Southend Adult Social Care and her GP in relation to alleged domestic abuse from her husband. She had made repeated 999 calls over the preceding months.

Mr A was interviewed under caution and Essex Police launched a manslaughter inquiry but the Crown Prosecution Service decided there was insufficient evidence to prosecute. Mr A himself died in November 2011. The Serious Case Review highlighted 'poor appreciation of the risks of domestic abuse in old age'. Because the couple were elderly and frail, police were inclined to treat the domestic violence allegations as a social care issue rather than potential crimes. On each of four previous occasions when the police attended the couple's home, those attending were unaware of earlier incidents and treated the call as if it were a first call. The police were also 'sidetracked by Mrs A's inaccurate description of her husband as having mental ill health'.

The SCR found that if a safeguarding meeting had been held, one outcome might have been better engagement with the family, including the couple's son and daughter, and greater understanding of the risks. There was liaison between social care and the police but 'it did not translate into effective action'; although 'any agency could have requested a safeguarding meeting, none did'.

(Southend Safeguarding Vulnerable Adults Board, 2012)

Reflective points

Make some time in a team meeting, or individually, to consider the number of referrals made to and from the MARAC relating to adults with care and support needs.

1. Is the MARAC understood in your organisation?
2. What tensions might exist between MARAC and MSP, and how do you address these locally?

Multi-Agency Public Protection Arrangements (MAPPA)

MAPPA exists to reduce the risks posed by sexual and violent offenders and protect the public, including previous victims, from serious harm. MAPPA brings together the professionals working with an offender to assess the risk that he/she presents and to devise a robust plan to manage that risk. Housing, mental health, and local authority safeguarding services all have a role to play by sharing information and identifying risks. For more information, see Ministry of Justice (2014).

Working with people who have, or are alleged to have, caused harm is part of the prevention agenda. In instances where people have care and support needs and are identified through MAPPA as high risk, careful consideration and a joined-up approach to manage risk with all parties might be achieved by adopting the MSP approach.

MAPPA and MARAC are formal statutory structures. Some local authorities have found additional structures to support safeguarding useful, as the following examples show.

Multi-Agency Safeguarding Hubs (MASH)

A MASH is a multi-agency team which co-locates key safeguarding agencies with a view to better identifying risks to children and adults and improving decision-making, interventions and outcomes. The creation of a MASH in a locality enables the multi-agency team to appropriately review their information systems, share all appropriate information in a secure environment, and ensure that the most appropriate response is provided to effectively safeguard and protect the adult at risk.

The final report on the Multi Agency Working and Information Sharing Project (Home Office, 2014) outlines different models for multi-agency safeguarding work and the benefits and challenges in the MASH model.

The agreed core functions of a multi-agency hub were listed as:

1. Acting as a single point of entry – gathering all notifications related to safeguarding in one place.
2. Enabling thorough research of each case to identify potential risk (and therefore the opportunity to address that risk).
3. Sharing information between agencies, supported by a joint information sharing protocol.
4. Triaging referrals, exemplified in the use of agreed risk ratings.
5. Facilitating early intervention to prevent the need for more intensive interventions at a later stage.
6. Managing cases through coordinated interventions.

The report, based on 37 local authority responses, suggested that where there was a form of MASH in place there was:

- More accurate assessment of risk and need, as safeguarding decisions are based on coordinated, sufficient, accurate and timely intelligence.
- More thorough and driven management of cases. Some felt this was the key benefit of multi-agency hubs, as it avoids cases getting ‘lost’ in the system, and ensures leads are chased up.
- Better understanding between professions, both in terms of the terminology used and the general approach to safeguarding.
- Greater efficiencies in processes and resources.

(Home Office, 2014)

Multi-agency Risk Management Systems

Some local authorities, for example Plymouth, Sheffield, Rochdale and Derbyshire, have set up Multi-agency Risk Management Systems. These coordinate responses to high-risk situations where the adult has capacity to make choices that are putting them at risk of extreme harm or death, and is not engaging with the services offered.

The system is useful where there is a public safety interest, a high level of concern from partner agencies, and where previous interventions have failed to safeguard the adult.

For some examples, see Rochdale Borough Safeguarding Adults Board's Multi-agency Risk Management Protocol (version 13):

www.rbsab.org/UserFiles/Docs/MRM%20protocol%20-%20v13.pdf

Hampshire and Isle of Wight's 4LSAB Multi-Agency Risk Management Framework (March 2016) developed in partnership by the four local Safeguarding Adult Boards

www.hampshiresab.org.uk/wp-content/uploads/Multi-Agency-Risk-Management-Framework-16-02-16.pdf

Safeguarding adults: Practice issues

Mental capacity

The Mental Capacity Act (MCA) 2005 and the accompanying code of practice provide a statutory framework to empower and protect people who may lack capacity to make decisions for themselves. This has particular relevance in relation to safeguarding. The MCA provides the legal framework for acting on and making decisions on behalf of individuals aged 16 or over who lack mental capacity to make certain decisions for themselves. Everybody must comply with the Act.

Mental incapacity is an inability to make a particular decision at a particular time due to 'an impairment of, or a disturbance in the functioning of, the mind or brain' (Section 2, MCA). It does not matter whether the impairment or disturbance is permanent or temporary.

Most people can make some decisions for themselves, and people should not be treated as unable to make a decision unless it is shown they cannot. Section 3 of the MCA provides a functional test of when a person is unable to make a decision for themselves. Someone is unable to make a decision if they are unable to:

- understand information relevant to that decision
- retain information relevant to that decision
- weigh up or use information relevant to that decision
- communicate their decision (whether by talking, sign language or any other means).

A person must not be regarded as unable to understand information if they can understand it when given in a way appropriate to their circumstances (eg, using simple language or visual aids). And the fact that a person may only be able to retain information for a short time does not in itself prevent them from being regarded as able to make the decision.

It is important to note that if a person makes an unwise decision, it does not necessarily mean they lack mental capacity.

When someone is unable to make a decision and that decision is to be made on their behalf under the Act, the decision must be made in their best interests. The MCA does not define 'best interests', because so many different types of decisions and actions are covered by the Act, but Section 4 sets out what professionals are required to do to ensure they are acting in the person's best interests. The MCA Code of Practice (Department for Constitutional Affairs, 2007) includes a checklist of common factors that must always be considered when deciding what is in a person's best interests.

- Working out what is in someone's best interests cannot be based merely on someone's age, appearance, condition or behaviour (see paragraphs 5.16-5.17 of the Code of Practice – Department for Constitutional Affairs, 2007).
- All relevant circumstances should be considered when working out someone's best interests (paragraphs 5.18–5.20).
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision (paragraphs 5.21–5.24).
- If there is a chance the person will regain the capacity to make a particular decision, it may be possible to defer the decision until later if it is not urgent (paragraphs 5.25–5.28).
- Special considerations apply to decisions about life-sustaining treatment (paragraphs 5.29–5.36).
- The person's past and present wishes and feelings, beliefs and values should be taken into account (paragraphs 5.37–5.48).
- The views of other people who are close to the person who lacks capacity should be considered, as well as the views of an attorney or deputy (paragraphs 5.49–5.55).

The checklist is only a starting point, however. It is important not to take shortcuts in working out best interests. Professionals must take into account all relevant factors that it would be reasonable to consider, not just those the professional thinks are important.

A proper and objective assessment must be carried out on every occasion. If a decision is urgent, there may not be time to examine all possible factors, but the decision must still be made in the best interests of the person who lacks capacity.

Section 1 of the MCA sets out five statutory principles that apply to assessment and best interests decisions. These principles are also set out in the Code of Practice (Department for Constitutional Affairs, 2007: 19):

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under the *Mental Capacity Act 2005* for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The MCA Code of Practice (Department for Constitutional Affairs, 2007) provides an overview of how the Act works, including the process for determining whether or not a person has the capacity make a particular decision. However, that process has now been augmented by case law. PC v City of York [2013] EWCA Civ 478 makes clear that the assessment must also pay close attention to the 'causative nexus'. What this means is that if a person has an impairment and lacks one of the functional abilities set out in Section 3 of the MCA (see above), then it is necessary to show that the functional inability is caused by the impairment. This means an assessment has three effective stages: (i) impairment; (ii) functional inability; and (iii) causation between (i) and (ii).

Most health and social care organisations have provided training for practitioners in the use of the MCA and have developed appropriate recording systems relating to assessments and decision-making. Research questions the effectiveness of one-off training, and suggests that workplace based learning and development facilitated by senior staff or trainers within an operational setting may work more effectively to embed the principles of the Act in practice (Gough and Kerlin, 2012).

It is important to record the outcome of any capacity assessment that you do, explaining why you think the person has, or doesn't have, capacity. A capacity assessment involves working out if a person understands the decision they need to make, and why it needs to be made; if they understand the consequences of the decision; if they are able to retain, use and weigh up information relevant to the decision; and if they can communicate their decision by any means. You should do everything you can to support someone to make a decision, such as asking them when they are at their most alert, providing supports such as communication aids, and using accessible language or other communication forms. If they do not have decision-making capacity, you must record all the ways that you have tried to support them to make the decision.

Further reading

The NICE guidelines on Decision-making and mental capacity (NICE 2018) aim to help health and social care practitioners support people who may have difficulty making their own decisions:

www.nice.org.uk/guidance

Case study:

Somerset v MK [2014] EWCOP B25

www.bailii.org/ew/cases/EWCOP/2014/B25.html

This case was a real example (as the solicitor said) of 'local authorities believing that their safeguarding powers can override their duties under the *Mental Capacity Act* and the requirement that there is lawful authorisation in place for their actions, however well intended'. In the case, a local authority was criticised for removing a young woman living with severe learning disabilities from her family while initially unexplained bruising was investigated. Unfounded allegations were made against her relatives, which were very upsetting, and the woman made it absolutely clear – by packing her bags, and taking staff by the hand to pull them to the door – that she wanted to go home. She became so upset at being separated from her family that she was medicated to subdue her behaviour.

Messages for practice include:

- When considering actions intended to safeguard a person, social workers and others must ensure they are not unduly breaching the rights of the person and of their relatives or friends.
- Management must ensure that social workers are correctly supported in their learning and practice around human rights and the *Mental Capacity Act (MCA) 2005*.
- Investigations must be timely and, in the words of this judgment, approach facts objectively rather than ‘decide what the picture was and then make the facts fit the picture.’

Case study:

London Borough of Redbridge v G & Ors [2014] EWCOP 17

Social workers, neighbours and friends were concerned that paid carers were abusing G, a woman of 94. C and F were systematically bullying, manipulating and misleading G into thinking that her only options were being cared for by them, or going into residential care. Despite very widespread concerns, G maintained that she wanted the carers, C and F, to remain in her house: she made a Lasting Power of Attorney (LPA) for health and welfare in C’s favour, and was in the process of changing her will to leave them everything. There was agreement that G lacked capacity to make decisions about where she should live and concerns around the coercive behaviour of the carers.

The case was heard at the Court of Protection and provides a good example of taking action to enable the person to participate fully. The social worker was praised for the measured and professional tone of her evidence. The case shows the importance of professionals building the trust of the person, and spending time with them alone, in order to understand the complete picture – even when the person may be expressing strong wishes or feelings.

Further reading

Pike L (2016c) Guidance sheet two: Mental capacity and coercion – what does the law say? Available online: **http://coercivecontrol.ripfa.org.uk/wp-content/uploads/Guidance_sheet_two_Mental_capacity_and_coercion.pdf**

RiPfA's Case Law and Legal Summaries **www.ripfa.org.uk/resources/case-law-summaries** (London Borough of Redbridge v G & Ors is summarised in July 2017's edition).

