

Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services

March 2013

This paper was developed by and with Directors for Directors. It was commissioned by the Local Government Association (LGA) *Safeguarding Adults Programme* in partnership with the Association of Directors of Adult Social Services (ADASS).

It is designed to give practical advice to Directors with statutory responsibility to ensure your service is moving in the right direction, is effective and would stand up to external scrutiny.

The full document can be downloaded from the LGA Knowledge Hub <https://knowledgehub.local.gov.uk/library> or <http://www.local.gov.uk/publications> or ADASS website <http://www.adass.org.uk/>



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Safeguarding Adults 2013

Introduction

Safeguarding adults is one of the **highest priorities** for Councils and will remain so; the Care and Support White Paper states that a high-quality service must be one which keeps people safe from harm. We are at a point where local Councils and Safeguarding Adults Boards have come a long way in their efforts to protect people from harm and are awaiting the detailed guidance and final new legislation.

But nobody can stand still, so this Advice Note intends to **fill the vacuum** until legislation is completed by bringing together the effects of recent changes, what we have learned, and anticipates forthcoming changes, in order to give Directors a common approach. It complements but does not replace the ADASS/LGA *National Framework of Standards*¹, Department of Health Guidance *No Secrets*² and its later *update*³.

Since the last ADASS Advice Note⁴ was published there have been **many and significant changes** in the wider world of adult safeguarding, including:

- The Law Commission's Review of Adult Social Care legislation⁵
- White Paper and draft Care and Support Bill published⁶
- Consultation on possible new safeguarding powers
- Implementation of the Mental Capacity Act
- Changes and developments in domestic violence legislation
- Developments in how hate crime is treated
- Winterbourne View, Ash Court, Mid Staffs and other high profile scandals
- Changes in the Care Quality Commission
- NHS re-organisation and new Healthwatch arrangements
- Police and Crime Commissioners
- Squeeze on public service spending

Further: sector lead organisations have agreed a set of standards; there has been a range of Council safeguarding peer reviews; ADASS, LGA and other relevant organisations have worked with the Department of Health on the safeguarding aspects of new legislation and guidance. However the final Care Quality Commission annual assessments indicated that, **despite all having some aspects of excellence, safeguarding continued to be the area that Councils had most difficulty with**. In an early keynote speech the Health Secretary Jeremy Hunt challenged the health and care culture of "*ticking the box, but missing the point*".

EXECUTIVE SUMMARY

The Vision

Our vision is that agencies who support people at risk of harm are able to prevent abuse happening, act swiftly when it does and are competent in achieving good outcomes for people. There must also be sufficient support, specialist, advocacy and justice provision within each area and the commitment from all agencies and organisations to work together.

THE VISION FOR ADULT SAFEGUARDING

*People are able to live a life free from harm,
where communities:*

- *have a culture that does not tolerate abuse*
- *work together to prevent abuse*
- *know what to do when abuse happens*

What Works

There is a growing body of documentation on most aspects of safeguarding, though less research into what works. A recent analysis of peer reviews⁷ and a 2012 LGA paper⁸ summarised the main findings taken from literature reviews, practice and policy reports, from which we are able to distil the following **key messages** for Directors:

- We must focus on **people** and the **outcomes** they want, valuing the difference that is made; process is an important means of achieving good outcomes but is not an end in itself.
- **Collaborative leadership** – supporting, integrating and holding partners to account – is key to cross agency engagement and effectiveness.
- **Effective interfaces** are essential - with developing Health and Wellbeing Boards, Community Safety Partnerships, Safeguarding Children Boards, etc.
- **Responsive specialist services** need to be in place and have a portfolio of responses to support people with difficult decision making.
- Make sure that concerns are addressed **proportionately** so that our systems are not swamped and we do not miss the really serious concerns.
- Commissioning, contracts management, care management review and safeguarding intelligence must be fully **integrated**.

Achieving Good Outcomes

Focusing on outcomes personalises safeguarding and entails working with people or their advocates from beginning to end of the process, while realising that their wishes may change along the way. People generally want more than one outcome and these are frequently hard to reconcile; they often relate to both wanting to be safe and wanting to maintain unsafe relationships. Safeguarding Adults Boards must also understand the role of **family carers** and ensure that policies, procedures and practice recognise their needs too.

Unless people's lives are improved, then all the safeguarding work, systems, procedures and partnerships are purposeless. Currently Directors and Safeguarding Adults Boards are faced with a plethora of input/output data but no way of telling from it if they really are making any impact. Directors must have a means of knowing what works and **how they are making a difference to people**.

