Local Government Association | directors of adass adult social services | Partners in Care and Health

Safe Care at Home Webinar

Wednesday 28 February 2024 - 2:00PM – 4:00PM
Partners in Care and Health

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The Local Government Association and Association of Directors of Adult Social Services are Partners in Care and Health (PCH) working with well-respected organisations.

PCH helps councils to improve the way they deliver adult social care and public health services and helps Government understand the challenges faced by the sector.

The programme is a trusted network for developing and sharing best practice, developing tools and techniques, providing support and building connections.

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Department of Health & Social Care

Home Office

An overview and progress update on the Safe Care at Home Review

Darshi Veluppillai, Adult Safeguarding Senior Policy Advisor, DHSC

Nazmeen Chowdhury, Strategy and Implementation Hub Lead, Home Office

28/02/2024

Contents

Why was the Safe Care at Home (SCaH) review launched?

What did the review find?

Leadership and accountability

- Fragmented oversight of, and accountability for, safeguarding in England
- Over-reliance on sector led improvement and missed learning opportunities

Effectiveness of the local response to abuse in the home

- Local responses to this form of abuse can be inconsistent and ineffective
- Frontline staff are not equipped with the right tools to understand its nature or navigate the complex legislative framework

Research, evidence and learning

- Relevant data held in disparate places across government departments and agencies
- Limited research on this type of abuse poses problems to understand and tackle it effectively

What are the recommendations?

DHSC & Home Office joint recommendations

- Cross government working group
- Input voices of victims and survivors
- Increase awareness of this form of abuse across networks
- Improve capacity of statutory agencies responsible for safeguarding adults at risk of this form of abuse
- Improve data and research about this form of abuse

DHSC only recommendations

- Revise and promote Chief Social Worker's 'Safeguarding in Practice' guidance
- Review the Safeguarding Adults Review (SAR) national escalation protocol
- Commission an analysis of SARs from 2019 – 2022

Home Office only recommendations

- National Domestic Homicide and Suicide Oversight Mechanism establishment
- £3 million allocated to organisations who support victims of abuse (older victims or victims living with disability)
- Online Library for the Domestic Homicide Reviews

What progress has been made on the recommendations?

Joint actions

First cross government working group held on 28th November 2023

The following recommendations were discussed at the working group:

1) Incorporating the voices of victims and survivors into policymaking

2) Strengthening the oversight of Safeguarding Adults Reviews (SARs)