Reflective points

How do you uphold the MCA principles in your work?

How do you check and account for the effect of coercion on a person's mental capacity?

Deprivation of Liberty Safeguards

The *Mental Capacity Act 2005* Deprivation of Liberty Safeguards (MCA DoLS) are intended to provide legal protection for people who lack capacity to make decisions on matters relating to their care and/or treatment, who may be deprived of their liberty within the meaning of Article 5 of the European Convention on Human Rights. (In 2018, following a review by the Law Commission, the Government introduced a Mental Capacity (Amendment) Bill, which would replace DoLS with a new system of Liberty Protection Safeguards (LPS) – see below.)

DoLS can only be used if a person is in hospital or a care home (although the Mental Capacity (Amendment) Bill proposes that the LPS would apply in any setting). There may sometimes be an overlap between safeguarding and DoLS, for example where a restriction become abusive.

The DoLS were introduced in 2007 (coming into force in 2009) following a ruling from the European Court of Human Rights. The court found that a man with autism had been unlawfully deprived of his liberty in Bournewood Hospital, because it had not used any legal framework to detain him. Because of this, his carers found it very difficult to get him released from hospital since there was no system to appeal against him being kept there.

A Supreme Court ruling in 2014 in the case of Cheshire West clarified what is now known as the ‘acid test’ for what constitutes a deprivation of liberty. A DoL happens when:

> *‘The person is under continuous supervision and control is not free to leave, and the person lacks capacity to consent to these arrangements’*
>
> **P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor [2014] UKSC 19).**

Where the acid test is met, or is likely to be met within the next 28 days, a standard DoLS authorisation must be sought (MCA Schedule A1, s.24). In urgent cases, the managing authority must, in the meantime, also make an urgent authorisation in writing (Schedule A1, s.76). Even with the ‘acid test’, it can sometimes be difficult to be clear when the use of restrictions in someone’s support crosses the line to a deprivation of liberty. In its guidance on DoLS, the Social Care Institute for Excellence (SCIE) advises that if the following features are present, a DoL application should be considered:

- frequent use of sedation/medication to control behaviour
- regular use of physical restraint to control behaviour
- the person concerned objects verbally or physically to the restriction and/or restraint
- objections from family and/or friends to the restriction or restraint
- the person is confined to a particular part of the establishment in which they are being cared for
- the placement is potentially unstable
- possible challenge to the restriction and restraint being proposed to the Court of Protection or the Ombudsman, or a letter of complaint or a solicitor’s letter
- the person is already subject to a deprivation of liberty authorisation which is about to expire.

(SCIE, 2015a)

The DoLS process has been misused to detain people in violation of their human rights. For example, Steven Neary was taken into respite care for a few days as his father (and carer) was ill, and detained for a year despite both he and his father wanting him to return home. The judge said:

> *‘The DoLS scheme is an important safeguard against arbitrary detention ... It is not to be used by a local authority as a means of getting its own way... Using the DoLS regime in that way turns the whole spirit of the MCA on its head, with a code designed to protect the liberty of vulnerable people being used instead as an instrument of confinement ... The DoLS process was used to mask the real deprivation of liberty, which was the refusal to allow Stephen to go home.’*
>
> **(London Borough of Hillingdon v Neary & Anor [2011] EWCOP 1377 (9 June 2011)**

Following a two-year review, in March 2017 the Law Commission published proposals for a replacement scheme for DoLS. The Law Commission found DoLS had been subject to heavy criticism since their inception, were 'overly technical and legalistic', and too often failed to achieve positive outcomes for the person concerned or their family. The Commission concluded there was a 'compelling case' for replacing DoLS. In March 2018, the Government published its response (HM Government, 2018), which agreed 'in principle' that the DoLS system should be urgently replaced. In July 2018, the Government introduced the Mental Capacity (Amendment) Bill, which would amend the MCA by introducing a new Schedule AA1 to replace DoLS with a new system of Liberty Protection Safeguards (LPS). The Government's Bill is based on a draft Bill published as part of the Law Commission's report. While the Bill has proved controversial, the Government expects it will receive Royal Assent in 2019.

Restraint

Pan London Multi-Agency Adult Safeguarding Procedures give the following description of restraint:

> *'Unlawful or inappropriate use of restraint or physical interventions. In extreme circumstances, unlawful or inappropriate use of restraint may constitute a criminal offence. Someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or where a person's freedom of movement is restricted, whether they are resisting or not.*
>
> *'Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do, for example, the use of keypads to prevent people from going where they want from a closed environment.'*
>
> **(London ADASS, 2016: 29)**

The law is clear on when restraint is permissible. Restraint is only permitted if a person lacks the relevant capacity with regards to an act in connection with their treatment or care, and the restraint is necessary to prevent harm to them, and the restraint is proportionate to both the likelihood and seriousness of that harm (Section 6, *Mental Capacity Act 2005*).

Further reading

SCIE (2015a, reviewed 2017) DoLS At a glance

www.scie.org.uk/mca/dols/at-a-glance

Series L (2014) *'What are the Deprivation of Liberty Safeguards (DoLS)? Brief Guide.* Dartington: Research in Practice for Adults

Age UK (2018) Factsheet 62: Deprivation of Liberty Safeguards

www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs62_deprivation_of_liberty_safeguards_fcs.pdf

RiPfA's Case Law and Legal Summaries
www.ripfa.org.uk/resources/case-law-summaries

Advocates and their role in safeguarding

Advocacy is underpinned by the principle of empowerment. It is about upholding human rights and ensuring that adults are supported to make decisions and action takes account of the adult's wishes and views. Independent advocacy enables people to have more choice and control over their own lives, making care provision more personalised and safeguarding the rights and dignity of people deemed 'vulnerable' or 'at risk'. Some authors argue advocacy has potential to shift the power balance in safeguarding decision-making towards people who use services (Cambridge and Parkes, 2004).

The Advocacy Charter (revised 2018) defines advocacy as:

> ***'Taking action to support people to say whet they want, secure their rights, pursue their interests and obtain services they need.***
>
> ***Advocacy providers and advocates work in partnership with the people they support and take their side, promoting social inclusion, equality and social justice.'***
>
> (National Development Team for Inclusion, 2018)

The Advocacy Charter draws on work done previously by other organisations, including Action for Advocacy.

Section 68 of the *Care Act 2014* requires that a local authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review if they have serious difficulty in understanding, retaining, weighing or using information or communicating their views, and there is no other appropriate individual to help them (see diagram on page 51). The Act also states that the advocate must be independent of the local authority; this means local authority social workers are unable to fulfil the role. Lawson's (2017b) guide on what good advocacy might look like in the context of Making Safeguarding Personal is a useful reference point.

In 2014 the Advocacy Code of Practice, which incorporates Advocacy Charter principles, was revised by the National Development Team for Inclusion (NDTi) to reflect changes in legislation and developments in practice. Also in 2014 the NDTI's re-launch of the Quality Performance Mark (QPM) included an additional set of indicators to ensure advocacy providers and advocates are knowledgeable and experienced in identifying safeguarding issues. This followed the abuse and neglect exposed at Winterbourne View and Mid-Staffordshire hospitals. (In May 2018 NDTI launched a fourth version of the QPM following feedback and learning from advocacy organisations; see: **https://qualityadvocacy.org.uk/2018/05/30/new-version-of-the-qpm-award-launched**)

The QPM highlights some important issues for advocates in relation to safeguarding. These include assisting a person to:

- Decide what outcomes/changes they want.
- Understand the behaviour of others that are abusive/neglectful.
- Understand which actions of their own may expose them to avoidable abuse or neglect.
- Understand what actions that they can take to safeguard themselves.
- Understand what advice and help they can expect from others, including the criminal justice system.
- Understand what parts of the process are completely or partially within their control.
- Explain what help they want to avoid reoccurrence and also recover from the experience.

Advocacy has been identified as preventing safeguarding situations from arising (Faulkner, 2012), while a lack of advocacy was noted as a theme in an analysis of Serious Case Reviews (Braye et al, 2015c).

Types of advocacy

Appointing an **Independent Advocate** under the *Care Act 2014* is a two-step process (as shown in the diagram on page 51):

Step 1. Assessment of 'substantial difficulty'.

Step 2. Determining whether there is an 'appropriate individual' to assist.

Independent Mental Capacity Advocates (IMCAs) can be appointed to assist and support individuals concerning decision-making and issues around capacity. The IMCA service was introduced by the *Mental Capacity Act 2005*. IMCAs are generally provided to support individuals who do not have relatives or other interested parties to act and assist them in an advocacy role. If there is no one else available to represent a person, an IMCA must be appointed in certain circumstances; for safeguarding, the relevant circumstances are if the local authority is changing a person's residence for more than 8 weeks or depriving the person of their liberty (see Sections 37-39 of the *Mental Capacity Act 2014*).

However, when a situation might include safeguarding issues, an IMCA can be appointed even if there are family members, relatives or other interested parties involved with the person. This can act as an important additional safeguard within the situation, since it acknowledges that family members could be directly involved in the mistreatment and not able to act in the individual's best interests, or that there may be other conflicts of interest that would make it difficult for them to be impartial.

There are distinct differences between an IMCA introduced under the Mental Capacity Act 2005, and an Independent Advocate introduced under the Care Act 2014. Independent Advocates cannot undertake advocacy services under the Mental Capacity Act 2005; however, appointed IMCAs may also provide advocacy for safeguarding under the Care Act 2014 where they are already working with that person.

Other types of advocate include:

Independent Mental Health Advocate (IMHA) - under the *Mental Health Act 1983*, 'qualifying patients' can access help and support from an IMHA. If a safeguarding enquiry begins while an IMHA is working with someone, the option for the same IMHA to support them should be given.

Independent Domestic Violence Advisor (IDVA) – IDVAs support victims of domestic abuse who are at high risk of harm. The main aim is to ensure the safety of the victim and the victim's children, where relevant. IDVAs assess the level of risk and work with the person to develop a safety plan. They work short- to medium-term and have to undergo specialist training.

Independent Sexual Violence Advocate (ISVA) – ISVAs provide support to people who are considering reporting or have reported rape, sexual abuse or sexual assault to the police. They provide practical and emotional support by helping victims understand how the criminal justice process works, and providing signposting and information.