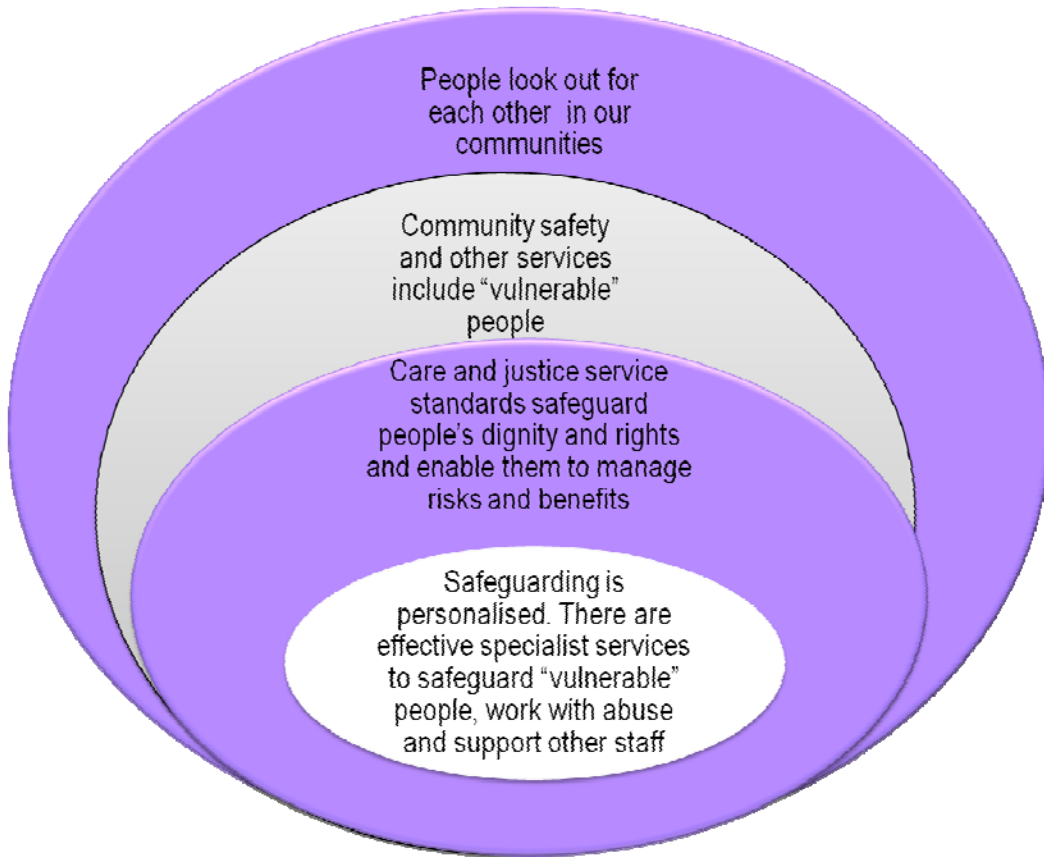
The Department of Health recently completed a review of its data collection and concluded that it must **do more to measure outcomes for service users** (see the latest version of the Adult Social Care Outcomes Framework ⁹). Some Safeguarding Adults Boards are developing new ways of capturing service users' views, aggregating relevant quantitative data, trends and emerging outcome measures to monitor their effectiveness. ADASS and LGA have worked with a number of Councils on an outcomes focus through Making Safeguarding Personal including a range of responses to safeguarding (see their latest standards and performance report ¹⁰). Similarly they are supporting the NHS Information Centre to pilot outcome measures.

Where Councils have looked at where people did not get the outcome they wanted, or were dissatisfied with the safeguarding service, it was often linked to not getting the justice and prosecutions through that they wanted.

Therefore we recommend **directors should ensure that:**

- you are leading a commitment to improve **outcomes** for people at risk of harm;
- you are developing the means to measure whether the outcomes people want are realised, so that practitioners, teams and the board know how effective they are;
- your service and procedures drive **engagement with people** and discusses with them the outcomes that they want at the beginning, middle and end of the process;
- your staff are competent in working with families and networks and have the skills, knowledge and permission to use the **full range** of legal and social work interventions;
- you are engaged with local criminal and justice services to make sure victims get the same **access to justice** as everyone else; and
- the performance of your safeguarding services is regularly checked and audited.

Safeguarding is everybody's business



Top Tips in Priority Areas

Achieving good outcomes for service users

- Ensure policies and procedures enable practitioners to focus on making a difference to people's lives.
- Build in the outcomes that people want right through the process.
- Adopt a performance framework that aggregates inputs, outputs, outcomes and trends, to measure how intervention has made a difference.
- Develop an inclusive approach that involves carers and families.

Responding to reported abuse

- Ensure all agencies agree on the definition of abuse.
- Ensure that guidance on alerts and referrals is proportional and kept under review according to levels of demand.
- Get all partners to agree and use a local multi-agency pathway for dealing with reports of suspected abuse.
- Have a system that regularly checks and reports response times and outcomes.
- Ensure procedures are easy to follow and emphasise user outcomes not processes.

Leadership

- Make sure safeguarding is embedded in corporate and service strategies across the Council and partners.
- Provide awareness training to Councillors and give them a role in preventing abuse.
- Present your Annual Safeguarding Report to the Overview and Scrutiny Committee and Health and Well Being Board.
- Make sure your new Police and Crime Commissioners, Clinical Commissioning Groups and Healthwatch have safeguarding high on their agenda.

Safeguarding Adults Boards

- Ensure the chair has the independence, knowledge and skill to challenge, lead and hold Board members to account
- Regularly review the Board's constitution to keep it up to date with NHS and other organisational changes.
- Make sure the Board has the capacity to plan and carry out its strategy and objectives.
- Ensure your Board is using its performance framework to measure its effectiveness and hold members to account.
- Use the self-assessment tool to audit your Board and plan how to fill gaps.
- Hold development sessions to keep members up to date and encourage joint working.
- Find ways for the Board to hear from and responds to people who have been through safeguarding.
- Build mechanisms to share data and intelligence.
- Test if risk management is proportionate and coordinated.
- Develop and deliver a communications strategy.

