Safeguarding adults

A study of the effectiveness of arrangements to safeguard adults from abuse

November 2008

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- put the people who use social care first;
- improve services and stamp out bad practice;
- be an expert voice on social care; and
- practise what we preach in our own organisation.

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Commission for Social Care Inspection

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Executive summary

Introduction

1 This study reports on arrangements in place in England to help prevent the abuse of adults and to support those who experience abuse. The study focuses on the effectiveness of these arrangements, rather than the prevalence of abuse. The Commission for Social Care Inspection has analysed evidence from the range of its regulatory and inspection functions across councils, care homes, home care agencies and other social care services to consider the responsiveness of safeguarding arrangements and the effectiveness of strategies to help prevent abuse and enable people to stay safe and be free to live their lives as they wish.

Background

2 A review is now under way of current government guidance on responding to adult abuse, *No secrets*[1], which aims to respond to some of the current challenges facing safeguarding services, including the need to:

- shift towards an approach to abuse which more strongly recognises individuals' human rights and their rights as citizens
- give more emphasis to prevention
- clarify language and terminology
- be clearer about the boundary between abuse and poor practice
- consider whether additional legislative powers or duties would be helpful in setting clearer expectations upon and between the responsible authorities.

The findings of this study are designed to contribute to this debate.

1 Department of Health (2000) *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.* London: Department of Health

Summary of progress in arrangements to safeguard people from abuse

3 The overall picture is one that shows:

i. Uneven progress in the development of effective arrangements by councils and care services to safeguard people.
ii. Variability in the quality of support provided to individuals who experience abuse, which is unacceptable given that abuse is a violation of a person's human rights.
iii. More needs to be done to ensure people who direct their own support on a daily basis are also able to benefit from appropriate and individually tailored safeguards.
iv. Actions to help prevent abuse and support better outcomes for people in the long term who have experienced abuse are variable within and across council areas and within individual care services.
v. The best councils are demonstrating active leadership on safeguarding and building strong strategic partnerships locally, but there is some distance between the best and worst performers.
vi. A correlation between the performance of councils and of regulated services in respect of safeguarding arrangements. In other words, if a council is performing well on safeguarding, a greater number of care services in the area are also performing well.
vii. A positive relationship between a care service's overall quality rating and its ability to safeguard adults.

People's experiences of arrangements to safeguard them from abuse

4 In councils taking part in this study, annual increases in referrals ranged from 10–150%, reflecting in part varied practice in raising awareness of abuse and the steps to take.

5 Councils are targeting information at older and disabled people, but are not always reaching people with mental health needs, those who misuse drugs or alcohol, people from black and minority ethnic communities and people funding their own care.

6 Once an alert about a possible incident of abuse reaches the council, individuals involved are generally responded to promptly, although out-of-hours responses tend to be less consistent. But some people, who councils are trying to safeguard, say that once 'in the safeguarding system', they can feel carried along by the process and lose or lack control.

7 People value advocacy support but 58% of councils inspected noted shortfalls in advocacy. There are examples of people being successfully helped by

independent mental capacity advocates but the service is still at very early stages.

8 Councils are beginning to provide options to help prevent abuse for people who direct their own support (under developments such as Individual Budgets) but the evidence indicates that no council yet has a systematic approach in place. Information and support to people funding their own care was also variable between councils.

9 In 20% of care services, no people using the service interviewed for this study could remember receiving and understanding information about what to do if they have concerns about abuse. This highlights the challenge for care providers in ensuring that people know and retain information about channels of help. However, services with high quality ratings seemed able to tackle this more effectively.

10 In 82% of care services, everyone interviewed for this study felt that they could speak to a staff member or manager if they felt unsafe but in only 61% of services did they all feel confident that the concerns that they raised with their service provider would be acted on.

The quality of support and care practice to keep people safe from abuse

Councils

11 In almost three-quarters of council inspections unacceptable variability was found in the standard of practice when supporting someone who has experienced abuse in at least two of the following: a clear chronology of events and core information; risk assessment; protection plans; and case recording. Evidence of this varied practice was also found by tracking individuals' actual experiences.