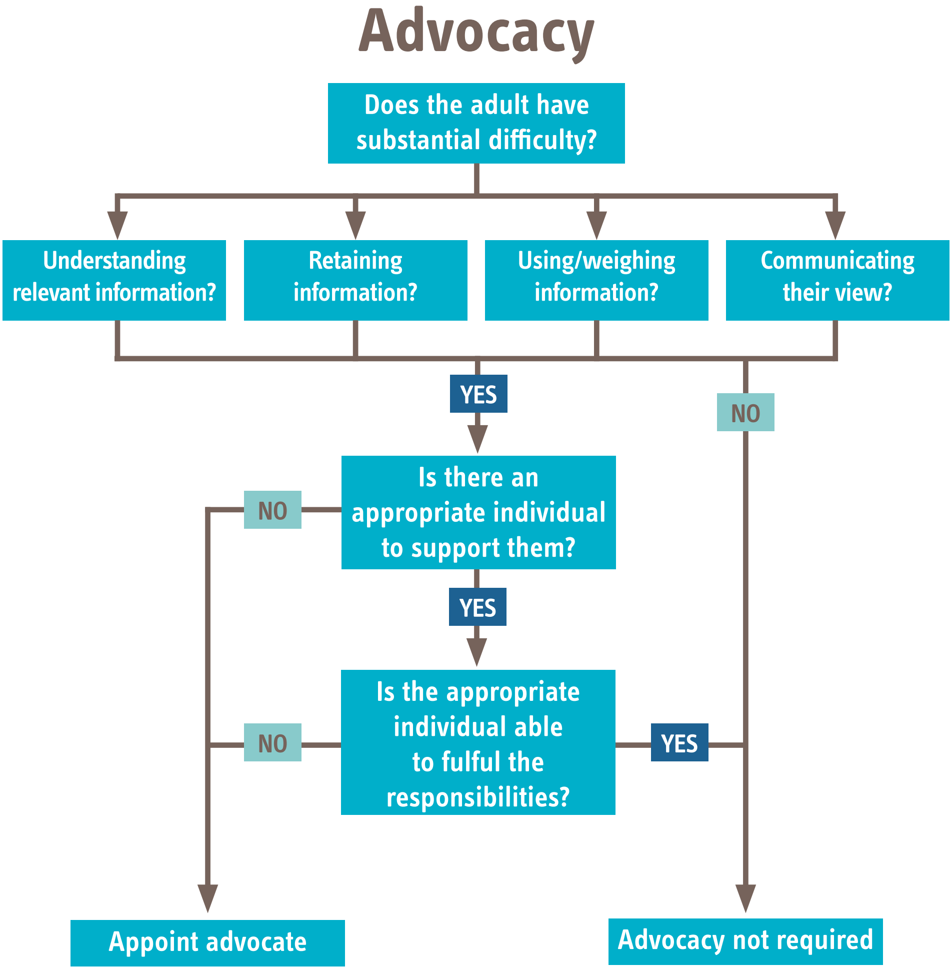
Providing support to adults with care and support needs in safeguarding is not just about advocacy. A requirement under the *Equality Act 2010* is for provision and adjustments to enable disabled people equal access to information and advice. Ensuring equality may reduce or remove substantial difficulty. Access to other services (for example, translators) should always be considered to ensure that the adults are afforded every opportunity to participate and be involved.

Further reading

Lawson J (2017b) *Making safeguarding personal: What might 'good' look like for advocacy?* LGA and ADASS

The following diagram is reproduced from the *London Multi-Agency Adult Safeguarding Policy and Procedures* (London ADASS, 2016).

When to appoint an independent advocate in safeguarding (adapted from the *Care Act, 2014*)



An 'appropriate individual' cannot be anyone who is 'engaged in providing care or treatment for the adult in a professional capacity or for remuneration' (Section 68(4)(b) *Care Act 2014*). If the person 'has capacity to consent to being represented and supported' by the appropriate individual, then consent is required (Section 68(5)(a)). If the person lacks capacity, the local authority must be satisfied it is in the person's best interests to appoint the appropriate individual (Section 68(5)(b); this means they should still be consulted and their views taken into account (see Section 4, *Mental Capacity Act 2005*).

Safeguarding adults: Process and practice

The basis of a safeguarding enquiry should be a conversation about the outcomes that the person or their advocate wants to achieve. Local authorities may use a structure to frame and monitor progress of the conversation. Practitioners should ensure they know what the local terms are and refer to local policy and procedures when dealing with abuse or neglect.

Which agency leads a safeguarding enquiry?

The local authority is generally the lead agency for safeguarding matters. However, it can cause others to make enquiries under Section 42. This can happen when another organisation is in the best position to lead on the enquiry (for example, a hospital team leading on an enquiry about pressure ulcers). The degree of involvement of the local authority will vary from case to case. At a minimum, it is likely to involve:

- decision-making about how the enquiry will be carried out
- oversight of the enquiry
- decision-making at the conclusion of the enquiry about what actions are required
- ensuring data collection is carried out
- quality assurance of the enquiry.

In some instances, the type of enquiry will determine who will be the lead agency. For example, the police are the only agency with the authority to investigate crime and, where the concern may be a criminal matter, they are the only agency who can determine whether something was a crime or not. In such circumstances, the local authority or another agency may need to work alongside the police to carry out best interest decisions where the adult may lack mental capacity to understand the criminal process, or to undertake risk assessments taking account of the personal strengths and resiliencies of the adult. This means that the safeguarding adults team will follow up safeguarding actions whilst the police undertake their investigations.

Lawson (2017c: 8) highlights that many methods used by the police can support Making Safeguarding Personal. These include:

- Achieving Best Evidence interviews.
- The use of special measures and intermediaries for vulnerable and intimidated witnesses.
- Use of advocates, including Independent Domestic Violence Advocates (IDVAs) and Appropriate Adults.
- The Victims’ Code.
- Restorative justice.
- Multi-agency Safeguarding Hubs (MASH) and the police role in these.
- Multi-agency risk assessment conferences in relation to Domestic Abuse (MARAC). There is growing awareness of the need to ensure that the victim’s views and wishes are heard especially if they are not present (see page 36).

Alternatively, it may be appropriate for one organisation to lead on the enquiry through HR disciplinary processes, whilst the local authority or another organisation lead on other aspects of the enquiry by working with the adult on risk enabling and achieving their desired outcome(s).

Health-related enquiries are best led by professionals with the clinical knowledge and skills to determine whether a concern is a safeguarding matter, perhaps relating to poor quality care and possible neglect, or symptomatic of a person's medical condition. Clinical commissioning groups may lead on such enquiries to avoid any conflict of interest within health provider organisations. Serious Incident Frameworks can be used to satisfy Section 42 requirements and achieve the outcomes people want through root cause analysis. Involvement and support for the person is embedded in the process.

There has been a growing realisation that staff working in the non-specialist housing sectors should also have adult safeguarding policies, procedures and training due to the increasing numbers of adults at risk living in general needs housing stock. The Housing and Safeguarding Adults Alliance strongly encourage social care to ensure that guidance and training is given to housing support staff when asked to 'make enquiries' under Section 42.

Further reading

SCIE (2016) 'Preventing abuse and neglect: Guidance for housing managers'

www.scie.org.uk/publications/guides/guide53/housing-managers/preventing-abuse-and-neglect

Lawson J (2017c) Making safeguarding personal: what might 'good' look like for police? LGA and ADASS.

Concerns

A safeguarding concern should be brought to the attention of the local authority whenever someone is aware that an adult with care needs might be experiencing, or is at risk of, abuse or neglect and is unable to protect themselves from it (see types of abuse on page 10). Organisations must make it clear how to escalate concerns. Anyone can tell the local authority about a concern – this includes the person themselves, family, friends, neighbours and staff.

If an adult is in immediate danger, the relevant emergency service should be contacted and immediate steps taken, if/as necessary.

The *Care Act* guidance is clear that staff should not try to 'second-guess the outcome of an enquiry in deciding whether or not to share their concerns' (DHSC, 2018: 14.199). In many cases that have led to either Serious Case Reviews or Safeguarding Adults Reviews, an understanding of the situation has only been developed after numerous people escalated concerns. It is important that concerns are raised (with the consent of the person wherever possible) if abuse or neglect is suspected.

Once the local authority has received a concern, it will decide whether it meets the threshold for a Section 42 enquiry or if another course of action would be more appropriate. If you have escalated a concern and are not satisfied that it is being responded to appropriately, discuss it in supervision with your manager, and don't be afraid to bring it to the local authority's attention again.

The Pan London Multi-Agency Adult Safeguarding Procedures suggest the following actions by the person putting forward the concern:

> The person who raises the concern has a responsibility first and foremost to safeguard the adult at risk.
>
> **a.** Make an evaluation of the risk and take steps to ensure that the adult is in no immediate danger.
>
> **b.** Arrange any medical treatment. (Note that offences of a sexual nature will require expert advice from the police.)
>
> **c.** If a crime is in progress or life is at risk, dial emergency services – 999.
>
> **d.** Take steps to preserve any physical evidence if a crime may have been committed, and preserve evidence through recording.
>
> **e.** Ensure that other people are not in danger.
>
> **f.** Report the matter to your line manager.
>
> **g.** If children or young people are at risk, a referral to children's safeguarding services must be made.
>
> **h.** Record all information as soon as possible.
>
> (London ADASS, 2016: 67)

Reflective point

Councils may wish to consider periodic analyses of concerns that were not progressed under safeguarding to build up a picture of the cases that come to their attention. This may act as further quality assurance that the right decisions have been made.

Recording low-level concerns

If information is received about low-level concerns which may not trigger any subsequent specific action, this needs to be recorded and may need to be passed on to others (for example, commissioners). In addition, if the information could have an impact on service provision, then provider agencies are likely to need to know about this.

Learning from Serious Case Reviews and Safeguarding Adults Reviews has shown that 'low-level concerns' are often overlooked. In one case, visits made to Accident and Emergency departments, and contacts with the police or housing services about minor matters were not shared with and between other agencies. Another found that persistent reports of anti-social behaviour were viewed in isolation, without recognition of the vulnerability of the people involved. A further review found that NHS Commissioners had no means of identifying patterns of concern about quality and safety; although 38 alerts had been made, commissioning managers were only aware of one fifth of them. In three cases – Steven Hoskin (Flynn, 2007), Fiona Pilkington (Leicester, Leicestershire and Rutland SAB, 2008) and Winterbourne View (Flynn, 2012) – the frequency of events and potential patterns of developing concern were not put together.

It is necessary to be aware of the potentially cumulative effect of incidents or concerns about care homes, domiciliary care or other provider services. While one-off incidents of missed visits or wet beds may not warrant further investigation on their own merits, authorities need to have effective systems in place to record and share information between departments and other agencies, enabling prompt identification should incidents accumulate in a particular home or service. Cumulative incidents are also an important consideration for individuals, for example in cases of domestic violence or incidents between people who use services. A shared information database that can be accessed by colleagues in all agencies would facilitate information sharing.

Reflective point

How does your organisation currently share low-level concerns?

Will any changes to this be needed in line with the General Data Protection Regulation (GDPR) (see page 23)?

Initial information gathering

To decide whether to begin a safeguarding enquiry or take alterative action, some initial information gathering may be needed.

Firstly, if there is any suspicion of a criminal act, the first point of contact should be the police. All attempts should be made to secure any evidence of the crime until the police can advise further. Finding out who the named safeguarding police officer is, or building up a rapport with the local Community Safety Unit for ongoing support and advice will help support multi-agency working. Research (Clarke et al, 2016) has found that disabled and older people's access to justice can be limited, and it is important to support people to access this right. Policing codes underline that everyone, regardless of whether they are termed a 'vulnerable victim' by police or not, has the same right to access justice. They also emphasise 'putting the victim first; responsive and supportive systems; treating people with respect and sensitivity' (Lawson, 2017c: 9).

If there is no evidence that a crime has been committed, an individual will be responsible for collating relevant information with the support of their manager or safeguarding coordinator. If you are this person, the responsibility for collecting the information and discussing the case with all the relevant agencies lies with you. This does not mean you should bear this responsibility in isolation. Discuss with your manager and your peers, gain support, and ensure you are supported by your agency's policies and procedures.

Discussion and interviews with people who use services should be your starting point. Efforts should be made to ensure that the person feels safe and secure throughout, and that they are able to raise and discuss any concerns they have. Practitioners should ask open questions to enable them to understand the issues without conducting a formal interview. Remember to keep in mind the person-centred principles to safeguarding.

The purpose of the initial information gathering stage is to establish whether the concern should progress to a referral to adult safeguarding, and to establish the level of involvement that the person wishes to have in the process (if it is initiated). Issues to explore in the information gathering stage include:

- If they are currently at risk of abuse and/or neglect.
- Whether they wish the referral process to proceed, and whether they have the mental capacity to make that decision.
- How involved they wish to be in the safeguarding process.
- Whether they need or would like an advocate to attend.
- Communication needs, and whether an interpreter or other support is needed.
- Whether there needs to be any adjustment to the adult's personal care and support arrangements.