Top Tips in Priority Areas

Safeguarding Adults Reviews

- Agree a local protocol for deciding how and when to undertake a Safeguarding Review and how it fits into the regime of other reviews.
- Agree a range of proportionate types of review.
- Get all partners' commitment to fully participate in multi-agency reviews.
- Agree on how learning from reviews will be followed up and embedded in practice and procedures.
- Ensure that the reviews from other areas are considered by the board and the learning applied.

Personalisation

- Do not start from an assumption that personal budgets and direct payments automatically increase risk.
- Make safeguarding and risk management are integral to self-directed support.
- Make sure all partners understand the principles of personalisation and its implications for them.
- Encourage and enforce providers' standards of dignity and rights.
- Find ways of accrediting providers in the open care market.

Legal powers

- Ensure Safeguarding workers have the resources to understand and use the powers available to them and partner agencies.
- Make sure your social workers and managers are legally literate and can easily access legal advice.
- Ensure data on use of the Mental Capacity Act is collected and analysed to monitor its usage and identify any areas for concern.

Workforce

- Ensure your Safeguarding Adults Board has a training and development strategy, which audits, delivers, and monitors.
- Get assurance that there is a full range of training levels to cover the needs of all people who work with adults.
- With partners, deliver awareness raising to all people who may come into contact with adults who may be at risk of harm through work outside social or health care fields.
- Adopt and implement recognised competency frameworks.
- Ensure your safeguarding staff have the skills and competence to deploy a full range of social and legal interventions.

PRIORITY AREAS

Responding to Reported Abuse

Definition

Definitions of 'vulnerable adults' have proved problematic. The Care and Support Bill therefore refers to a person who:

- a) has needs for care and support (whether or not the authority is meeting any of those needs),*
- b) is experiencing, or is at risk of abuse or neglect, and*
- c) as result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it*

What is important is keeping the safeguarding effort focused on working with the person being harmed, to support improvement in their safety and wellbeing. Disabled people tell us that we should also use inclusive terminology: for instance refer to theft or fraud not 'financial abuse' and to rape not 'sexual abuse'.

Referrals and alerts

The growing awareness of adult abuse has led to a **big increase in reports of concerns and subsequent workload** for Social Services Departments.¹¹ There is widespread worry that services will either be swamped by demand or that cases of serious harm will fall through the net. However, analysis of alerts has shown that concerns have often been fed into the safeguarding system when **they should have been dealt with through alternative routes** such as contractual, managerial, complaints or disciplinary procedures. Many areas have developed their own guidance on referral thresholds; see ADASS North East Region¹² and North West Region¹³ for examples. Much safeguarding work could also be prevented by Safeguarding Adults Boards proactively ensuring that all providers, Health, Care and Police **address standards** to ensure that people's dignity and rights are respected.

There needs to be a **pathway that swiftly responds to alerts** by logging, giving information or referring them on to the appropriate organisation. When an **alert escalates into a referral** the multi-agency procedures must make responsibilities clear and put the victim at the centre. Partner agencies must all be agreed on how a decision is made as to the type of enquiry that will take place (eg Serious Untoward Incident, criminal investigation, disciplinary, etc) and how it will be reported back and acted on. Particular attention must be made to coordinate when more enquiries than one are running on the same case.

Making enquiries

The Bill proposes a **duty for local authorities to make enquiries**. It encompasses the concept of an adult needing care and support and not being able to protect themselves from actual or potential harm. How local authorities go about making such enquiries is presently variable but what matters is that **clear evidence** is established about the allegations made, so that people can be supported to manage the risks they face and to achieve their desired outcomes. A **quick response** is always necessary but where complexity indicates a lengthier timescale every effort must be made to keep the victim involved in

progress. Where there was previously no consistency (and a danger of people falling through a gap) in defining who was responsible to take safeguarding actions where a person was placed **out-of-area**, there is now an agreed protocol¹⁴, which all Councils should be using.

Leadership

We have learnt that safeguarding needs to operate on a number of levels and across a range of organisations to be effective - safeguarding has to be everybody's business. Directors of Adults Social Services must be **leaders in the wider role** of Councils, organisations and communities to make them safe for people. Directors should be working to build prevention into the infrastructure as opposed to being taken by surprise and reacting to events.

As part of their **corporate leadership role**, Directors should be visibly driving their Council towards zero tolerance of adult abuse and the equivalent priority for adults as they have for children. They should ensure there is a Council-wide approach to preventing abuse and keeping people safe embedded within its overall policy framework with strategies to support it. Councillors are rooted in local communities and can be extra eyes and ears so it is vital that they are made aware of adult abuse and know what to do if they come across it. A recent LGA guide¹⁵ gives advice and examples on how to involve councillors in safeguarding.

Outside the Council, Directors play a pivotal role in building strong relationships with other organisations such as the NHS, the police, third sector and providers. They will form the trust and bedrock on which a multi-agency approach thrives and lead the formation of sound local policies, procedures and lines of accountability.

Some Directors also chair their Safeguarding Adults Board; where they do so they must provide leadership and challenge to all Board members and show their **strength of independence** to equally challenge their own service and Council.

Safeguarding Adults Boards

Local authorities have always been expected to **lead** adult safeguarding and the proposed legislation will **formalise that as a duty**. Directors of Adult Social Services are in the frame to make it happen and will be held to account if it does not. The vision can only be achieved locally through organisations working constructively together - the local Safeguarding Adults Board provides the best means of bringing the diverse elements together and making it all work.