12 Some councils are providing more specific guidance to staff to distinguish between allegations that should be investigated through safeguarding procedures and concerns that should be dealt with in other ways. The best arrangements appear to be where there is a broad and inclusive definition of safeguarding but a number of options regarding the approach to take, dependent on the circumstances of the abuse.

13 Councils' protocols for information sharing were found to be good in 83% of service inspections. However, difficulties were reported in respect of GPs' and hospitals' understanding of confidentiality and information-sharing protocols, particularly mental health services. Information sharing with care providers can also be problematic for councils.

14 The support provided to people after they experience abuse is variable. The best councils had a wide menu of both short and long-term support to draw on which could be tailored to personal needs.

15 Intervention from councils to support people who experience abuse in residential settings needs strengthening, for example by councils providing ongoing support to individuals through care plan reviews or developing personalised protection plans, rather than only working with providers to drive up the overall standards in the service.

16 The use of legal powers to protect individuals from perpetrators is very patchy and appropriate legal remedies are not widely understood by front-line staff.

17 Training about safeguarding has risen from 71% of relevant council staff in 2006-07 to 81% in 2007-08[2]. But councils report that only 46% of independent sector staff have had council commissioned training – this needs to improve to ensure that staff from all sectors are equally informed about local arrangements for protecting people from abuse.

Care services

18 In a seven-month period in 2007-08, the Commission received safeguarding alerts in respect of 6.3% of poor services and 2.9% of adequate services, compared to 1.9% of good services and 1.0% of excellent services. Alerts were received about a higher proportion of privately run services (alerts received about 2.0% of services) than council or voluntary sector services.

19 The proportion of regulated services meeting the National Minimum Standards (NMS) on protection from abuse has risen substantially over the past five years, with 78% of care homes for older people and 77% of care homes for younger adults meeting the standard in 2006-07. This is up from 46% and 47% respectively in 2002-03, the year the NMS were introduced. For home care agencies the figure was also 77% in 2006-07, up from 55% in 2004-05 when they first came into regulation. Private sector services are least likely to meet the standard, across all types of service. Whilst progress is to be welcomed, and many of the shortfalls in 2006-07 in meeting the NMS assessed by inspectors were relatively minor, it remains unacceptable in the context of such an important standard – five years after it was introduced for most services – that even minor deficiencies are still present.

20 Moreover, the thematic inspections of care services suggest that the picture is somewhat worse when the standard is examined in closer detail. One

2 From the self-assessment survey of council adult social services.

reason for this is that the NMS concentrate substantially on the processes for safeguarding people, for example whether there are robust procedures for reporting abuse, rather than examining outcomes, such as whether staff have a good understanding of their role in safeguarding people, which it was possible to examine in the thematic inspections.

21 The most common shortfalls in regulated services are inadequate staff training and implementation to ensure staff understand safeguarding, written documentation such as safeguarding policies and procedures, and recruitment practices.

22 Of the managers of regulated services interviewed for this study, 73% said they understood the process for making a safeguarding referral, although there were marked variations in different areas. It was noticeable that managers of regulated services in the areas of the higher performing councils had a better understanding than managers in the areas of the lower performing councils.

23 Understanding of the local procedures by managers in regulated services can be hampered if the provider's policy on safeguarding does not dovetail with the local council multi-agency procedures. In 5% of inspections of regulated care services during a two-week period, it was noted that the provider's policy and the council policy were incompatible. This may be an underestimate as this was not a specific issue on which inspectors were asked to report.

24 Nearly all managers of regulated services who were interviewed said that they were carrying out Criminal Records Bureau checks at the point of recruitment but there was less confidence about the range of other checks. Over 40% of managers could not explain the role of the Protection of Vulnerable Adults (POVA) list adequately and 19% said they did not know about the POVA list and how to use it.

25 There appears to be a correlation between staff training on safeguarding and the overall quality rating of a service, ranging from 40% of the lowest-rated services indicating all staff had received training to 100% in the highest-rated services.

26 Despite the effort and resources going into developing the workforce, training *and its implementation in practice* still topped the list of statutory requirements placed on providers in the thematic inspection of regulated services.