Key message: Make sure that you find out from the person what they want to happen and whether they would like a safeguarding enquiry to begin.

Will there need to be a Section 42 enquiry?

Once the initial information has been gathered, a decision will be taken about whether an enquiry is needed. The decision is based on the initial assessment and reports, the person's views and wishes, and the professional judgment of the manager in conjunction with the other professionals involved. Where the three step criteria below is met, the *Care Act* guidance (DHSC, 2018: 14.10) states that local authority must make enquiries, or cause others to do so.

A person has care and support needs.

They may be experiencing or at risk of abuse and/or neglect.

They are unable to protect themselves from that abuse and/or neglect because of their care and support needs.

Three-step criteria for making Section 42 enquiries

If the person is not defined as someone who has care and support needs (regardless of whether or not they are in receipt of services), there is no duty to make an enquiry. If it is decided that the situation does not constitute abuse, or if safeguards have already been put in place that the person is satisfied with, then an alternative course of action may be taken. However, learning from Safeguarding Adults Reviews shows that screening out Section 42 requests can mean that crucial information is not shared, so opportunities for joined-up, multi-agency approaches should always be sought.

It's important to remember that the safeguarding duty applies to people with care and support needs regardless of whether those needs are being met, as Bateman explains:

> *'Practitioners should note that the Care Act (2014) 'eligibility criteria' are not relevant in relation to safeguarding. Safeguarding inquiries should be made on the understanding of the risk of neglect or abuse, irrespective of whether the individual would meet the criteria for the provision of services. Operational guidance on screening safeguarding concerns... requires practitioners to exercise professional judgement based on consideration of the wellbeing principles set of in s1 of the Care Act (2014).'*
>
> **Bateman (2017: 155)**

Where a member of staff is alleged to have caused harm, the organisation's disciplinary process may also need consideration. Disciplinary processes may run alongside a Section 42 enquiry where a member of staff is the person alleged to have caused harm, but they should not be used as a substitute for a safeguarding enquiry. These processes should be carried out regardless of whether a referral progresses to a Section 42 enquiry, as they perform separate functions. For example, the outcome that the person wants may not be achieved through a disciplinary process; and employment rights issues will not be addressed by a Section 42 enquiry.

If you have concerns that an individual has harmed, or poses the risk of harm to ‘vulnerable groups’, you need to take appropriate action in addition to bringing a safeguarding concern to the attention of the local authority. Consider:

- contacting the police
- disciplinary action under your organisation’s HR processes
- checks/referral to the Disclosure and Barring Service.

In some instances a criminal offence may have been committed. The police determine whether there should be criminal investigations by people in positions of trust where there is ill- treatment and wilful neglect. The person leading the enquiry should refer any apparent breaches of health and safety to their organisation’s health and safety lead. Suspected instances of organisational abuse should be referred to the Care Quality Commission and relevant professional bodies, such as the Nursing and Midwifery Council or the Health and Care Professions Council.

Feedback to people bringing the concern to the attention of the local authority

It is important that practitioners provide feedback to the person/organisation raising the concern regardless of the course of action to be taken. Where possible safeguarding adults referral points should advise the adult directly, so that they have an opportunity of providing additional information, agreeing to an alternative course of action, or making a representation if they disagree with the decision.

It is important for organisations to know as soon as possible whether the matter is to progress to an enquiry so they can work with safeguarding teams and the adult. Feedback can be utilised by organisations to gain a better understanding of safeguarding adults.

Occasionally situations arise when workers within one agency feel that the actions, inaction or decisions of another agency do not adequately safeguard an adult. Establishing an inter-agency policy for resolving such professional difference must be agreed by the Safeguarding Adults Board. Disagreements can arise in a number of areas, including:

- levels of need
- roles and responsibilities
- the need for action
- progressing plans and communication.

In the event that there is disagreement between professionals open dialogue between organisations to talk through differing views is encouraged. The safety of the adult must remain paramount, together with swift resolution.

Key message

Feedback must be provided to people who voice concerns. Multi-agency policies with broad sign-up can help ensure that all partners know what roles and responsibilities they have in relation to safeguarding.

Undertaking a safeguarding enquiry: Conversations with the adult

When the concern is progressed to an enquiry, the local authority must make or cause to be made an enquiry under Section 42 of the *Care Act 2014*. An enquiry should establish whether any (and what) action needs to be taken to prevent or stop abuse or neglect.

The *Care Act* guidance explains that safeguarding should be outcomes-focused: what people want to achieve. Outcomes are identified through good conversations with people with care and support needs. Outcomes-focused conversations work best with the application of relationship-based working. Getting the conversation right from the start is critical to building relationships that are honest, open and trusting.

Whilst it is essential to put the adult at ease and to build up a rapport, the objectives of an enquiry should focus the conversation. These are:

- Establish facts.
- Ascertain the adult's views and wishes.
- Assess the needs of the adult for protection, support and redress and how they might be met.
- Protect the person from the abuse and neglect, in accordance with the wishes of the adult (or in the best interests of an adult found to lack the relevant mental capacity).
- Make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect.
- Enable the adult to achieve resolution.

(DHSC, 2018: 14.94)

This is a significant departure from previous approaches to safeguarding adults that focused on 'investigations' to find out whether allegations were 'substantiated' or 'unsubstantiated'. This related much more to the process of safeguarding than to the overall impact of the safeguarding enquiry on the person (did it make a positive difference to their lives?). An outcomes-focused conversation aims to rebalance this.

Practitioners need to handle enquiries in a sensitive and skilled way to ensure minimal distress to the adult. Where information is already known, people should not have to repeat their account, although this doesn't prevent clarification being sought where necessary.

There are several practical issues that should be considered prior to holding this key conversation:

- Where would the person prefer to talk to you – and is it possible to talk to them on their own?
- Where would be a safe place for you to meet?
- Do you have accessible information to provide to them, and additional support to signpost them to if necessary?

There is some evidence that people from minority communities are more likely to discuss sensitive issues such as abuse with somebody who speaks the same language and is able to understand their specific perspective. On the other hand, such arrangements may be seen as problematic in terms of confidentiality, if the person providing support is closely associated with, for example the same BAME or dDeaf community as the alleged perpetrator.

Agencies should not assume that just because a professional belongs to the same BAME group as the person accessing services, she/he is competent and best positioned to provide support. Allocation of cases based on the worker's ethnic background may have a negative impact on their professional development and reinforce the problematic message that cultural competence is something that people have by virtue of their belonging to a particular ethnic group, rather than something they need to learn and develop.

Talking through the safeguarding issues may resolve the situation in some cases. If not, a plan needs to be drawn up. If the adult no longer wishes to pursue the enquiry, the safeguarding lead must decide whether further action under Section 42 should continue without their consent or involvement. Decisions should be made on a case-by-case basis. A decision about what is in the public interest needs to balance the rights of the individual to privacy with the rights of the individual (protecting their Article 2 and 3 rights) and others to protection.

Throughout the safeguarding enquiry practitioners must remember the impact that the abuse may be having, or has had, on the adult with regard to making decisions. Are they still fearful for their safety? Are they subject to undue influence or coercion from the alleged perpetrator? Is their capacity being affected by coercion or intimidation?

Case example: Public interest

Mariam has disclosed to a social worker that she thinks a domiciliary worker has stolen money from her. She does not want to contact the police, neither does she want the worker questioned by their employer as she likes the worker and does not want to get them into trouble, and considers the amount allegedly stolen inconsequential. The public interest in this case is that the worker visits a number of other adults with care and support needs, and is a person in a position of trust. The situation should be looked into to protect Mariam and others, including the worker who has had the allegation made against them. If the person alleged to have caused harm was a family member and no other adult with care and support needs was likely to be affected, then there may be no public interest, and the practitioner in this case might focus on wellbeing and how it could be enhanced by proportionate action under safeguarding.

Outcomes-focused conversations

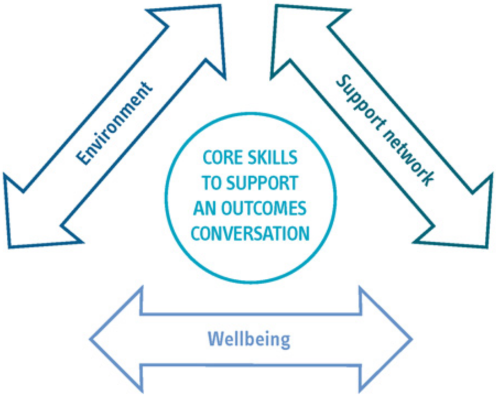
> *'Outcomes are, by definition, personalised where they relate to the priorities and aspirations of an individual person. An outcomes-focused approach must place the person at the centre of discussions from the outset, finding ways to engage and empower them so that they are able to explain their needs, concerns, problems and circumstances. Only then can the whole person, their current situation and history be understood so they can discuss and negotiate with those supporting them what their desired outcomes are and how they might be achieved.'*
>
> **(Johnstone, 2014: 2)**

There is a skill involved in eliciting information and asking the right questions. Outcomes-focused conversations ascertain what the concern is, how it impacts on the adult at risk, what action they would find acceptable, and the level of associated risk. Developing your knowledge and skills in different types of questions including open (see below), closed (did you?, when?) and circular (a method used in systemic therapy) will enable you to engage people in conversations and discuss essential information.

Open-ended questions help people to tell their story in their own words. An open-ended question is a question that requires a full answer using the subject's own knowledge or feelings. Examples of open-ended questions are:

- What happened after X left?
- Why do you think that X ... ?
- Tell me about ...
- What do you think about ... ?

The **Outcomes Triangle** (below) aims to support outcomes-focused conversations. It prompts practitioners to consider the importance of environment, support network and wellbeing of the person when discussing their outcomes, and advises on the core skills they might need for those conversations. You can find out more about the different components at **http://outcomes.ripfa.org.uk/outcomes-triangle**



The outcomes that people want from the safeguarding enquiry can change over time. This means it is important to ask about them at the beginning, throughout the process, and again at the end of the enquiry. Manthorpe et al (2014), reporting on Making Safeguarding Personal, found that people could at times identify unrealistic outcomes, but by discussing them, expectations could be managed and practice could become more person centred.

At the end of the enquiry, people should be asked about whether they feel each outcome they stated had been achieved, and this should be recorded. One way of recording this is stating whether the outcome was fully, partially or not achieved (NHS Digital, 2017). Each local authority will have its own way of recording safeguarding enquiries, so local guidance should be followed.

Tips on recording conversations about outcomes can be found at this open access resource:
http://outcomes.ripfa.org.uk/skills/recording

The MSP temperature check (Cooper et al, 2016) noted that Making Safeguarding Personal and personalisation are natural partners. The authors found that using an outcomes approach allowed practitioners to be more creative and inventive, and in fact some of the outcomes that people wanted were 'very modest: for example, an apology; reassurance that it would not happen again; recognition of the risks and how to deal with them'. Asking the person about the outcomes they want at the start of the safeguarding process means that people have more control over their safeguarding enquiry.

Further reading

McClure B (2014) *What are outcomes? Brief guide*. Dartington: Research in Practice for Adults.

Johnstone L (2014) *Working with outcomes: Practice Tool*. Dartington: Research in Practice for Adults.

Johnstone L (2017) *Good recording: Practice Tool*. Dartington: Research in Practice for Adults.

http://outcomes.ripfa.org.uk
is RiPfA's new website to support social workers and other health and social care practitioners to develop their knowledge and skills to work in an outcomes-focused way.

Family group conferences (FGCs) and mediation

Family group conferences (FGC) and mediation are two areas that are developing in addressing adult safeguarding concerns. FGCs aim to work collaboratively with an adult and their network of family, friends and supporters. Facilitated by an independent coordinator, they aim to arrive at solutions to specific problems that are agreed on (along with specific actions) in discussion with the group (Guthrie, 2017).