The pivotal role of Safeguarding Adults Boards has been nationally recognised and the Care and Support Bill proposes to put them on a statutory footing, in summary:

- **Local authorities** will be responsible for establishing and running Safeguarding Adults Boards.
- Boards must co-ordinate and **ensure the effectiveness** of what each of its members does.
- The local authority, Clinical Commissioning Group and chief officer of police must be **core members** (Boards have the power to determine other appropriate members).
- The Board must **publish a strategic plan** each financial year setting out how it will protect people at risk of harm and what each member is to do to implement the strategy.
- At the end of the financial year the Board must **publish an annual report** on its achievements, members' activity and findings from any Safeguarding Reviews during that period.
- It must consult its area's **Healthwatch** and involve the community in preparing the strategy.

What Makes Boards effective

Current research has shown that Safeguarding Adults Boards are variable in their structure and effectiveness, for example see *The governance of adult safeguarding: findings from research into Safeguarding Adults Boards*¹⁶. However while there is not a magical template, there are **clear principles that make for a high performing Board**.

A dynamic chair

The Chair has a critical role to **lead collaboratively**, give advice, support and encouragement but also to hold partners to account and ensure that interfaces with other strategic functions are effective. The chair will set the **tone and pace** and speak publically on behalf of the members. While not necessarily from a social care background they should have a profound understanding of the complexities of dealing with adult abuse and insight into the aspirations and pressures of the member organisations. Skills in leading senior management groups or committees are essential as well as the ability to cut through jargon and engage with lay people.

Research has suggested that chairs '**with independence**', rather than 'independent chairs' per se, are what has made a difference. In some areas the Chair of the Safeguarding Adults Board may also chair the Local Safeguarding Children Board. It is also possible for one Board to cover a combined number of local authorities but the efforts in balancing conflicting local interests may outweigh the economies of scale.

Good governance

Safeguarding Adults Boards operate mainly by consensus and influence so it is vital that their relationship to other boards, committees and organisations is clearly defined. There should be **agreed reporting arrangements** and assurance that safeguarding is embedded in the strategies and plans of the Council and its partners. The local authority will have established the Safeguarding Adults Board and should have linked it into the relevant Overview and Scrutiny Committee, portfolio holders and cabinet. The Board should have corporate links with the Safeguarding Children Board, Community Safety Partnership, Learning Disability Board, etc making sure that the work of the respective groups is mutually compatible both strategically and operationally. If not already done so, a formal link should be made with the new Health and Wellbeing Board and Clinical Commissioning Groups, with regular cross-reporting arrangements and member representation.

A concise **constitution** will set out an operating framework, the roles and expectations of Board members including their financial contributions and sign-up. Some Boards have joined with others to agree a **sub-regional** set of multi-agency procedures (for example, Pan London Multi-Agency Policy and Procedures¹⁷), and benefit from the advantage of consistent pathways for regionally based services and cost effectiveness. However Boards should keep their governance under review to anticipate and quickly respond to outside organisational changes.

Sound strategy and planning

It is fundamental that Boards have a sound structure, methodology and implementation plan to deliver their safeguarding strategy, but in some areas it is not that clear. Proposed legislation will make Boards **more publicly accountable** - they will have to annually publish their strategy and Annual Report.

The Board's **strategic plan** should set out its local vision, aims and objectives and it should have fully engaged its members and the local community in developing and signing up to it. It should state how it will achieve its objectives and what each member has to do. The Board should then follow up by detailing in its **Annual Report** what the members have done to implement the plan, evidence of progress and any Safeguarding Reviews.

Directors will want to ensure that the Board has full support and commitment from all members in maintaining its own structure of action and standing groups, performance management and reporting mechanisms by which it can gauge progress and identify potential problems. It must also have the **capacity to coordinate the work streams and keep them on track**.

Holding people to account

Safeguarding Adults Boards are accountable to local authorities and governing arms of member organisations. They are also in the public eye, most noticeably through their published reports, appearances at Overview and Scrutiny Committees/Panels, and when things go wrong. This means Boards sometimes have to account for themselves directly to the public. In turn the chair must have the means to **hold Board members to account** for their actions or inactions. For example, commissioners about unsafe delivery of residential care, or the police about inadequate response to disability hate crime. Therefore organisational representatives must be of **sufficient seniority** to make commitments and have the authority to ensure they are carried out.

A recent paper¹⁸ identifies the gap in safeguarding for **social housing** tenants, an area that has not yet been fully developed. It outlines how all providers need to ensure that they have appropriate policies and procedures in place to help prevent, detect, and deal with abuse. These policies should apply to all tenants at risk of harm, not just those living in sheltered, extra care and supported housing.

Criminal justice system members will need to ensure that their organisations support enquiries and enable adults at risk, victims and witnesses to have access to justice. Those working with domestic violence, hate crime and anti-social behaviour must be alert to and include people who may be at risk of harm.