Checking that the arrangements work and making improvements

Councils

27 Over two-thirds of councils are failing to monitor safeguarding adequately, through appropriate management overview of both individual cases and the arrangements as a whole. At a casework level, over half of the councils inspected need to improve recording and supervision, and two-thirds to improve auditing processes.

28 At a strategic level, councils are recording the number of people receiving support because of abuse, which provides a better measure of levels of activity in safeguarding work. However, most councils need to put systems in place to obtain feedback from people who have experienced abuse and monitor the outcomes for people in order to improve services.

29 Councils vary in how well they commission services that have good arrangements for safeguarding people. However, the better-rated councils overall had more care homes in their area meeting the NMS protection standard. Accordingly, more than 8 out of 10 three-star councils have 90% or more of the care homes in their area meeting NMS protection standards. By contrast, only 7 out of 10 one-star councils achieved this.

Care services

30 Only 38% of managers said they had used their experience from a safeguarding incident to improve practice. Only 16% of managers said that they were enabling people to give regular feedback on how the service could improve to make people feel safe. Higher-rated services are performing better in both learning from incidents and using feedback surveys to improve practice in safeguarding people.

The regulator

31 Some members of the public, staff in councils and in care services remain confused about the role of the regulator in respect of safeguarding; both in situations where individual people need support because they have experienced abuse and in the development of local safeguarding arrangements, for example through adult safeguarding boards. The Commission has taken a number of actions on safeguarding, including agreeing a protocol with the Association of Directors of Adult Social Services and the Association of Chief Police Officers to ensure that the Commission's working practices contribute to a reduced risk of abuse. Regulation methods for care services now target services that need closer monitoring or enforcement action. A new Key Threshold for safeguarding in the performance assessment for councils limits the star rating that a council can receive if it performs poorly on safeguarding people from abuse. The Commission has also introduced a

policy to clearly define the difference between allegations of abuse, where local multi-agency arrangements are triggered, and other types of complaints about providers.

32 Work needs to continue to ensure a strengthened focus on safeguarding under the forthcoming new regulatory framework for health and care services and councils and to communicate the role of the regulator. Obtaining individual redress for complaints, rather than alerting councils to the abuse of individual people, is outside the scope of regulatory activity; the Commission welcomes the extension of the powers of the Local Government Ombudsman to deal with second-stage complaints about care providers from people funding their own care.

Local strategic work to safeguard people

Councils

33 There is significant variation in the degree of priority shown to safeguarding adults within and across council areas. This is shown by differences in the resources allocated to safeguarding work, the seniority of representatives on safeguarding boards and the profile of safeguarding in commissioning strategies, as well as wide variations in the increase in the number of alerts reported to different councils.

34 Council service inspections showed that only about half of local adult safeguarding boards were judged to be working effectively. All boards had representation from the key statutory agencies, although not always of the appropriate level of seniority. GPs, housing and probation services were the least involved.

35 Most safeguarding boards are struggling to find practical ways of engaging people who use services and other local people to inform decision-making about strategic development or service design in respect of safeguarding.

36 A minority of councils considered safeguarding as a matter of course across their strategies on health and well-being, crime and disorder, domestic violence and regeneration. A majority of councils were developing some strategic work on safeguarding but this was not a theme that ran through all strategies and few outcomes were yet evident.

37 Councils were at different stages in explicitly including safeguarding in their core commissioning strategies for both universal and specialist services.

Improving the current situation

38 Amongst both people using services and statutory partners there are mixed views about whether additional legislative powers would ensure more effective partnership working and better outcomes for people who have experienced abuse. There was most support for a duty to co-operate and share information across the main agencies.

39 Work to prevent abuse happening in the first place, by 'designing safeguarding into services', is essential. Whether new legal powers are introduced or not, it is clear that councils, care providers and regulators all have crucial roles to play in ensuring the essential components of prevention and early intervention are in place, namely:

- people being informed of the right to be free from abuse; and supported to exercise these rights, including having access to advocacy
- a well informed, competent and properly vetted workforce operating in a culture of zero tolerance of abuse
- good universal services targeted at older and disabled people that can reduce the risk of people experiencing abuse, for example community safety services or services that increase people's access to advice or maintain informal support networks
- thorough needs assessments supported by risk assessments where required to inform people's choices
- a sound framework for confidentiality and information sharing across agencies
- a range of options for support to keep safe from abuse that can be tailored to people's individual needs – both for people using care services and for those directing their own support
- service provision which gives prominence to the need for sound safeguarding arrangements *as well as* the promotion of people's independence
- a public which is aware of – and alert to – these issues.