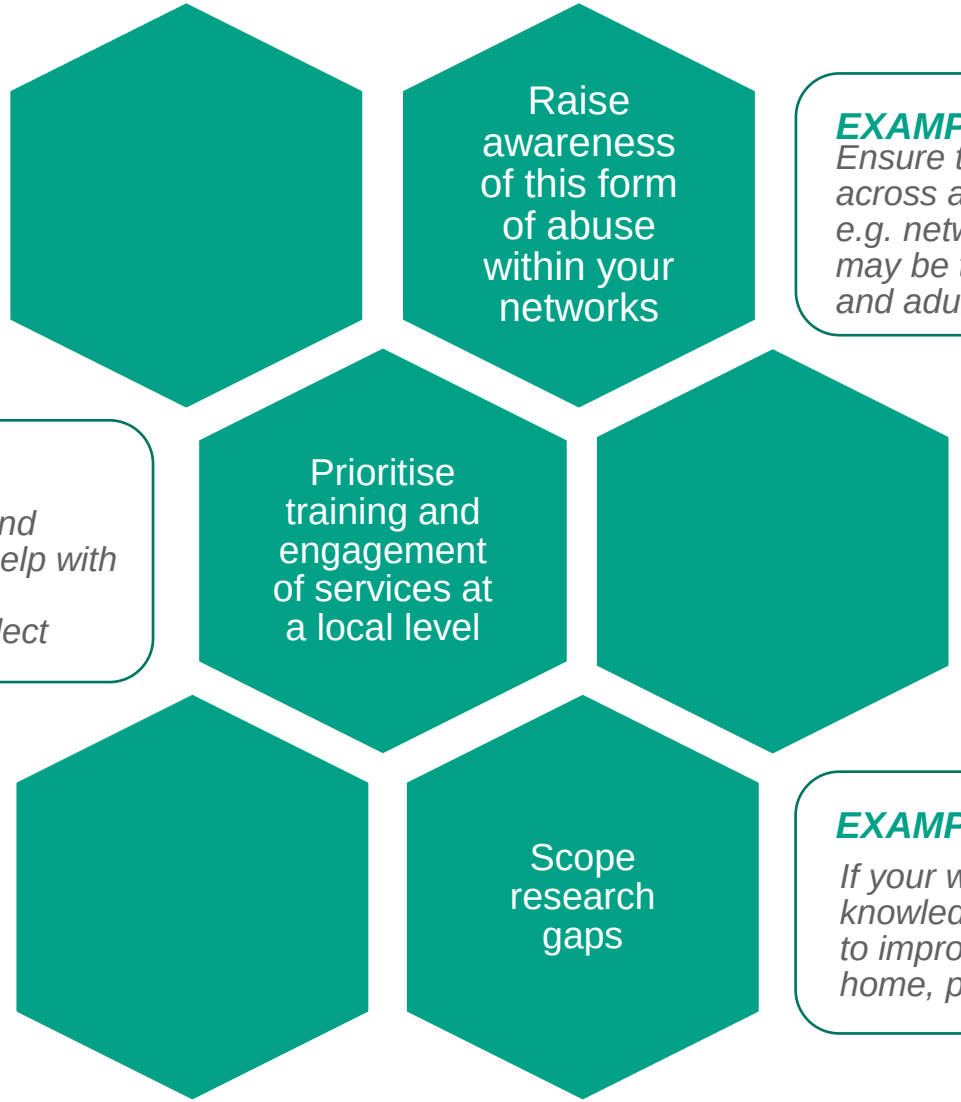
DHSC

- Second national analysis of SARs
- Reviewed updated SAR escalation protocol
- Discussed how to strengthen SAR oversight at a SAB business manager meeting
- Included specific recommendations to the specification for the sector led improvement offer for FY24/25

Home Office

- Continuing to consider ways to collate best practice and limitations of practices in which to incorporate the voices of victims and survivors into policymaking
- The DACs office have been undertaking work on survivor engagement through putting into a victim engagement mechanism
- The DAC want to promote good practice in survivor engagement

What can you do now to build on the findings from the review?



EXAMPLE

Ensure this form of abuse is shared across a diverse range of networks, e.g. networks with young adults who may be transitioning between children and adult social care services

EXAMPLE

Learning about LGBTQ+, older and disabled victims and kinship, to help with understanding how this impacts vulnerability to abuse and/or neglect

EXAMPLE

If your work reveals gaps in our knowledge and understanding of how to improve the safety of care in the home, please share this with us