Mediation is an established mechanism for resolving concerns or disputes, and may include a large circle of people in the group. It is often used where there is a need for rebuilding trust, resolving conflict or improving communication. Parties must be open to seeking a solution and be willing to compromise if necessary. Careful consideration needs to be given to using mediation if the adult is not prepared to negotiate on their desired outcome, or where it could lead to increased risk for the individual. For more information see SCIE (2012).

For these methods to be effective, participants must be willing and open to reaching resolution. The potential benefits of both FGCs and mediation include:

- Empowering the adult.
- Keeping the adult at the centre.
- Facilitating the adult and their personal network to focus on a shared solution.
- Agreeing on shared solutions that may act as a preventative measure in relation to further abuse.
- Providing an equal playing field for participants.

A lack of mental capacity to make decisions about safeguarding does not rule out FGCs or mediation.

Adults who lack capacity to make decisions about their safety can participate through supported decision-making, as the MCA Code of Practice makes clear (Department for Constitutional Affairs, 2007). (A person's capacity to take part in mediation should be assessed. If they have capacity, they can consent or refuse; if they do not have capacity, then it is a question of 'best interests'.)

There are some situations where FGCs and mediation are not appropriate, however. For example, where a partner or family member is suspected of using coercive or controlling behaviour against an adult. Practitioners should check with someone with the necessary level of expertise before using these methods.

Case study:

Camden

‘Our feedback in Camden is that FGC is useful and appropriate for our communities. We do more than 250 conferences per year with a range of people. They’re free to access, the criteria for referral can be very broad, and for adults working with adult social care they can have a powerful impact ... it’s encouraging to see how FGC is being used with adults, and a burgeoning UK Family Group Conference with Adults Practice Network shows that this practice is on the move in all kinds of areas including safeguarding, disability, self-neglect and homelessness.’

Tim Fisher (2017), blog post: **www.ripfa.org.uk/blog/family-group-conference-in-social-work**

Further reading

SCIE (2012) *Safeguarding adults: Mediation and family group conferences.* Available online:

www.scie.org.uk/publications/mediation/index.asp

Taylor M and Tapper L (2017) ‘Participative practice and family group conferencing’ in Cooper A and White E (eds) *Safeguarding Adults Under the Care Act 2014: Understanding Good Practice.* London: Jessica Kingsley Publishers

Bishop K (2017) *What is a family group conference for adults? Brief Guide.* Dartington: Research in Practice for Adults.

Guthrie L (2017) *Evaluating family group conferences with adults: Practice Tool.* Dartington: Research in Practice for Adults.

Quality assurance

The local authority is responsible for assuring that the safeguarding enquiry meets standards and that any report is fit for purpose. Where there are gaps, the local authority may choose to undertake an additional enquiry. It may be helpful to agree standards across local partnerships so that the Safeguarding Adults Board is assured that enquiries make a difference. Standards might include:

- Enquiries are achieving the outcomes that the person wanted.
- There is evidence of involvement by the adult.
- Advocacy and support was available and used where needed.
- The enquiry was proportionate and timely.
- The enquiry looked at prevention.
- The person was involved in agreeing levels of risk.

Outcome and evaluation

At the end of the enquiry safeguarding leads should assess the effectiveness of the intervention. The outcomes of the enquiry should be reviewed, and a decision made about whether any further safeguarding action is needed. This should involve further conversations with the adult, and draw upon their evaluation about whether their desired outcomes have been:

a. fully met

b. partially met

c. not met.

This data is part of NHS Digital's annual safeguarding adult collection, which reports the statistics on safeguarding. In 2016-17, 93 local authorities (61 per cent) submitted voluntary data on Making Safeguarding Personal. Of those, in 67 per cent of enquiries the adult was asked about the outcomes they wanted to achieve; and where outcomes were expressed, 69 per cent of them were 'fully met' (NHS Digital, 2017).

It is also important to find out whether the person feels safer as a result of the enquiry, and to what extent. Are there any outstanding safeguarding or other actions that might be needed?

Good practice on case closure

When a case is closed, ensure that the adult, the referrer who brought the concern to the attention of the local authority and the alleged perpetrator are all contacted if they aren't already involved. The adult should have the opportunity to discuss the outcome of the case and any necessary next steps. Referrers should be contacted and told the outcome (this doesn't need to include any case details). They should receive a statement of thanks for reporting their concern and an acknowledgement that it has been addressed. People alleged to have caused harm should be contacted and informed of the decision made and the implications for them (if they are not already aware of these).

Reflective point

The most important question is – how do we know that the safeguarding enquiry has made a positive difference to the person's life? How do you find out the answer to this question in your organisation?

Supporting people alleged to have caused harm

Most enquiries will not result in legal action or sanctions; it should be recognised that alleged perpetrators are the subject of an allegation and nothing more. People alleged to have caused harm may be staff members or support workers, family members or unpaid carers, or fellow service users. There are several points in the safeguarding process where they may require support or considerations:

- They should be kept informed, as far as possible, with the progress of the enquiry throughout.
- They may require support or advocacy when interviewed or if they attend meetings.
- If staff members are suspended then this should be for as short a period as possible.
- On return to work when a suspension ends, careful consideration may need to be given about how to reintroduce the worker back into the workplace, particularly if this will mean working with or around the person subject to the enquiry.
- If the person accessing services continues to remain living with, or being supported by, the person alleged to have caused harm there may be support that could be offered to both parties.

If allegations are made towards employees it is essential that throughout the safeguarding process due regard is given to employment and disciplinary procedures, including the appropriate recording.

If allegations are made towards another person who uses services then it will be necessary to complete various stages of the safeguarding process with both the alleged victim and the alleged perpetrator. Organisations should also consider what support the alleged perpetrator may need not to abuse others. A Safeguarding Adults Review concerning a woman with learning disabilities who was physically assaulted by a fellow resident six times over seven weeks found that historical information about the perpetrator was not used to inform decisions. This meant accumulative risk was not recognised and neither the perpetrator nor the victim were supported adequately (Elwick and Burkett, 2016). If the person alleged to have caused harm is a carer, consideration should be given to whether they are themselves in need of care and support. Carers have the right to an independent assessment under the *Care Act 2014*.

Following the enquiry and outcome, decisions about whether there needs to be an ongoing safeguarding plan, subject to periodic review, should be taken based on the level of ongoing risk and agreement with the adult.

Reflective point

How do you use supervision to discuss tensions between supporting the alleged perpetrator and supporting the adult?

Referrals to professional bodies

Employers, 'personnel suppliers' or volunteer managers of people working in regulated activity have a legal duty to refer to the Disclosure and Barring Service (DBS) where they believe someone has harmed, or poses a risk to a child or an adult with care and support needs. Further information is available on the DBS website: **www.gov.uk/guidance/making-barring-referrals-to-the-dbs**.

Where appropriate, employers should also report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council, the Nursing and Midwifery Council and the Health and Care Professions Council. The legal duty to refer to the DBS may apply regardless of a referral to other bodies. Practitioners should discuss any concerns they have over colleagues' practice or behaviour with their manager.

Safeguarding plans

> ***'Safeguarding plans should empower the adult as far as possible to make choices and to develop their own capability to respond to [risks].'***
>
> **(DHSC, 2018: 14.97)**

The safeguarding plan aims to bring together shared ideas about how the adult can stay safe in the future, and achieve resolution and recovery. It is informed by the outcomes that the adult or their advocate has stated, and aims to detail the actions needed by different stakeholders to achieve those outcomes. The relevant agencies and other members of the adult's support network should be involved, and the adult should be able to state who they want to be a part of their safeguarding plan wherever possible. The plan should outline roles and responsibilities, contact details for the person responsible for monitoring the plan and who to contact if further concerns arise.

Stanley (2017) recommends using a 'Signs of Safety' practice framework to lead to the safety plan (see page 96 for an outline of the framework). He outlines the following stages:

1. **The person has already started** – practitioners should be aware that the person probably already has ideas about how to resolve the issue and improve their wellbeing. The person should drive the decisions that lead to a support plan.
2. **Find out who is and what is helpful to the person, and what is working well** – work through the framework and discuss why you are involved, then draw an eco-map showing who and what is around the person that could potentially help. This helps to develop shared understandings about needs, safety, wellbeing and risks.
3. **What is the way forward for improved wellbeing? What is not going so well?** This stage begins with an in-depth understanding of the person's 'physical social and emotional situation, and any impairment(s) or illness(es)'. The focus should be on the impact of each issue on the person's wellbeing, the outcomes sought, and what powers or duties practitioners could use in response.
4. **Scale wellbeing and scaling any risk** – the practitioner analyses the situation through a respectful conversation with the person. The person is asked for their 'wellbeing score' (see pages 96-97) and subsequent questions are asked about how to improve the score, with reference to the eco-map drawn in Step 2 and consideration of the person's rights. This means that the plan focuses on wellbeing. An overall statement of need or concern is developed with the person, which leads to an overall goal.
5. **Planning together to build safety and wellbeing** – the safety plan is then developed from the statement of need or concern. It includes adding necessary resources and sources of support, and should be written in clear language that the person can understand.

(Stanley, 2017: 49-51)

Review and closure

Review

Each agency involved in the safeguarding partnership is likely to have their own approach to keeping cases open and reviewing cases. It is important to follow your own internal procedures and to explain and communicate these to people from other agencies who are involved in the situation. This means all agencies have a clear understanding of how and when to review a case, and of the roles and responsibilities in relation to reviews. Reviews of adult safeguarding plans, and decisions about plans should be agreed with the adult at risk and/or their advocate. The purpose of the review is to:

- Evaluate the effectiveness of the adult safeguarding plan.
- Evaluate whether the plan is meeting/achieving outcomes.
- Evaluate risk (present/future).

Following the review process, it may be determined that:

- The adult safeguarding plan is no longer required; or
- The adult safeguarding plan needs to continue.

Any changes or revisions to the plan should be made, new review timescales set (if needed) and agreement reached regarding the lead professional who will continue monitoring and reviewing. Safeguarding plans should not, however, be open-ended. Where there is ongoing risk, it may be necessary to hold further 'working with risk' meetings with the adult to establish ways of mitigation so that the risk is reduced to a level that is agreed by the adult and the enquiry lead.

If new concerns have arisen, it may also be necessary to instigate a new Section 42 enquiry. If it is decided that further enquiries would be a disproportionate response to new or changed risks, further review and monitoring may continue, with the aim of supporting the adult through care management or other means of ongoing support.

Closure

Where there is agreement that an adult remains at risk of abuse, a case cannot be closed; arrangements for regular monitoring and reviewing are therefore essential. Some authorities require that a meeting or case conference (virtual or actual) is held before a decision to close a case. Others may not require this, but it is essential that an accurate record is kept of how and when the decision was reached to close a case. Other agencies should also be kept informed so they can consider the implications of the case closure on their practice. A further enquiry might be initiated about the same adult if new or additional concerns are brought to the attention of the person making an enquiry.

It might be helpful for councils to set out a checklist for closures that aligns with data required by Safeguarding Adults Return, aggregated data required by the Safeguarding Adults Board, and oversight by Health and Wellbeing Boards.

Multi-agency working

Multi-agency working has consistently been identified in Serious Case Reviews and Safeguarding Adults Reviews as needing improvement. Braye et al (2017) point out it is needed for information sharing, communication, assessment of risk and decision-making, and should span Children's Services and Adults' Services, mental health, housing and other agencies. Multi-agency working can be supported by formal organisational structures, but it is also about good relationships and a thorough understanding of how information sharing, data protection, and multi-agency communication work together in practice.