There are a range of internal and external mechanisms available on the LGA hosted Knowledge Hub¹⁹ to evaluate whether systems are working effectively and the desired outcomes are being achieved. These run from auditing case files and service user feedback, to peer review and benchmarking, which has become the norm in **sector-led improvement**. It is important not to rely only on a single means but to be able to triangulate information from different sources to objectively evaluate effectiveness. We recommend that Boards assess themselves by applying the **self-assessment tool**²⁰, which was developed by and used within the sector, and use the results to set priorities and targets for improvement. Some Boards now run annual **challenge events** modelled on Safeguarding Children Boards Section 11 Challenge which puts every organisation in the hot seat.

Active members

Most Boards currently have as a **minimum membership**: a range of Council functions including adult social care; NHS commissioners and providers; police and other blue light services; independent care providers and third sector. But all members of a well functioning Board will be actively involved in its work and have gone through the local **induction training**. The Board should keep track of **attendance to**

ensure continuity and a means of holding organisations to account if their engagement deteriorates. Members will be clear on what is expected of them and be a **safeguarding champion** within their own organisation. Many of the members will be working together in other networks and making connections to improve safeguarding across them. While Board level meetings may be as far apart as three months, there should be regular **development sessions** to build common understanding, keep members up to date with local and national changes and respond in-depth to significant issues.

People using safeguarding services and family carers can add a rich dimension to meetings and will help to keep the focus on outcomes, however many Boards have struggled with how to achieve engagement that is not merely a token and have settled on group representation. **Voluntary sector** and organisations of disabled, older and mentally ill people play a crucial role with regard to the provision of advocacy, signposting and prevention. We encourage directors to challenge their Boards to develop user representation; the ADASS Advice Note on involving carers in safeguarding²¹ and a guidance paper from the Social Care Institute for Excellence²² are helpful resources.

Intelligent commissioning

Although Safeguarding Adults Boards do not commission services they do bring together commissioners and providers, set standards and influence commissioning decisions in both social care and health sectors. Effective Boards gather and share market intelligence from a wealth of sources - the more diverse and active its members the better. The data will be both **formal** (alerts, referrals and trends) and **informal** (generalised concerns, unresolved allegations, users' complaints and expressions of dissatisfaction). When gathered together into a database, patterns will emerge which can prompt further enquiries or a watching brief. Open to all members, it will shift the Board from reactive to proactive - preventing harm before bad practice can build up. The LGA are shortly due to publish a guide on pooling data and intelligence which will be available on their website²³.

When services are commissioned safeguarding should be the **overarching standard**, which is underpinned by all other care standards, such as privacy and dignity, clinical governance and poor practice concerns. Boards should ensure they are working with emergent **Healthwatch** organisations to share areas of concern and gain an additional perspective on providers. The Board needs to give particular attention to the reports on Winterbourne View²⁴, the resulting programme of action Concordat²⁵ and the report on Mid-Staffs Hospital²⁶. Your Board should have considered these reports and agreed a local response to ensure similar scandals will not happen in your area.

Joined-up risk management

The emphasis must be on sensible risk appraisal, not risk avoidance, which seeks a **proportionate** tolerance of acceptable risks. In the words of Lord Justice Munby²⁷ "*What good is it making someone safer if it merely makes them miserable?*"

There is an important distinction between putting people at risk and enabling them to choose to take reasonable risks. When abuse does take place, it needs to be dealt in a way that allows the adult at risk to stay in as much control of the decision-making as possible. Social workers must make sure that people are making their own informed decisions about what protection means to them and are **supported to weigh up risks and benefits**. People should be engaged in their own risk management by the most relevant means, a wide range including: hate crime arrangements; anti-social behaviour panels; and Multi Agency Public Protection Arrangements (MAPPA). There should be advocacy available

and, where people lack capacity, Independent Mental Capacity Advocates (IMCAs) and the skills to know when to use them. Good risk management will spell out for the Board, organisation and affected individuals what risks are being taken and how they will be managed.

Partner organisations should have internal procedures and systems to manage the risks that they and their workers have to take but that is not enough in a multi-disciplinary setting. By its very nature **managing adult safeguarding is a risky business**, there must be a cross-agency approach built into the Board's safeguarding procedures which recognizes inherent risks and has a system for agreeing how and when decisions are taken on individual cases. When partners share case information they are far less likely to miss vital signs, workers and managers are more likely to develop alternative views on complex situations and hence make better decisions. Some Boards have set up **risk management sub-groups** to offer advice to managers and practitioners on individual cases. For further reference we recommend The Social Care Institute for Excellence's Good Practice Resource²⁸ which includes a section on risk assessment and management.

Pro-active Communications

If Boards have an agreed approach to communications they will usually be on the front foot, working preventatively and in the best position to respond to a crisis. The recommended way to do this is through a communication strategy consisting of the following elements:

- An information-sharing protocol between partner organisations.
- A user-friendly web site that explains how safeguarding works in your area.
- Posters, displays and campaigns telling people what to do if they suspect someone is being abused.
- A programme of regular messages to the public along with annual reports, strategy and plans.
- A range of channels for service users and their families to make their voice heard.
- Recognition of hard-to-reach groups and a means of engaging them.
- A means of coordination for the public release of information and speaking to the media.

Safeguarding Adults Reviews

Serious Case Reviews (SCRs) have developed as a significant **learning mechanism** in child and adult safeguarding but as media attention has focussed on them (particularly in child care) they have been increasingly perceived as inquiries rather than reviews where, in extreme cases, no-one will participate without a lawyer present.