Safe Care at Home Review

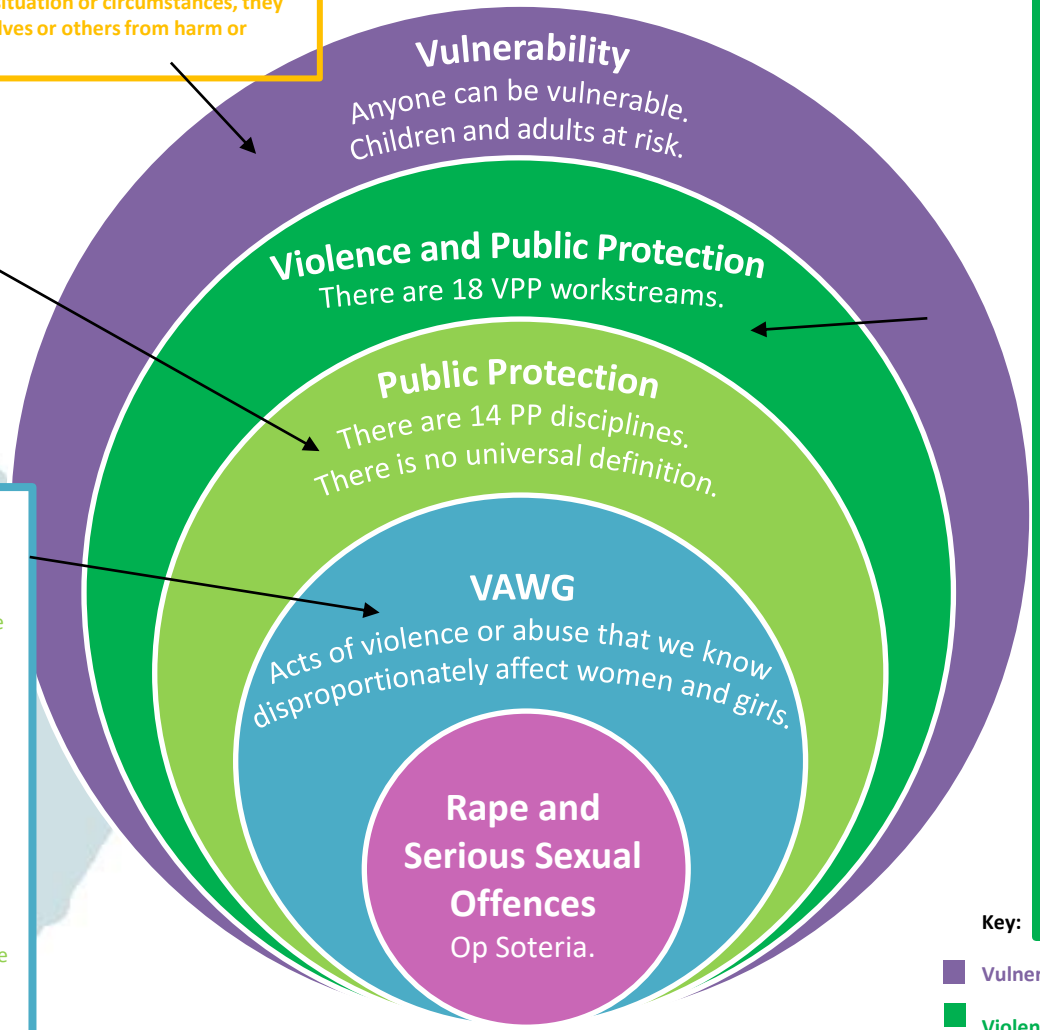
Overview of Police Response

Dr Jim Gale

NPCC Lead: Adults at Risk

A person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation.

1. Domestic Abuse
2. Stalking and Harassment
3. Child abuse
4. Child Exploitation (CSE/ CCE)
5. Serious Sexual Offences
6. Female Genital Mutilation
7. Honour Based Abuse
8. Prostitution
9. Forced Marriage
10. Human Trafficking
11. Adults at Risk
12. MOSOVO
13. Missing
14. Vulnerability to Radicalisation



1. Modern slavery and Organised Immigration Crime – including National Referral Mechanism (NRM)
2. NPCC Child Protection Abuse Investigation Working Group
3. Group based CSE
4. Multi Agency Safeguarding Hub (MASH) and Early Intervention
5. Missing Persons
6. Management of Sexual Offenders and Violent Offenders
7. Public Protection (VISOR/MAPPA Multi Agency Public Protection Arrangements)
8. Adults at Risk
9. Gangs and County Lines
10. Domestic Abuse
11. Female Genital Mutilation and Forced Marriage and Honour Based Violence
12. Stalking and Harassment
13. Adult Sex Offences/Rape
14. Knife Enabled Crime
15. Violence against Women and Girls (VAWG)
16. Prostitution & Sex Working
17. Online Child Sexual Abuse Activist Groups
18. Acid - Corrosive Attacks

Domestic abuse

Rape and serious sexual offences

Child sexual abuse and exploitation - for female victims aged 10 years and over (in line with the NPCC VAWG definition which incorporates victims aged 10+)

Modern slavery and human trafficking

Honour based abuse

Stalking and harassment

Adult sexual exploitation and sex work

Tech enabled VAWG which includes online harassment

VAWG in different space types: public, private and in places of education

Spiking

Key:

- Vulnerability
- Violence and Public Protection
- VAWG
- Op Soteria

Adults at Risk Working Group

- Consists of senior PPU investigators and partners from across the country
- Significant variation in regional engagement
- Huge ‘appetite’ for work in this arena by these professionals (see ‘Risk’)
- Range of plans

Key Risk

‘Protecting vulnerable adults at risk of harm or exploitation is a safeguarding priority for police and partners, yet it does not have an equal standing with child safeguarding or domestic abuse. There are problems with definitions and responsibilities, there is limited national investment in devising adult safeguarding risk assessments, and data sharing continues to be challenging.’