A key challenge identified by Cooper et al (2016) in the Making Safeguarding Personal temperature check was that of ensuring that all multi-agency partners were as committed to the approach as adult social care. A shared understanding of person-centred and outcomes-focused safeguarding is needed.

Reflective point

What do you think are the key ingredients for good partnership working? How is this currently working in your area? What could be done to improve it?

The role of the Safeguarding Adults Board

The *Care Act 2014* enshrines aspects of safeguarding adults in law. Since April 2015 each local authority has been required to have a Safeguarding Adults Board (SAB) with a statutory requirement of core membership from the local authority, the police and the NHS (specifically the local Clinical Commissioning Group/s). Core members can also invite other members including providers, GPs and representatives from advocacy services, the Care Quality Commission and children's safeguarding. The SAB has three specific duties; it must:

1. Publish a strategic plan for each financial year.
2. Publish an annual report detailing actions taken to achieve its objectives, and reporting the findings of any Safeguarding Adults Reviews (SAR).
3. Decide when a SAR is necessary, arrange for its conduct and if it so decides, implement the findings.

Publicising the strategy and annual report, together with regular briefings from the SAB to frontline staff, may assist practitioners to understand the strategic thinking surrounding safeguarding to inform their practice. The SAB provides a key opportunity for ensuring good working relationships between partner agencies and should act as a model of good practice.

Legislative guidance stresses the need for partner cooperation in order to protect adults experiencing or at risk of abuse or neglect. The five aims of cooperation between partners are pertinent to safeguarding:

- Promoting the wellbeing of adults needing care and support and of carers.
- Improving the quality of care and support for adults and support for carers (including the outcomes from such provision).
- Smoothing the transition from Children's Services to Adults' Services.
- Protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect.
- Identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

(DHSC, 2018: 15.16)

You can find an outline of common barriers to and enablers of good partnership working on page 99.

In the RiPfA Practice Tool *Working with people who self-neglect*, Braye, Orr and Preston-Shoot (2015a: 10) outline possible difficulties in multi-agency working. These are relevant to most safeguarding situations, and are shown in the table below:

Possible difficulty	**Yes/No**	**If no, what can be done about this?**
Do you have involvement from all agencies, groups and networks who could make a contribution to the individual's wellbeing?		
Have any barriers that service boundaries present to securing useful input been discussed and addressed?		
Have any differing organisational priorities or thresholds that present a barrier to working effectively been identified and addressed?		
Is everyone involved clear on their own roles and relationships and those of others?		
Is there shared understanding of goals and priorities between the different practitioners involved?		
Is appropriate communication and information-sharing happening effectively?		

Named contacts in each agency can increase the chances of multi-agency communication and working. Other techniques of maximising multiagency communication have included using a 'triggers protocol' (Nash et al, 2010). The system was developed following a Serious Case Review which showed that a man who was eventually murdered by people he thought were his friends had made repeated and frequent contact with a number of NHS and police services prior to his death. Flynn (2007: 5.8) wrote:

> *'Individual agencies did not have access to what other parts of their organisation and other agencies knew. Each held a piece or pieces of the jigsaw puzzle without any sense of the picture they were creating, or indeed the timeframe within which the puzzle had to be completed.'*

Nash et al (2010) detail that a trigger may be based on repeat contacts between an individual, group or address and an NHS service or the police. These warning markers are shared between agencies and discussed at regular meetings, where safeguarding concerns can be identified.

Adopting a whole family approach may be valuable, which involves close working with colleagues in Children's Services to identify areas of mutual concern. This can also lead to areas of different priority and focus being highlighted. For example, in a situation where a person with care and support needs is experiencing abuse, but is also a mother, the priorities of adult social care and children's safeguarding will be different. Children's Services will necessarily likely focus on the safety and wellbeing of the child – and evidence from situations of domestic violence show that the mother's needs can be neglected. By enabling discussions where each agency sets out their 'must dos' and 'can't do's', a better overall outcome is likely to be reached.

Respecting the expertise that different agencies bring, and showing a willingness to work holistically by placing the adult at the centre of all decision-making so that there is a one-team approach, supports the principles of partnership and accountability for all concerned.

Further reading

ADASS et al (2015) *The Care Act and whole family approaches.*

www.local.gov.uk/sites/default/files/documents/care-act-and-whole-family-6e1.pdf

LGA and ADASS have developed a series of guides outlining how multi-agency partners including police, health and social care commissioners, housing and advocacy can support Making Safeguarding Personal.

www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal/resources

Information sharing

Sharing personal information is allowed only in exceptional circumstances, but safeguarding will often be one of those exceptions. The Data Protection Act 2018 and the General Data Protection Regulation (GDPR), which came into force in May 2018 (see page 21), provide a framework for information sharing, and Article 6 of the GDPR sets out the exceptions.

Sharing the right information at the right time and with the right people, when it is lawful to do so, is fundamental to good safeguarding practice, however. Everyone working to safeguard adults should view the lawful use and safe sharing of information as part of their responsibility. So in sharing information in relation to safeguarding, practitioners should be clear which exception to the general rule they are relying on.

In practice, safeguarding information will most often fall under one of the following three exceptions:

> ‘Consent’: the person has given their consent for personal information to be shared for one or more specific purposes

> ‘Legal obligation’: sharing is necessary to comply with a legal obligation

> ‘Vital interests’: sharing is necessary to protect the vital interests of the person or someone else (Article 6, GDPR).

Unless a person consents to the sharing of their personal information, it is not permissible to share more than is strictly necessary to protect the person (or others), or to fulfill a statutory duty. Article 6 of the GDPR also allows for information to be shared ‘for the performance of a task in the public interest’, but this means disclosure can only be justified in the broad interests of society; very few safeguarding enquiries will fall under that exception.

In its recent guidance on safeguarding adults and sharing information, SCIE (2019) identifies those circumstances where it would not be permissible for practitioners to share pertinent information with relevant safeguarding partners. These would be where the person involved has mental capacity to make the decision and does not want their information shared and:

> Nobody else is at risk

> No serious crime has been, or may be, committed

> The alleged abuser has no care and support needs

> No staff are implicated

> No coercion or duress is suspected

> The public interest served by disclosure does not outweigh the public interest served by protecting confidentiality

> The risk is not high enough to warrant a multi-agency risk assessment conference (MARAC) referral

- No other legal authority has requested the information.

  (‘Safeguarding adults: sharing information’, SCIE, 2019).

Further information on this topic is available from SCIE: **www.scie.org.uk/safeguarding/adults/practice/sharing-information**

Practitioners working to safeguard adults should make themselves familiar with any local information sharing protocols that set out the principles for sharing information.

Reflective point

What are the key elements of your local information sharing protocol?

How do you use this in practice?

Confidentiality

Your agency should have an agreement in place relating to confidentiality and information sharing that sets out the principles for sharing information in the interests of the person with care and support needs.

While practitioners should be mindful of confidentiality, it is likely that there will be occasions when there is a need to break confidentiality to safeguard against the risk of abuse and/or neglect (see above). The person should be kept informed about how and with whom their information is being shared, and informed consent should be sought wherever possible to do so.

However, it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse and neglect, particularly in those situations when other adults may be at risk of abuse and/or neglect. In order to aid the understanding and involvement of the adult and their advocate, practitioners should explain why they cannot assure absolute confidentiality.

Key messages

Find out what local agreements or information sharing protocols exist in your area and make sure you work in line with these agreements.

Registered practitioners must comply with the standards of conduct detailed by their professional body. These include standards on confidentiality, information sharing and recording.

Further reading

SCIE (2019) *Adult safeguarding: Sharing information.*

Home Office (2014) *Multi-agency Working and Information Sharing Project – final report.*

For up-to-date information about the GDPR, see:

NHS Digital:

https://digital.nhs.uk/information-governance-alliance/General-Data-Protection-Regulation-guidance

Information Commissioner's Office:
https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

Recording

Recording is a professional requirement and practitioners 'are personally responsible for, and must be able to justify, their decisions and recommendations' (HCPC, 2017). Records of safeguarding minutes and meeting could be used in legal processes. All the major professional codes of conduct highlight the need for good record keeping (see, for example, HCPC, 2016).

Quality recording is a core part of defensible decision-making. It not only safeguards adults, but also protects workers by evidencing decision-making based on the information available at the time.

The way we record also has an ethical dimension. Feedback from people who use services following the consultation on the Care Bill (2012) showed that they wanted workers who are both technically competent and who can think critically. The factors below are what people wanted from assessment:

- accountability and transparency
- competence and clarity
- proportionality and no duplication
- respect and empowerment
- self-awareness and lack of bias
- ethical practice
- knowledge and judgment.

Problems occurred when professionals' concerns overtook those of the person or records failed to focus on the person. People were wary of being labelled and becoming known by their record.

These factors are reflected in the characteristics of good recording outlined on the following page.

Further reading

Johnstone L (2017) *Good recording: Practice Tool*. Dartington: Research in Practice for Adults.

Find exercises to practice your recording skills at:

http://outcomes.ripfa.org.uk/skills/recording

Ethical
Non-judgmental in tone; uses respectful language; considers the person's rights, consent and confidentiality as well as that of other people or professionals involved or referred to within it; doesn't label, stereotype or put people into boxes.

Lawful
Adheres to the requirements of the *Care Act 2014* and other relevant legislation such as that around mental capacity, mental health, equalities and human rights; follows relevant national and local guidance, policy and/or procedures.

Person-centred
Accurately reflects the person's circumstances, tells their story; shows person was as fully involved as they wanted to be/as possible; considers capacity; clearly states the person's views, wishes, feelings, beliefs and their desired outcomes.

Strengths-based
Looks at the person's individual strengths, resilience, capacity and networks, as well as needs and risks; takes account of strengths and assets which may be available via the person's immediate network, family, friends, neighbours and those available in the wider community.

Appropriate
Information is gathered and recorded in a way which is suited to the person's circumstances in terms of their needs and preferences; involves the person as much as they want to be involved and allows them to lead the process as much as possible.

Holistic
Looks at the person's life as a whole, all areas of their wellbeing, and any interdependence between different areas of this; considers whether, and to what extent, the person's needs impact on their wider support network - for example, family and friends.

Joined-up
Involves other relevant people, for example, professionals where appropriate; takes account of, and references, other relevant assessments, reports and information which may be available.

Proportionate
Reflects the person's view of what's important and what is needed; the number of needs and people involved; the complexity of the situation; the likelihood of change; the likelihood and consequence of risk; the likelihood of dispute and how unusual the situation is.

Accountable
Is clear about what is fact, opinion, hearsay and where these originate from; explains rationale behind opinions, decisions and action/inaction; states what was done, by whom and why; is signed and dated.

Analytical
Weighs up information; is informed by evidence; explains meaning; identifies gaps; includes professional judgments, reasoned decisions and recommendations; avoids irrelevant speculation, subjective comments or personal opinions - for example, comments about the person's life choices or character.

Useful
Includes clear outcomes for the person; reaches a conclusion about needs and eligibility; ensures links between need, impact, outcome and eligibility rationales are clear; includes actions and is clear about what will happen next - the 'what', 'who', 'when' and 'why'; contains only relevant information.

Well-written
Is written in clear, correct English; logical and concise; uses empowering language; avoids repetition or duplication; uses Plain English; reflects the principles of professional writing.

Nosowska (2014)

Working with providers

The *Care Act 2014* places a duty on local authorities to shape markets and ensure that there is sufficient choice and availability of providers who are able to demonstrate continuous improvements and foster a workforce that are skilled and provide a safe, quality service to meet local need. However a review of Serious Case Reviews (SCRs) and Safeguarding Adults Reviews (SARs) in the South West (Preston-Shoot, 2017) found that almost half of reports highlight the provider market as impacting negatively on the case.