1

Purpose and scope of the study

1.1 This study reports on the safeguarding arrangements in place to protect adults from abuse. Based on inspections in councils and regulated care services, fieldwork in a sample of council areas and councils' self-assessment reports, this study considers:

- whether people are supported well by current arrangements for safeguarding
- how well care services are responding and intervening to safeguard people
- the priority and leadership given by councils and the effectiveness of local partnerships to help prevent abuse and ensure a good response to people who experience abuse
- whether additional powers or new responsibilities are warranted to make a step change in the current situation.

Defining 'arrangements to safeguard people from abuse'

The systems, processes and practices in place to:

- ensure adequate awareness of issues about the abuse of adults
- ensure priority is given to safeguarding people from abuse
- help prevent people experiencing abuse in the first place
- recognise and act appropriately when there are allegations of abuse and support the person who has experienced abuse.

Councils lead and co-ordinate local arrangements with partner organisations. Social care providers have responsibilities to keep people using their services safe from abuse.

Abuse as defined in *No secrets* (see Chapter 2) includes physical, sexual, psychological, financial or material, neglect or acts of omission and discriminatory abuse.

1.2 Councils lead and co-ordinate local arrangements with partner organisations. Social care providers have responsibilities to keep people using their services safe from abuse.

Abuse as defined in *No secrets* (see Chapter 2) includes physical, sexual, psychological, financial or material, neglect or acts of omission and discriminatory abuse.

1.3 The study has examined the whole spectrum of arrangements, including councils' lead responsibilities for co-ordinating safeguarding policies and practice, the role that regulated social care services play in keeping people safe and the effectiveness of local partnership working. Critically, the experience of people using services, particularly those who have personal experience of abuse or of interventions concerning safeguarding arrangements, has informed and underpinned the findings.

Evidence has been drawn from:

- Performance of all the care homes and home care agencies in England against National Minimum Standards relating to protection from abuse and recruitment of staff.
- Self-assessment reports provided by the 150 councils in England.
- Findings about safeguarding from 23 detailed CSCI inspections of councils' adult social services (service inspections). Every such inspection since October 2007 has included safeguarding as a key theme.
- Fieldwork in five council locations, including tracking 30 people's experiences of how the arrangements to protect them from abuse worked from their perspective, looking at case files and talking to the people concerned. Meetings were held with people using services and key partner agencies to discuss local arrangements and the national policy framework.
- 94 thematic inspections of care homes, home care agencies and adult placement schemes in seven areas, representative of geography and council type and including the five fieldwork locations, focusing on safeguarding. This was supported by 250 further inspections throughout the country where extra questions about safeguarding were asked during scheduled inspections. More details of the thematic inspections are given in Appendix 1.

About this report

Chapter 2 provides a brief background to the development of the existing arrangements and an outline of key contemporary issues and challenges around safeguarding people from abuse.

Chapter 3 describes people's experiences of local arrangements on safeguarding, including how people first get information, find help and the type of response they receive. It also looks at how well

people are supported after the initial response to their concern so they can feel safe and lead independent lives.

Chapter 4 assesses the quality of support and care practice by councils and individual services to keep people safe.

Chapter 5 considers how councils and services are monitoring these arrangements and making improvements.

Chapter 6 focuses on the strategic work of councils and local partnerships to respond to and prevent abuse.

Chapter 7 draws conclusions on how safeguarding arrangements could be strengthened and improved, at local and national levels.