Main Challenges

- Entirely consistent with 'Safe Care at Home' Key Findings:

- Fragmented leadership and accountability
- Competing priorities and insufficient resources
- Limited sharing of information and data, and learning from best practice
- Type of harm and relevant legislation poorly understood
- Frontline police officers often lack the training and resources to fully identify, protect and support those at risk
- Lack of available data, and knowledge, on prevalence of abuse in care relationships

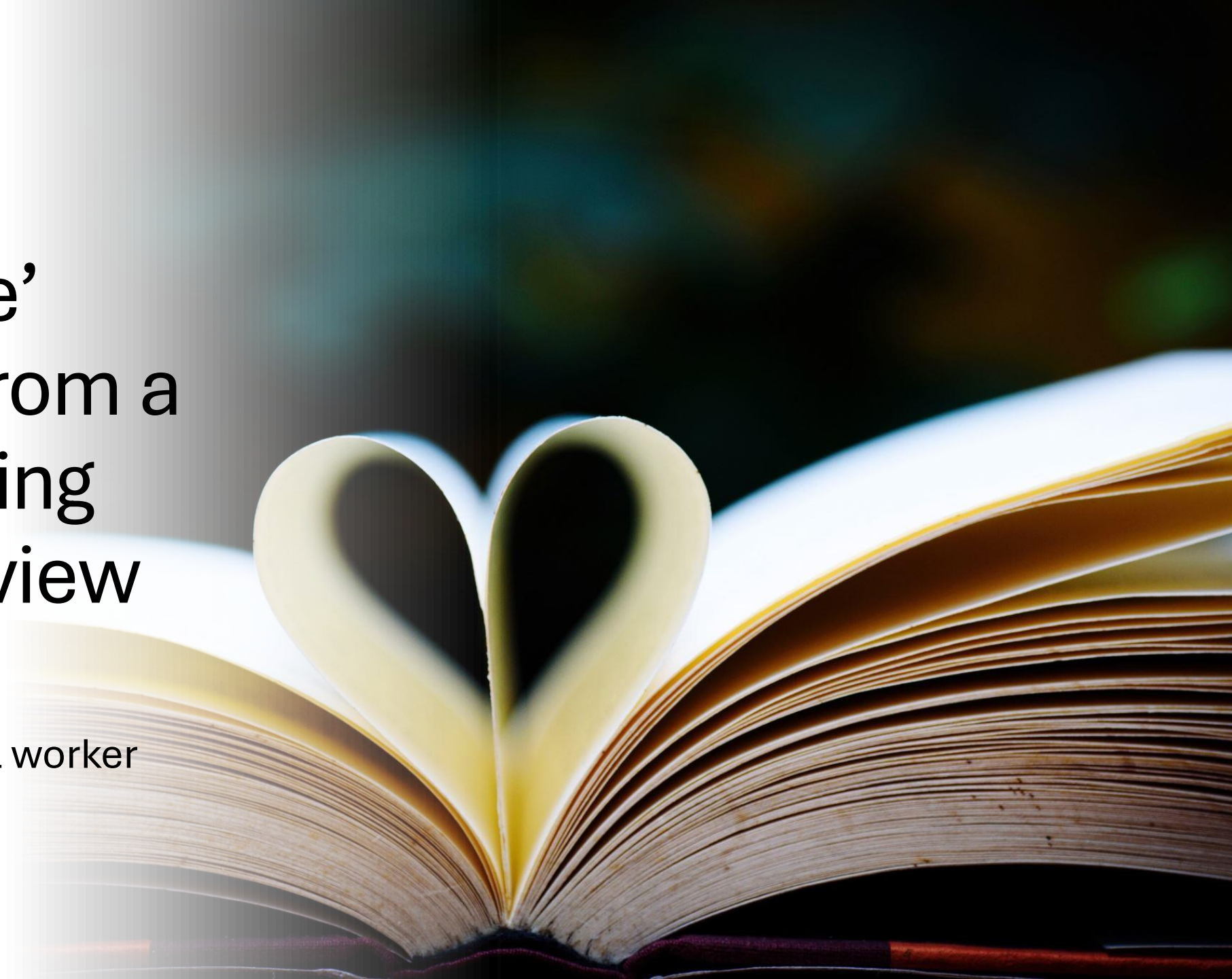
Immediate Plans

- Live national survey amongst all 43 forces in England and Wales to:

  - Understand gaps in existing structures
  - Understand data-sharing pinch-points
  - Understand training gaps
  - Examine referral pathways
  - Build effective regional networking and sharing of best practice
  - Build plans, counter risk, give coherent national voice

‘tough love’ Learning from a Safeguarding Adults Review

Annie Ho
Independent social worker
and SAR reviewer



‘the cared for’ and ‘the carer’

This review is

> ‘*talking about **ordinary people** – carers and cared for – who find themselves in potentially extremely difficult situations that they didn’t choose, with immense emotional and practical implications for their lives*’.