The Care Quality Commission (CQC – the independent regulator of health and social care services in the UK) focuses on five key lines of enquiry to assess the provision of care by providers. These are:

- safe
- effective
- responsive
- caring
- well-led

Gathering feedback about services

The CQC, commissioners and practitioners should be assured through listening and talking with people who use services and their families that services demonstrate good practice in identifying and responding to safeguarding issues. Based on the findings of SCRs and SARs, practitioners have a strong role in supporting adults and their families to raise issues with commissioners and the CQC, and in following up concerns. Making complaints about services may be difficult for adults or their families due to fear of repercussions and shortage of other options, and there is some evidence that advocacy organisations can help to improve practice in this area.

Complaints around adult safeguarding should be treated as a matter of urgency and in some instances should be managed through safeguarding adults procedures, not complaint procedures. Practitioners should ensure that people using services are aware of their right to complain and the relevant complaints procedure. Practitioners must make regular checks at reviews by speaking with the adult or their relative alone, to see if they have made any complaints and how they were responded to.

Another option for quality assurance is through Healthwatch England, the national consumer champion in health and care. Healthwatch England was established by the *Health and Social Care Act 2012* as part of the Care Quality Commission.

The following link provides details on the role and responsibilities of Local Healthwatch.

www.healthwatch.co.uk/find-local-healthwatch

One function of Healthwatch is to be able to 'Enter and View' publicly funded health and social care services to find out about people's experiences of the service and to assure quality. Read more about Healthwatch Somerset's approach to this here:

https://healthwatchsomerset.co.uk/project/enter-and-view

Organisational abuse (see page 10 - types of abuse) can remain undetected for long periods. This quote from the SCR into Winterbourne View shows why it is so important to speak to individuals about the care they receive rather than relying on paperwork:

> *'On paper, the policy, procedures, operational practices and clinical governance of Castlebeck Ltd were impressive. However, Winterbourne View Hospital's failings in terms of self-reporting, attending to the mental and physical health needs of patients, physically restraining patients, assessing and treating patients, dealing with their complaints, recruiting and retaining staff, leading, managing and disciplining its workforce, providing credible and competency based training and clinical governance, resulted in the arbitrary violence and abuses exposed by an undercover reporter.'*
>
> **(Flynn, 2012)**

Case study: Quality checkers

Various councils have introduced a Quality Checkers programme. Quality Checkers are trained volunteers who visit care settings and day services to consider four aspects of care: compassion, choice and control, and, where applicable, food and activities. After the visit they provide feedback to a paid safeguarding member of staff by answering three questions based on the conversations they have had with people using the service and their observations.

1. What impressed them?
2. What would they say are areas for improvements?
3. Would they want to use the service for themselves or a member of their family?

Quality Checkers are given control to decide how each visit is managed. They decide how long to stay at each service, how many people to speak to and whether they remain in the establishment in pairs or whether they look at different aspects separately. The Quality Checker programme is not intended to substitute contract monitoring or auditing processes; rather it is designed to supplement available information from the perspective of lay people and people using services, and provide a fuller picture of what it is like on the ground. Although the volunteers receive appropriate training they are not accredited professionals and add value to the intelligence on the quality of services. Since its inception at the end of 2011 it has recruited 54 volunteers working on this programme.

There are many quality checkers programmes around the UK.
Find out more about the Skills for People quality checkers programme here: **http://skillsforpeople.org.uk/?q=what-we-do/quality-checkers**

Hull University has undertaken considerable work in identifying concerns in learning disability services and older people services that might trigger action under a provider concerns process (White and Marsland, 2012). In work with one Safeguarding Adults Board, the researchers conducted interviews and analysed the literature to develop guidance for practitioners on early indicators of risk (see page 100 for more information).

Acting on feedback about services

However intelligence is gathered, it is important that timely action is taken and early conversations are held with providers, where it is safe to do so. Providers are unable to put matters right unless they are aware of the concerns. A judicial review (Davis v West Sussex, 2012) found in favour of a care home after they were not given adequate notice of allegations against them, not shown the evidence against them, nor given an opportunity to provide evidence into the safeguarding investigation (as it was then) themselves.

Risk and proportionate responses should guide further action. Examples might be:

- Meeting convened by contract monitoring officers.
- CQC brings forward inspections.
- Health commissioners assess services are delivering to commissioner requirements (eg, where rotas require two members of staff to one service-user, evidence that this is happening).

In some cases it may be necessary to invoke a provider concerns process. Provider concerns should involve the following professionals:

- Safeguarding adults team
- Commissioners
- Clinical Commissioning Group (where there are clinical concerns)
- Funding authorities
- Police (to consider wilful neglect and ill-treatment, or other criminal matters)
- Care services
- CQC (if regulated service)
- GP (especially where there is an assigned GP; however potential conflicts of interest should be considered).

Other staff and agencies might be involved, but this will be determined on a case-by-case basis.

Involving people who use services where there are provider concerns

People and/or their families have the right to know where there are concerns related to quality and safety in the provider service that they access. This must be balanced against raising anxiety and distress, however. People and their relatives are likely to see a number of professionals making visits and asking questions which in themselves may raise concerns.

Where providers work with safeguarding adults teams it may be possible to agree how to inform adults and families in the best way. This might be by holding a resident and relative meeting, agreeing on dialogue with the provider and using a form of words that indicates the provider wants to make improvements and is gaining the support of the safeguarding adults team. People should be assured their views matter and offered opportunities to raise concerns through a variety of means such as dedicated telephone lines, one-to-one meetings and sharing concerns at care management reviews.

The key to involving people in the process is to ensure regular and effective communication. Newsletters reporting back on actions in response to adults and their relatives are always helpful.

Where services are community based, it might be helpful to find out from those with a named social worker or other regular visitor (eg, a district nurse) whether they have concerns and if they are satisfied with services.

When sharing concerns with people, the potential for affecting commercial interest by damaging the provider's reputation must be considered. However, the primary and overriding concern must always be the safety of the people using the service.

Your local policy and procedures should be followed in managing any large-scale safeguarding enquiry.

Prevention of abuse

Prevention is one of the guiding principles of a person-centred approach to safeguarding adults as outlined in the *Care Act 2014*. Central to prevention is relationship building and discussion of outcomes, promotion of empowerment and choice, and encouragement to disclose, as well as multi-agency working and inter-agency collaboration (see page 99 for more detail).

SCIE's (2016) resource for housing managers identifies ways of preventing abuse and neglect. This offers (although not exhaustive) guidance that can be adapted by other professional groups. Practice tips include:

- Developing a 'prevention of abuse' strategy based on risk indicators such as isolation, alcohol/ substance misuse and mental illness.
- Empowering tenants and making them more connected with the community.
- Equipping people with information to safeguard themselves.
- Having named people for referrals and named people who support tenants while investigations are taking place.
- Working with tenants 'whose behaviour poses risks to the wider community'.
- Holding community meetings, developing advocacy and intermediary services, working with police liaison officers and with neighbourhood safety initiatives.

Risk factors for abuse that have drawn much attention in recent years are social isolation and loneliness. A think piece from ADASS (Jones, 2017) highlights evidence that:

- Social isolation can be a risk factor for abuse and exploitation, such as domestic abuse, 'mate' crime and scamming.
- A lack of social inclusion, for example in a residential home, may be experienced as a form of neglect.
- The experience of abuse may cause further social isolation due to negative impacts on mental health.
- In around 50 per cent of Safeguarding Adults Reviews into self-neglect, the person lived alone.

It recommends a preventative approach that encourages friendships and social connectedness in people's lives.

Making Safeguarding Personal (MSP) may be contributing to prevention in safeguarding. In a 'temperature check' where all 152 local authorities were surveyed about their progress in implementing MSP, Cooper et al (2016) found evidence that the approach led to a decrease in 'revolving door' cases, because people were more likely to reach resolution and have the core issue resolved. One participant commented, 'there is a belief that MSP takes longer – sometimes it does but in fact it is outweighed by far better quality outcomes and real prevention' (Cooper at al, 2016: 21).

Part of Making Safeguarding Personal is ensuring a good understanding of the person's context. The World Health Organization has developed an 'ecological framework' on violence prevention, which outlines the factors that can increase a person's risk of experiencing interpersonal violence, among four dimensions: individual, relationships, community, and society. By examining each factor in turn, it may be possible to identify risk factors and work with the person to mediate them. For more information see:

www.who.int/violenceprevention/approach/ecology/en

Raising public awareness about safeguarding adults

Raising awareness through national, regional and local campaigns has become more commonplace. Where there is multi-agency collaboration on raising awareness there may be greater success. Engaging all communities will require creative and proactive approaches to meet individual communities' needs.

The Local Government Association has collated examples of films that raise awareness or provide information about various aspects of safeguarding:

www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal-audio-visual-resources

Case Study:

Hounslow Council Safeguarding Adults Week September 2014

The Safeguarding Adults Team led on the programme and had service-user involvement as its theme. It included a conference with speakers from the police on home and personal safety, a service user drama group who sent out the message to say no to exploitation, and audience participation for a safeguarding quiz. A service user who had been scammed by a firm selling new kitchens shared his experience of safeguarding and told the audience how trading standards, the police and social workers had worked together to get his money back. Services had prevented the same company working in the local area, linking in with other authorities to prevent the same thing from happening to other people. Partners with safeguarding adult responsibilities were invited to have stalls to inform service users and local residents on fire safety checks, crime prevention, health checks, healthy eating and keeping safe whilst on the internet. A successful communication strategy was developed to ensure invitations reached all communities.

Providing information, advice and advocacy

Section 4 of the *Care Act 2014* states that local authorities must 'establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers'. This includes advice about safeguarding, and should include both information on how people can keep themselves safe, and how to support other people to keep safe. Services should also signpost people to relevant resources in the community that can help to develop social networks, and potentially alleviate isolation and loneliness.

Advocacy can provide opportunities for people (especially people with communication or other needs) to disclose experiences of abuse, and support them through the process of reporting and resolving it. Advocacy has also been found to have the potential to change organisational cultures, and it represents good value for money (Pike, 2015). For more information on advocacy, see page 48.

Good recruitment, supervision and disciplinary processes

Registered health and care providers must demonstrate safe recruitment practices to the Care Quality Commission (CQC). Other organisations not subject to regulatory inspections should ensure that staff and volunteers who are in a position of trust are recruited following safe recruitment processes. Skills for Care's recruitment and retention pages give useful guidance on finding, recruiting, developing and retaining good workers in social care:

www.skillsforcare.org.uk/Recruitment-retention/Recruitment-and-retention.aspx

Support to practitioners requires an ongoing commitment from organisations to ensure that there is regular, meaningful supervision that does not just focus on casework but looks at the challenges and complexity of safeguarding. It might be helpful to agree how individual learning and reflection can be used within teams to support all practitioners to continually develop and improve knowledge on safeguarding issues as part of a strengths-based approach.

Supervision does not necessarily mean one-to-one meetings. Supervision can be provided through:

- peer supervision
- group supervision
- team discussions.

One of the aims of supervision is to improve the quality of decision-making and interventions, so it has a key role in identifying (and preventing) potential safeguarding concerns. Good supervision should give practitioners space for reflection, provide support for workers, and act as a channel of communication between staff and workers. Most professional standards include sections on accessing supervision, and practitioners should be familiar with the relevant ones.