There is a clear expectation in the proposed Bill that safeguarding Adults Boards should be commissioning and learning from reviews. While it drops the title of "Serious Case Review" in favour of "Safeguarding Adults Review", it helpfully brings together differing definitions

"An SAB must arrange for there to be a review of any case in which -

*a) an adult in the SAB's area with needs for care and support (whether or not the local authority was meeting any of those needs) was, or the SAB suspects that the adult was, experiencing abuse or neglect, **and***

b) the adult dies or there is reasonable cause for concern about how the SAB, a member of it or some other person involved in the adult's case acted."

A recent review²⁹ of 22 SCRs concluded that there was evidence of poor inter-agency communication in 17 of them and nearly all SCR investigations highlight a breakdown in partnership working as key factor in failing to keep people safe. There was no consistency on thresholds for holding a Serious Case Review and little evidence of action plans and follow-up.

The overriding reasons for holding a review must be to learn from past experience, improve future practice and multi-agency working. **It is not the role of Safeguarding Adult Reviews to apportion blame** - that is for the courts or other arenas. Boards should have a protocol for how and when to commission a Safeguarding Adults Review and, equally importantly, stating how they will implement and monitor the recommendations.

Cost effectiveness is an issue for Safeguarding Adults Boards as an independent commission can prove expensive and in some areas there is an all-or-nothing approach to commissioning reviews. Some Boards, and very recently all the London authorities³⁰, have developed a **proportionate approach** which offers Boards a range of options to match against the seriousness and circumstances of the case, allowing a faster and more cost effective response while maximising the Board's learning.

Personalisation

The introduction of personalisation has brought a change to how safeguarding risks present themselves and how they are recognised and managed. Along with increased freedom to choose and arrange your own care has come the concern about risk of exploitation (although increased control also potentially reduces risk). Local authorities are losing their leverage as large scale commissioners with some ability to ensure quality in provider standards while individual service users are a lone voice. Directors are striving to **balance two elements**: maximising people's personal freedom and safeguarding adults who are at risk of harm and abuse.

Personalisation and safeguarding are two sides of the same coin: empowering people to speak out, enabling them to make informed choices and encouraging communities to look out for one another. The two concepts are also inseparable from **quality and dignity**. Personalisation needs to work for everyone including those who are least able to access services or those considered at greatest risk. Well designed self-directed support processes should be unique to the individual and have checks and balances built in - overprotective approaches can in themselves put people at risk.

Where people receive a personal budget or direct payment they often use it to employ a personal assistant. The individual employing them is put in a very difficult legal and emotional situation if the assistant abuses them. They are expected to act within employment law and may also be reluctant to disclose problems of harm as they are afraid of having their payment suspended and the ultimate fear of losing their independence.

Care management, good contracts management and quality assurance will go a long way to addressing safeguarding and personalisation, but without **social work skills** people will remain with merely increased services or monitoring rather than improved circumstances and outcomes. The LGA "Making

safeguarding personal: A toolkit for responses"³¹ is a good practical guide to methods of working with individuals and families.

All providers should share a common value base ensuring that people are treated with dignity and respect, safeguarded from harm and founded in person-centred care. Directors and their Boards need to ensure that this is explicit in all service delivery systems and assured that it is fully understood by all staff. Some Councils have developed **market places** which control quality assurance of care providers and easy-access to the full range of services for people with direct payments. The Department of Health's guide "Practical approaches to safeguarding and Personalisation"³² provides a briefing on how self-directed support can help to prevent or reduce the risk of harm and shows how Councils are integrating safeguarding and personalisation. The following principles need to be in place in your area

- There are options for people to choose **accredited services** and supports (including an offer of CRB/Vetting and Barring and quality checks).
- Care planning is person-centred and **regularly reviewed**.
- People have access to **information and advice** about protecting themselves, the services they use and what to do if they are being harmed or abused.
- **Advocacy** services are available for people who are unable to challenge or change circumstances that they experience as abusive or harmful.
- Commissioning by the NHS and local authorities in health and social care services builds in the assurance that a quality framework is in place and is tested.
- **Whistle blowing help lines** are available to staff of all care providing organisations.

Legal Powers

A balance has to be struck between safeguarding against harm and not overruling the wishes of people with the capacity to decide they do not want to go through a safeguarding process. Practitioners need to be clear that people are making decisions free from undue influence or coercion. There is a range of criminal, civil and other powers and duties to support the practice of adult safeguarding, however, we have found that **many of these are underused** and that practitioners are not as aware of them as they ought to be. Directors should therefore make sure your staff are **legally literate**, that is they know what these powers are and when and how to use them in the best interest of the person at risk of harm. They should also be sufficiently trained, up to date and have easy access to legal advice when they need it. Also Safeguarding Adults Boards need to be assured that Council, Police and Health services are working together to make best use of existing powers.

Of course all safeguarding work should be based on the principle that people who have experienced harm or exploitation should be **fully involved and in control of safeguarding processes**. Work with individuals should take place within the **least restrictive** context but some situations will dictate the need to resort to the statute book. Choice and risk need to be integrated with the duty of care established in common law in relation to all services - a duty that is both about how services are provided and what the outcomes are. An individual with capacity may choose to take risks, however providers or commissioners could be exposed to litigation if *they* place people in a position of risk.