(a quote from a carer who contributed to the LGA/ADASS briefing note on ‘carers and safeguarding’)

organisations who contributed to review

- Adult Social Care
- GP
- Hospitals
- Hospice
- Police
- Ambulance
- Resident Services Housing
- OPG
- Hourglass (previously Action on Elder Abuse) – advisory member of SAR panel

key lines of enquiry

1. How did agencies work together to support P?
2. What were the challenges and barriers to understanding P's needs and responding to them?
3. How did agencies balance taking a person-centred approach whilst working with P's family / carers?

key focus themes

- physical health vs mental health
- end-of-life care
- MCA – P's wishes and feelings, mental capacity, decision making authority (LPA and OPG)
- potential coercion and control
- impact on carers
- impact on agencies
- safeguarding framework and risk enablement
- information sharing and multi-agency working

critical analysis

- person-centred palliative care
- promoting overall wellbeing of both the cared for and the carer
- mental capacity / unwise decisions / wishes and feelings
- decision-making authority / LPA H&W / OPG
- coercion and control – who controls who?
- fear of the person, fear of family members and professional fears
- impact on P / impact on carer / family dynamics / impact on professionals
- transgenerational domestic abuse / unintentional or intentional harm or neglect / MARAC
- balance between safety and protection vs autonomy; risks vs wellbeing

transgenerational domestic abuse

‘There is a lot of shame and guilt around. How did we get this far?... This love is a love from birth.’

(video ‘When adult children or grandchildren abuse an older family member’)

- https://www.youtube.com/watch?v=044a9S_dOMw

learning from case law

‘a relationship in which the two men (Mr Meyers and his son) *have become so enmeshed that the autonomy of each has been compromised’*

Hayden J concluded that the interference with Mr Meyers’ Article 8 rights was *‘a necessary and proportionate intervention’*. (Para 41, Southend-on-Sea Borough Council v Meyers [2019] EWHC 399 (Fam))

‘*The judgement is a stark reminder that reliance upon the presumption of capacity and the ‘right’ of individuals to make unwise decisions cannot, in and of itself, discharge public bodies of Article 2 ECHR to take practicable steps to secure that person’s life*.’

reflection – the cared for vs the carer

- challenges of ‘role reversal’ – increased guilt and shame on both sides and the fear of reaching out for help
- competing needs of each requiring separate focus; consideration of wellbeing of both the cared for and the carer
- value of psycho-social admission to hospice for respite
- support carer to understand the condition of the cared for and to care more safely
- focus of carer assessment on emotional (not just practical) support
- research shows carers reported ‘chronic verbal aggression’ and ‘psychological abuse’
- monitoring of DP arrangements
- use of formal safeguarding framework for measuring and monitoring risks over time / robust safety plan
- independent advocacy for the cared for and separately for the carer

reflection – end-of-life care

- palliative / long-term illness as a trigger for family conflict
- expertise of hospice in working with end-of-life clients – pragmatic approach in balancing the person's view alongside deeply entrenched family relationships and dynamics
- potential value of Family Group Conferencing and other models of safeguarding work with vulnerable adults and families
- pro-active advance care planning conversations – social and health care
- multi-agency and inter-professional model of end-of-life care

reflection – single and multi-agency response

- organisational and professional boundaries
- balance between safeguarding principle of proportionality and MCA principle of least restrictive option
- applied knowledge of interface between legislative framework covering mental capacity, mental health, safeguarding and human rights
- professionals attempted to ‘placate family’ and ‘going above and beyond’ – ‘treating the family rather than the patient’
- professional reservations to avoid negative impact on working relationships vs information sharing
- individual agency responses to increasingly confusing messages vs multi-agency working
- ‘professional curiosity’ and ‘authoritative doubt’ – address professional anxiety about working with hostile or resistant individuals/families, willing to have challenging conversations and hold respectful scepticism
- focus on staff welfare separate from operational management and case supervision
- formal reporting on staff experience of harassment and abuse
- multi-agency strategy discussion and shared decision making including specialist third sector organisations e.g. Hospice and Hourglass

two sides of the story

‘There are dark days… feeling no one understands me, feeling very alone, feeling just on my own… It’s a hard topic. It’s time to talk about caring.’