People who arrange their own care through personal budgets might seek advice from local authorities on safe recruitment of personal assistants. Enfield Safeguarding Adults Board has produced a factsheet on safe recruitment of a personal assistant, advising on contracts, background checks, and references:

https://new.enfield.gov.uk/services/adult-social-care/safeguarding-adults/about-safeguarding-adults/adult-social-care-information-safe-recruitment-of-a-personal-assistant.pdf

Education and training of staff

Safeguarding adults training is mandatory in most organisations. The Bournemouth University National Competency Framework for Safeguarding Adults (2015) sets out the level of training according to roles and responsibilities and reflects the *Care Act 2014*. Some councils have adapted this to better fit with Making Safeguarding Personal.

The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health. It applies across social care and health, links to National Occupational Standards and other qualifications, and covers what is needed to be caring. The Care Certificate gives workers a good basis from which they can develop their knowledge and skills.

For more information see:
www.skillsforhealth.org.uk/standards/item/216-the-care-certificate

Training is used extensively to standardise practice, meet requirements, induct new staff, embed new ways of working and improve practice. However, without considering the system in which the training is taking place (including whether a workplace will provide a supportive environment to use new skills), training is unlikely to be effective (Pike, 2012). Braye et al (2013) suggest that work*force* development is insufficient to improve practice without being accompanied by work*place* development – ie, addressing the factors that will support staff do things differently. The Safeguarding Adults Boards has a role in ensuring that training should be based on a learning needs analysis of staff needs; be relevant, timely, contextualised and provide chances for staff to practise their skills; and be followed up by managers when staff return to work. The impact of training should be measured through performance and quality data. Practitioners should ensure that they provide feedback on the quality and relevance of training.

Reflective and experiential learning is necessary to help staff become more aware of their own beliefs and unconscious biases. Adopting an evidence-informed practice approach – drawing from research, practice knowledge, and user voices – can help challenge assumptions and stereotypes. Safeguarding training can usefully be combined with learning about human rights, equality, diversity and inclusion and mental capacity in order to encourage practitioners to take a person-centred, rather than service-led, approach to safeguarding.

Education and training with people who use services

Training and information for people with care needs about staying safe, including how to report safeguarding concerns, is a key element of prevention. People who use services benefit from being able to run and attend courses on safeguarding, and participate in Safer Places schemes. These are often run by people with lived experience of abuse and safeguarding, and aim to recruit local businesses, shops and community venues into the scheme, which provides safe places for people who may be feeling threatened or unsafe.

Case study: Safer places

Wokingham's Safer Places scheme – where people who feel vulnerable in the community can identify a safe place through a sticker in the window of a shop or business, and be offered help or a quiet place to sit – is co-produced with people who use services. Through a Community Safety Grant, Safer Places employs three experts by experience (who could be seen as 'adults at risk') as champions. The team make presentations to shops and businesses, support the scheme's coordinator, carry out admin tasks and help to promote the scheme to residents and at community events across the borough. They have also presented to other local authorities about the scheme.

www.wokingham.gov.uk/community-and-safety/community-safety/find-a-safe-place

Reflective points

1. What preventative measures are you able to implement within your current resources?
2. How do you work with adults to ensure that their strengths and their personal networks are utilised in preventing abuse and neglect?
3. What are your local policies, procedures, and training opportunities to support preventing abuse and neglect?

Further reading

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Conclusion

This handbook aims to provide practitioners with practical advice about all aspects of safeguarding adults, from prevention through to the closure of enquiries.

While safeguarding adults is a complex area of practice, the key element is to ensure that the person (and their family or carers, where relevant) is at the centre of decisions made. With this in mind, practitioners can introduce the research and practice evidence, awareness of the law, and knowledge of their own organisation's context, policy and procedures in order to support the adult in the most effective way.

Taking the time to discuss and reflect on decisions with colleagues, including those from other agencies, can help enhance professional judgment and work towards good outcomes for the adults we support.

References and further reading

Links and references are found throughout this publication under 'further reading' headings. Full references are listed below.

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Tools and checklists

Factors to consider when supporting people through a safeguarding enquiry

Capacity

1. Does the person have capacity to make decisions about protecting themselves from the risks they may experience?
2. Does the person have capacity to make decisions about their involvement in the safeguarding enquiry?

Support

What support is required to actively involve the person in the process?

What can provide it?

Could an advocate support the person? If so, how are they accessed?

Information

What can be shared and with who?

How should it be provided?

Is there an inter-agency agreement or protocol covering information sharing?

Organisational culture

Safeguarding is a multi-agency responsibility but agencies have different cultures and approaches to how they involve people who access services.

Is there agreement about how to proceed at every stage?

Is there an inter-agency agreement or protocol covering the involvement of people who access services?

The 'Signs of Safety and Wellbeing' practice framework

From Stanley (2017)

> *'The practice framework is a simple three-column design with a wellbeing continuum along the bottom of the following page. It is easily drawn up on a blank piece of paper, so practitioners can create a one-page outline, and then apply the appreciative inquiry approach to solicit ideas and examples of assets, and explore people's dreams and wants while noting down who and what is around to help achieve the goals. A visual representation of the person's situation is created, and case planning emerges based on and informed by the conversations that have taken place. All the practitioner needs is a pad, pencil, and a creative approach to practice. This is a very different approach from traditional care management.'*
>
> **(Stanley, 2017: 47)**

See page 68 for further guidance from Stanley on the steps taken to use this practice framework.

Signs of Safety and Wellbeing practice framework

Headline (why we are involved)?

Eco-map (who/what is around the person?)

Issues that need to be addressed	Who and what is helping?	What needs to happen next?
What is not going well?	Strengths/resources (what's working well?)	Overall goal of the plan
Complicating factors (things we can't change)	Contribution to safety and wellbeing	Next steps
Statement of overall concern/need	Plan	

Current wellbeing score 0-10

This is the wellbeing score of the person, the practitioner's score and others involved (eg, family and those in the eco-map).

Understanding the experience of self-neglect

In their practice tool, Braye et al (2015a) outline the importance of 'concerned curiosity' when working with people who self-neglect. By understanding the factors that may be underlying the situation, there will be a better chance of offering appropriate support. This tool can also be adapted and used with people experiencing other types of abuse and neglect.

What the practitioner needs to inquire into

- What is the person's own view of the self-neglect?
- Is the self-neglect important to the person in some way?
- Does the person have mental capacity in relation to specific decisions about self-care and/or acceptance of care and support?
- Is the self-neglect intentional or not?
- Is the self-neglect a recent change or a long-standing pattern?
- What strengths does the person have? What is he or she managing well and how might this be built on? What motivation for change does the person have?
- Are there links between the self-neglect and health or disability?
- Is alcohol consumption or substance misuse related to the self-neglect?
- How might the person's life history, family or social relations be interconnected with the self-neglect?
- Does the self-neglect play an important role as a coping mechanism? If so, is there anything else in the person's life that might play this role instead?

Barriers and enablers to multi-agency working

The following table outlines some of the barriers to and facilitators of partnership working. Consider your practice in relation to the points below, and in relation to the range of agencies you work with. What could be improved?

	Challenges	Solutions
Culture	> Lack of understanding about each agency's role > Different language and terminology > Different agendas and pressures > Tendency to defend own professional role > Erosion of specific 'professional' roles, eg, joint working in an integrated team > Working together can be time consuming	> Develop an understanding and respect for each agency's role > Identify and share common goals > Demystify language and avoid using acronyms > Appoint an independent chair to coordinate the safeguarding board > Keep focused on the common goal to safeguard individuals
Systems	> Lack of common training systems > Lack of joined-up recording systems can lead to duplication > Different information and policies > Timeframes not joined up across agencies	> Develop common IT systems > Ensure that you refer to the agreed information sharing protocol > Establish a designated administration team to set meetings, send letters and record minutes > Pool resources and budgets so all agencies have invested in the safeguarding system
Confusion reigns...	> Lack of coordination > Ambiguity in lead agencies > Conflicting priorities > Unclear processes	> Ensure there is a clear agenda in meetings that is adhered to > Make use of safeguarding champions in each team > Attend joint multi-agency training that addresses how best to work together > Take all available opportunities to network with colleagues from other agencies

Early indicators of concern in residential and nursing homes for older people

‘There are six main areas to think about:

1. Concerns about management and leadership

The people who manage the home and other managers in the organisation. What are they doing, or not doing that might put people at risk of abuse?

2. Concerns about staff skills, knowledge and practice

The people who work in the home. What are their skills and practice like? What are they doing that might put people at the risk of abuse? Remember this is not just people who work as care workers or nursing staff. For example, this section also includes the practice of managers and other non-care staff who work in the service.

3. Concerns about residents’ behaviours and wellbeing

The people who live in the home or service. How are they? Are they behaving in ways which suggest they may be at risk of abuse?

4. Concerns about the service resisting the involvement of external people and isolating individuals

Are the people in the home cut off from other people? Is it a “closed” or an “open” sort of place? Does the service resist support from external agencies or professionals?

5. Concerns about the way services are planned and delivered

This is about the ways in which the service is planned and whether what is actually delivered reflects these plans. For example, are people receiving the levels of care which have been agreed? Are the residents a compatible group? Is the service clear about the kind of support they are able to deliver?

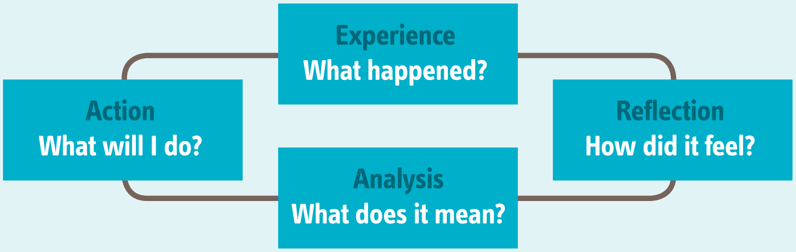
6. Concerns about the quality of basic care and the environment

Are basic needs being met? What is the quality of the accommodation like?’

Taken from White and Marsland (2012: 2). The full report and guidance is available at: **www.bsab.org/media/Hull_Report_2012.pdf**

Exercise: Outline for analysing a case in supervision

Rather than providing examples of safeguarding cases to analyse and discuss, we have outlined a framework for analysing your own cases in supervision below.



The aim of this exercise is to practise using the four parts of the Kolb cycle (above) in a problem-solving situation.

The supervisee volunteers a dilemma – one where they have had a difficult experience with a case and been unsure how to resolve it. Only a brief outline is needed and remember to maintain confidentiality.

The supervisor will ask questions to explore the problem.

> Firstly, spend five minutes asking questions around how the supervisee experienced the dilemma. 'What happened before the event, what did you expect, what happened, what did you notice, what happened after the event?'

> Then spend five minutes asking questions around how the supervisee felt about the dilemma. 'What did you feel before, how did you feel during it, what association were there, how did the other person feel, what feelings were you left with?'

> Then spend five minutes asking questions around analysing the experience. How did the supervisee explain the dilemma at the time, afterwards and now? What went well and what didn't go well? Why? What is not known?

> Finally, spend five minutes asking questions around identifying actions. How does the supervisee summarise where things are now and what needs to be done next? What further information is needed? What extra support is needed? What would be a successful outcome? What do you need to do more/less of? How can you prepare for this? What is your contingency plan?

> Summarise back what you heard from the supervisee at each stage. What did you learn from the information that came out at each stage? What action will you take?

research
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This handbook came out of a Change Project called *Safety Matters*, which took place in 2009 and brought research and practice together to identify what works best in safeguarding. The handbook was first updated in 2013, and this is now the third edition.

The 2019 edition reflects policy and practice changes in safeguarding adults under the *Care Act 2014*.

The focus is on developing practice in safeguarding by highlighting research messages and good working practices, and is intended to promote reflection and discussion among practitioners.

First published in 2009, authored by George Julian and Bridget Penhale.

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