Care should be taken to ensure proper assessments of a person's capacity to make decisions for themselves, using the Mental Capacity Act (MCA), are diligently followed and that the potential for undue influence from others is fully taken into account. The underlying philosophy of the MCA is to ensure that any decisions made, or actions taken such as deprivation of liberty, on the individual's

behalf is in their best interest **not for the convenience** of their family or carers. Some Boards have established **sub-groups** to monitor and advise on the use of the MCA; regular reports on such activities are a good way of gauging their under- or over-use. Local guidance should always lay out the **alternative legal avenues** such as common law, Court of Protection, domestic violence legislation (covered in a new LGA guide³³), etc. We recommend the Social Care Institute for Excellence's guide³⁴ to safeguarding law for practitioners for further information.

There is currently a debate about whether any more powers are needed to **protect people with capacity**. The government published a separate consultation document³⁵ alongside the Draft Care and Support Bill. It sought views on whether there should be a new power to make safeguarding enquiries where staff cannot gain access to a person with capacity whom it believes could be at risk of harm. We are aware however that when discussing potential powers of entry with people, that some of the examples of where they thought it would have proved useful could (and perhaps should) have deployed other existing powers.

Workforce

It is evident that there are **considerable workforce development issues**. Councils have invested significantly in training and in many areas they are funding courses for the majority of staff from partner and provider agencies. However, the majority of resource seems to go into basic level awareness-raising or training on process and procedures, at the expense of the more **specialist** social work skills of responding and seeking to resolve people's circumstances with them while investigating and managing cases. Safeguarding managers need to be confident and competent leaders, able to put policy into practice, supervise and support their staff to achieve positive outcomes for citizens and carers. Social workers need to be able to assess, analyse, manage and mitigate negative risks with citizens and carers, alongside enabling positive risk taking. As mentioned above, social workers need to be legally literate, able to understand and access appropriate legal interventions where and when necessary. All staff must keep up to date with developments in practice, policy changes and understand what might be available to support their work. But safeguarding is wider than adult social care and people in all sectors who are in contact with adults at risk of harm must be able to recognise abuse and know what to do if they have concerns.

Training should be competency based to ensure that workers' practice meets consistent standards. We recommend that Boards embrace **competency based frameworks** to support leaders and managers in ensuring that their workforces are appropriately developed. Serious consideration should be given to embracing the "Learn to Care" National Competence Framework for Safeguarding Adults³⁶. Resources are available to help in the form of the recently revised ADASS and Skills for Care Advice Note³⁷ on social work in adult social services accompanied by a web-based resource³⁸.

It should follow that when providers, safeguarding teams and commissioners, sign up to standards of care they will have in place the right staff training to deliver them. Directors need to be assured that organisations know what **levels of training are expected** for their staff, have **audited** their needs, and that they are delivering the right training. Monitoring will come through contract compliance for commissioned services and sector-based information through the Safeguarding Board - most Boards will already have a training and development **sub-group** reporting directly to it. We strongly advise Directors to ensure their Board has a safeguarding **training and development strategy** that links into the main training strategies of their member agencies and is an integral part of the Board's annual strategy.

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REFERENCES and RESOURCES

- ¹ "Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work", ADASS, October 2005 <http://www.adass.org.uk/images/stories/Publications/Guidance/safeguarding.pdf>
- ² "No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" Dept. of Health, March 2000. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_407454_0.pdf
- ³ "Statement of Government Policy on Safeguarding Adults" Dept. of Health, May 2011. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126770.pdf
- ⁴ "Safeguarding Adults 2011: Advice Note", ADASS/LGA, April 2011. <http://www.adass.org.uk/images/stories/Safeguarding%20Adults/SafeguardingAdviceNote0411b.pdf>
- ⁵ "Adult Social Care" The Law Commission, May 2011. http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf
- ⁶ "Draft Care and Support Bill", HMSO, July 2012. <http://www.dh.gov.uk/health/2012/07/careandsupportbill/>
- ⁷ "Early Messages from Peer Reviews" Richard Humphries, The Journal of Adult Protection Issue 2 Vol.13 2011. <http://ww4.emeraldinsight.com/journals.htm?issn=1466-8203&volume=13&issue=2&articleid=1927697&show=abstract>
- ⁸ "Key Messages in Relation to Adults from the Sector" Cathie Williams, LGA Adult Coordinating Group, April 2012
- ⁹ "The Adult Social Care Outcomes Framework 2013/14" Department of Health November 2012. <http://www.dh.gov.uk/health/files/2012/11/The-Adult-Social-Care-Outcomes-Framework-2013-14.pdf>
- ¹⁰ "Adult Safeguarding: Standards and Performance Summary", LGA and ADASS, July 2012. http://www.local.gov.uk/c/document_library/get_file?uuid=d902ca07-7eca-4933-9b90-3f5531cf7aa6&groupId=10171
- ¹¹ "Abuse of Vulnerable Adults in England, 2011-12: provisional report, experimental statistics", The Health and Social Care Information Centre, November 2012. http://www.ic.nhs.uk/webfiles/publications/009_Social_Care/Abus-Vuln-Adul-Eng-1112-prov/abus_vunr_adul_eng_11_12_prov_rep.pdf
- ¹² "North East Safeguarding Threshold Guidance," North East ADASS Region, 2011. http://www.adass.org.uk/images/stories/Regions/North%20East/Safeguarding_thresholdsNEJan12.pdf
- ¹³ "Safeguarding Adults Thresholds Guidance," South West ADASS Region, March 2011 <http://www.torbaycaretrust.nhs.uk/ourservices/SafeguardingAdults/Documents/South%20West%20Thresholds%20FINAL.docx>
- ¹⁴ " Out-of-Area Safeguarding Adults Arrangements", ADASS Guidance Note, December 2012. http://www.adass.org.uk/images/stories/Policy%20Networks/Safeguarding_Adults/Key_Documents/ADASS_GuidanceInterAuthoritySafeguardingArrangementsDec12.pdf
- ¹⁵ "Councillor's Briefing - Adult Safeguarding", Local Government Association & Research in Practice for Adults, March 2013. <http://www.local.gov.uk/publications>
- ¹⁶ "The governance of adult safeguarding: findings from research into Safeguarding Adults Boards", Braye, Orr and Preston-Shoot, Social Care Institute for Excellence, September 2011. <http://www.scie.org.uk/publications/reports/report45.pdf>