(video ‘Two sides of the story’)

https://www.youtube.com/watch?v=gHQ6hQ3SQUM&t=14s

references

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Professor Michael Preston-Shoot

SAFE CARE AT HOME

SOME FINDINGS FROM THE SECOND NATIONAL ANALYSIS OF SAFEGUARDING ADULT REVIEWS (APRIL 2019 – MARCH 2023)

SAFE CARE AT HOME

SOME FINDINGS FROM THE SECOND NATIONAL ANALYSIS OF SAFEGUARDING ADULT REVIEWS (APRIL 2019 – MARCH 2023)

QUANTITATIVE DATA

N=652 – all 136 SABs responded

- Cases featuring neglect/acts of omission – 299 (46%)
- Cases featuring domestic abuse – 107 (16%)
- Abuse/neglect by partner/relative/friend/carer – 166 (25%)
- Cases involving abuse/neglect at home – 151 (23%)
- Cases involving exploitation – 70 (11%)
- Cases featuring denied or difficult access – 32 (5%)
- = the breadth and complexity of adult safeguarding

WHEN FAMILY MEMBERS PREVENT ACCESS

- Westminster (2011) BB
- Newcastle (2014) Adult D
- Surrey (2014) Mr D
- Glasgow (2015) Ellen Ash
- City of London and Hackney SAB (2016) Mrs Y
- Blackpool SAB (2023) SAR Jessica
- Kent and Medway (not published)
  - Think family – assess the relationship history & dynamics
  - Family members may hold useful information & may help to gain entry
  - Assess impact if and when they withdraw help
  - Carer assessments
  - Assess mental capacity in terms of undue influence, situational capacity and the impact of controlling behaviour
  - What might lie behind a relative's resistance and hostility?

DOMESTIC ABUSE AND COERCIVE CONTROL OF OLDER ADULTS

- Salford SAB (2022) SAR Irene
- South Gloucestershire SAB (2019) Family Z
- Barking and Dagenham SAB (no date) SAR George.
- These SARs contain themes, including the difficulty of obtaining access to administer medical treatment and care and support (see, for example, Richmond and Wandsworth SAB (2021) SAR Evelyn).
- Scenarios are understood through the lens of carer stress rather than recognising abuse/neglect/exploitation.
- Lack of challenge for fear of losing all access to an adult at risk.

COMMENTARY FROM SECOND NATIONAL ANALYSIS (N=229)

GOOD PRACTICE

- Use of think family approach – 8%
- Work with unpaid carers – 4%
- Transition planning – 3%
- Safeguarding referrals for neglect by unpaid carers
- Challenging the care provided
- Recognising and exploring family dynamics/relationships
- Seeking views, responding to concerns and explaining risks

SHORTCOMINGS

- Use of think family approach – 38%
- Work with unpaid carers – 27%
- Transition planning – 15%
- Culture of resignation so concerns not addressed
- Fear leads to a lack of curiosity and challenge
- Individuals not seen privately, for example when access restricted or terminated
- Failure to consider "was not brought"
- Care giving not seen as abusive but through a lens of carer stress
- Lack of carer assessment – are they willing and able to care

SAR ANTHONY AND MARY (CORNWALL AND ISLES OF SCILLY SAB)

- Son with mental distress and alcohol dependence moves back to live with his mother.
- His mother is terminally ill. Her refusal to accept a care package not explored.
- Concerns escalate regarding his increasing self-neglect (alcohol-dependence and lack of self-care) and neglect of his mother's needs.
- Some concern about domestic abuse and whether he is able or willing to be a carer for his mother.
- Some concern about his mother's emotional wellbeing and relationship with his son.
- Very little focus on the backstory of their relationship and his alcohol-dependence.

There was some evidence of avoidance of difficult discussions.

"*Insufficient note appeared to be taken of the accumulating evidence of neglect in terms of access to medication and medical appointments, isolation from birth family, cancellation of the commissioned care package, preventing X making the decisions she had capacity to make, failing to ensure privacy and dignity and failing to ensure that X was clothed and groomed appropriately*."

"*Lack of practitioner confidence to challenge parents blocking professional best interests decisions for their son*."

"*Social workers feeling intimidated was not addressed in supervision*."

"*There was no consideration of the nature of the relationship between X and his informal carers, specifically whether he was subject to undue influence and/or whether he was a victim of coercion and control.*"

“The pressure to discharge potentially impacts on safety in the decision-making and discharge planning by inpatient services. District nurses acknowledged a referral from the ward but this was never activated or allocated for a visit, which showed up a weakness in the referral system, whereby when a referral is acknowledged electronically it disappears from the referrals inbox. The effect of this was that [the patient] was discharged with higher needs for both health and social care. These were unmet in the subsequent periods and contributed to her decline in an unsuitable home environment.”

“Her informal carer was given brief training on pressure ulcer care. However, there was no follow-up checks to ensure the pressure ulcer care was being done properly and no follow-up support offered.”

Practitioners did not always recognise risks from family members:

"*When her self-funded care package was ended by her partner a decision was made, without any reference to concerns that she was allegedly experiencing coercion and control, that her family member could provide this care instead.*"

Risk assessments were sometimes static rather than dynamic and were not regularly reviewed when an individual's circumstances changed. Examples include:

- Lack of reappraisal of risk when a young woman returned to live with her family
- Lack of risk review following cancellation of a care and support package
- Risk of violence within the family not considered when an individual returned home following
- prison release
- Failure to recognise that in the context of the Covid-19 pandemic, pre-existing risks could be
- exacerbated by isolation and restrictions

COMMISSIONING AND QUALITY ASSURANCE OF PROVIDERS (SAFE CARE AT HOME) (N=229)

- Shortcomings in commissioning – 24%
- Shortcomings in quality assurance – 10%
- Hospital discharge before care package in place – fit for discharge does not mean safe for discharge
- Care provider not notified to recommence care package
- Care provider staff do not raise safeguarding concerns
- Difficulty of finding home care providers, for example in rural areas or because of the complexity of needs

“Social worker did not discuss the case with the team manager. Care provider declined to accept the increase in a care package because of lack of resource. A second care provider was meant to begin but this did not happen due to poor communication. Lack of awareness that this care package was not being delivered. Not all available information was recorded or able to be seen by the different services involved.”

“Each individual working with [named individual] understood that there was a fire risk, but none had received training on fire risk to vulnerable people in the home and partners did not fully share their understanding of the risks with each other so they could not have gained a comprehensive view of the risks, including an understanding of the accelerant effect of emollients. All partners agree that practitioners did not receive appropriate fire training. While all partners are provided with traditional training on fire safety in relation to the workplace, there is insufficient awareness about fire safety in people’s homes and this needs to be addressed urgently.”

Comparison of the percentages between the first and second national analyses identifies a rise in cases featuring partners / relatives / friends / unpaid carers from 19% to 25%, endorsing the recent policy emphasis on safe care at home. Perpetrators classed as 'other professionals' (all practitioners apart from care workers or care provider agencies) have increased from 12% to 28% and there was a marginal increase in cases involving social contacts as perpetrators (from 9% to 11%). However, there was a small decrease in the frequency with which care workers / care providers were identified as the perpetrator (down from 30% to 28%).

How do SABs seek assurance about safe care at home?

Are current arrangements for addressing concerns about people in positions of trust adequate?

How well are we supporting practitioners to raise concerns (professional curiosity) about unsafe care at home?

PROFESSOR MICHAEL PRESTON-SHOOT

- Independent Chair, Somerset, Greenwich and Lewisham Safeguarding Adults Boards
- Joint Convenor National Network for SAB Chairs
- SAR Author
- Joint Lead, Second National Analysis of SARs

- michael.preston-shoot@beds.ac.uk

research
in practice

Considering practice in relation to Safe Care at Home

Lisa Smith

research in practice

Domestic Abuse and Disability

- Women with disabilities are twice as likely to be subject to domestic abuse, and typically experience it for longer before accessing support. (SafeLives, 2017)
- More disabled men experience domestic abuse than other men, with the risk to a disabled man being similar to that to women in general. (PHE, 2015)

I didn't notice it … he loved doing things for me … I'd never been taken care of properly … He was killing with kindness. If it wasn't kindness, he was booting me in the stomach so no one could see the bruises.

(Thiara *et al*, 2011)

research
in practice

Challenges in Responding to Controlling and Coercive Behaviour

- invisibility
- risk
- psychological impact – think trauma
- intersections with other oppressions and barriers
- interactions with care and support needs and mental capacity.

In situations of captivity, the perpetrator becomes the most powerful person in the life of the victim, and the psychology of the victim is shaped by the actions and beliefs of the perpetrator.