-
- ¹⁷ "Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse", Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board, January 2011.
<http://www.scie.org.uk/publications/reports/report39.pdf>
- ¹⁸ "Adult safeguarding and the role of housing", Imogen Parry, Journal of Adult Protection Vol.15 No. 1 2013.
http://www.emeraldinsight.com/search.htm?st1=imogen+parry&ct=jnl&fd1=all&bl2=and&st2=%221466-8203%22&fd2=isbn&form_button=Search
- ¹⁹ Local Government Association Knowledge Hub, Adult Safeguarding Community of Practice Group
<https://knowledgehub.local.gov.uk>
- ²⁰ "Safeguarding Adults Board Self-assessment", LGA/ADASS/NHS Confederation/Social Care Institute for Excellence.
http://www.adass.org.uk/images/stories/Safeguarding%20Adults/Safeguarding%20Standards%202010_11.pdf
- ²¹ "Carers and Safeguarding Adults - Working Together to Improve Outcomes", ADASS publication, July 2011.
<http://www.familycarers.org.uk/Libraries/Local/866/Docs/Resources/Other%20Resources/carers-and-safeguarding-document-june-2011-5730.pdf>
- ²² "User involvement in adult safeguarding", Janet Wallcraft and Angela Sweeney, Social Care Institute for Excellence report 47, September 2011. <http://www.scie.org.uk/publications/reports/report47/files/report47.pdf>
- ²³ "Making effective use of data and intelligence to improve safety and quality in adult social care services", Local Government Association, March 2013. <http://www.local.gov.uk/publications>
- ²⁴ "Transforming Care: A national Response to Winterbourne View Hospital", Department of Health, December 2012.
<https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf>
- ²⁵ "DH winterbourne View Review Concordat: Programme of Action", Department of Health, December 2102
<https://www.wp.dh.gov.uk/publications/files/2012/12/Concordat.pdf>
- ²⁶ "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary", The Stationery Office, February 2013. <http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>
- ²⁷ "What price dignity?", Lord Justice Munby, keynote address at LAG Community Care conference: Protecting liberties, London, 14 July 2010. <http://www.lag.org.uk/files/93404/FileName/LordJusticeMunby-speechatLAGCommunityCareProtectingLibertiesconference14July2010.pdf>
- ²⁸ "Protecting adults at risk in London: Good practice resource" Social Care Institute for Excellence, October 2012.
<http://www.scie.org.uk/publications/adultsafeguardinglondon/index.asp>
- ²⁹ "Serious Case Reviews in Adult Safeguarding in England: An Analysis of a Sample of Reports", Jill Manthorpe and Stephen Matineau, in British Journal of Social Work Advance Access, September 2010.
<http://www.sequeli.com/docs/scr%20bjsw%20sept%202010.pdf>
- ³⁰ "Serious Safeguarding Adults Reviews: Guidance note on options for London", Working Paper, November 2012.
http://www.scie.org.uk/adults/safeguarding/files/SCR_Options_London.pdf
- ³¹ "Making safeguarding personal: A toolkit for responses", Local Government Association, December 2010
http://www.local.gov.uk/c/document_library/get_file?uuid=1d2d2327-7d01-491a-bf7b-2512e13fd130&groupId=10171

-
- ³² *"Practical approaches to safeguarding and Personalisation"*, Department of Health, November 2010.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121671.pdf
- ³³ *"Safeguarding adults and domestic abuse: a guide for practitioners and managers"*, Local Government Association, March 2013 <http://www.local.gov.uk/publications>
- ³⁴ *"Safeguarding adults at risk of harm: A legal guide for practitioners"*, Social Care Institute for Excellence, December 2011
<http://www.scie.org.uk/publications/reports/report50.pdf>
- ³⁵ *"Consultation on New Safeguarding Power"*, Department of Health, July 2012.
<http://www.dh.gov.uk/health/files/2012/07/Consultation-on-New-Safeguarding-Power.pdf>
- ³⁶ *"National Competence Framework for Safeguarding Adults"*, Bournemouth University, Learn to Care, Skills for Care and the Social Care Institute for Excellence, September 2010.
<http://www.surreycare.org.uk/cms/uploads/downloads/generic/safeguarding/competencies.pdf>
- ³⁷ *"Social work in adult social services"*, ADASS and Skills for Care revised Advice Note, July 2012.
http://www.cpea.co.uk/FSWM2_index.html
- ³⁸ http://www.cpea.co.uk/FSWM2_index.html