(Herman, 1992)

I couldn't see life beyond the abuse that I was experiencing, and I was also too fearful he had so much power over me that it would always make me go back.

(AVA and Agenda, 2018)

research in practice

Coercive Control and Safeguarding Adults

- A local authority's duty to make (or ask others to make) safeguarding enquires and determine what action is needed to protect "an adult at risk" are triggered by "reasonable cause to suspect" that an adult with health and social care needs is experiencing **coercive control** (where their needs prevent them from protecting themselves). (Department of Health (2016) Care Act Statutory Guidance)
- The statutory guidance in relation to the offence of controlling or coercive behaviour states it should be dealt with as part of adult and/or child safeguarding and public protection procedures.
- Multi-agency working: MARAC & MAPPA

research
in practice

Coercive Control and Older People

- Domestic abuse as a ‘largely hidden phenomenon’ comprising multiple forms of harm or abuse by people who are or have been intimate partners.
- A lack of conceptual clarity between domestic abuse and elder abuse.
- Complexity of family dynamics and relationships with abusers.
- Deficit in dedicated service recognition and provision. (McGarry et al, 2014)
- Invisibility of certain forms of violence, e.g. sexual violence, due to perceptions of older people. (Bows and Westmarland, 2017)

research
in practice

Coercive Control and Learning Disabilities

- Two small scale studies interviewed female survivors of domestic abuse in England, and found very high levels of physical violence. (Walter-Brice *et al*, 2012; McCarthy *et al,* 2015)
- Another study found people with a learning disability were over-represented in those accessing sexual assault support. (Majeed-Ariss *et al,* 2020)

*He used to take the p*** out of me because of my learning disability. He used to show me up in front of his mates if I couldn't work something out. He'd say 'you're useless, you can't do nothing'.*

(McCarthy *et al,* 2015)

research
in practice

Coercive Control and Carers

- Carer: someone who "provides or intends to provide care for another adult"; not a volunteer or contracted worker. (*Care Act*, 2014)
- Carers do abuse the person they are caring for; a carer could also be the victim of abuse. (Hague *et al*, 2008)

People pity him because he is taking care of you and so noble. So people are reluctant to criticise this saint or to think he could be doing these terrible things. … And people don't easily see a disabled woman as a wife, partner, and mother.

(Hague *et al*, 2008)

research
in practice

What do people subject to controlling and coercive behaviour want?

- Proactive asking about abuse.
- Acceptance and understanding: no blame.
- Recognition of risks / prioritising safety.
- Practical support and assistance.
- Space for action e.g. contact with others, friendship and mutual support.
- Strengths-based and Trauma Informed.

(Humphreys and Thiara, 2003; Abrahams, 2007; Ava and Agenda, 2017)

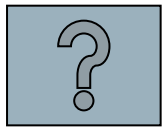
research in practice

Your role and responsibilities

"Treat me like a human being, like someone who matters."

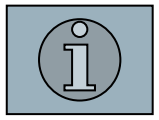
Holly & Scalabrino, 2012

Be aware of controlling and coercive behaviours



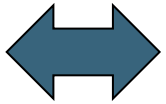
Ask people about abuse and coercive control

Listen – Validate – Do Not Blame – Work WITH

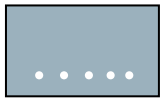


Offer appropriate support

Work with other services



CONSENT



Record accurately

research
in practice

Safe Enquiry

- Ensuring the potential perpetrator is not, and will not, easily become aware of the enquiry.
- Confidentiality – explain the limits.
- Ensure you are alone with the person – never ask in front of a partner, friend, family member or child.
- Make sure you can't be interrupted, and that you – and the person – have sufficient time.
- Only use professional interpreters and advocates (IMCA / IDVA / ISVA).
- Do not pursue an enquiry if the person lacks capacity to consent to the interview unless you have already arranged an advocate.
- Record! (but not in client/patient held records or organisational systems to which the perpetrator may have access).

Your Own Emotional Safety

- Be aware that intervention can create risk:
  - ensure documentation cannot be accessed by the perpetrator
  - work with the person: they understand their risk best.

(Cattaneo *et al*, 2007)

- But it can also lead to safety.
- Seek advice and guidance; work with others.
- Use supervision to discuss concerns and the impact it has on you.
- Acknowledge the emotional impact of the work.

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Questions and Discussions

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Thank you
Closing Remarks