2

Setting the scene

2.1 Recognition of the issues

Abuse is a violation of a person's human and civil rights. People should, wherever possible, be protected from abuse in the first place. Those who do experience abuse or are considered at risk should be able to get the right support that enables them to feel in charge of what happens, to be safe, and where appropriate to get justice through the courts. If people are less isolated and have support to participate in their community, this may provide some protection from abuse. Popular awareness of issues surrounding child abuse and child protection have a long history. Whilst awareness and reports of adult abuse and neglect in both domestic and institutional settings can be traced back to the 1970s and earlier, it was only in the 1990s that co-ordinated campaigning led to pressure to organise a more coherent response to keep adults safe from abuse. As a consequence, in the past decade, the protection of adults from abuse has become a defined issue in its own right with distinct policies, guidance and research[3].

Although in many respects establishing policies and guidance in this field has followed the journey taken by child protection, there are important differences. Not least, it is accepted that adults have rights to exercise choice and control over their lives even if they lack mental capacity[4]. Few would argue that the arrangements in place to protect children can be transferred wholesale to the adult context.

2.2 Which adults should be protected from abuse?

A vulnerable adult is defined by the *No secrets* guidance as a person:

"...who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of

3 Brown H, Kingston P and Wilson B (1999) 'Adult protection: an overview of research and policy'. Journal of Adult Protection, 1: 6–16

4 Stevenson O (1996) *Elder protection in the community: what can we learn from child protection?* London: Kings College

him or herself, or unable to protect him or herself against significant harm or exploitation[5]."

Vulnerability is a word defined in various pieces of legislation, but there is a lack of precision as to what constitutes a vulnerable person and how this relates to abuse. It is argued that the term implies that abuse is a consequence of an individual's impairment rather than the perpetrator's behaviour and the circumstances in which abuse occurred. The use of the term 'safeguarding' is preferred by the Commission as it emphasises the responsibility placed on agencies to identify and respond to risks to an individual's independence and their ability fully to exercise their rights.

In practice, attempts have been made to limit the scope of definitions used in *No secrets* to those people already in receipt of services and to specific forms of abuse and living situations, but Government has made clear that the guidance applies to all those in need of services and covers all types of abuse and settings[6]. For example, a person with a learning disability may not want any support from social care agencies until they experience disability hate crime.

2.3 What is abuse?

Abuse is a violation of an individual's human and civil rights by any other person or person and takes many forms, summarised in the following box.

What constitutes abuse?[7]

A consensus has emerged that the main different forms of abuse are:

- **physical abuse**, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions
- **sexual abuse**, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting
- **psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks

continued below

5 Department of Health (2000) No secrets: guidance on developing and implementing multi-agency polici*es and procedures to protect vulnerable adults from abuse.* London: Department of Health

6 Government's response to the recommendations and conclusions of the Health Select Committee's inquiry into elder abuse, 2004.

7 Department of Health (2000), *ibid*

- **financial or material abuse**, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- **neglect and acts of omission**, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- **discriminatory abuse**, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

While there is a consensus that the broad categories of abuse described above should be addressed in guidance[8/9], there is much less agreement about the threshold of seriousness that should trigger action. Understanding the dynamics of abuse and, importantly, tailoring a response that properly balances the need for protection, prevention, independence and justice requires a more refined means of understanding and responding to people's experiences.

Evidence from research and earlier Commission findings[10] from inspections of regulated services show that staff in care services have difficulty in judging whether certain situations warrant action under formal procedures. For example, where acts of omission on the part of care staff cause discomfort and demonstrate lack of respect, and where there is abuse and bullying between people using services.

The grey area between abuse and poor care practice is illustrated in the use of restraints in care[11]. The Commission has emphasised that decision-making on restraint should not be left to individual staff members; it needs to be determined in a context of human rights supported by guidance, training and management support. The same applies to judging thresholds for engaging formal procedures to keep adults safe from abuse.

8 O' Keeffe M, Hills A, Doyle M, McCreadie C, Scholes S, Constantine R, Tinker A, Manthorpe J, Biggs S and Erens B (2007) *UK study of abuse and neglect of older people: qualitative findings.* Completed for Comic Relief and the Department of Health. London: National Centre for Social Research

9 Moore D (2001) 'Friend or foe? A selective review of literature concerning the abuse of adults with learning disabilities'. *Journal of Intellectual Disabilities*, 5: 245-258

10 Commission for Social Care Inspection (2006) *In Focus – Quality Issues in Social Care: better safe than sorry*. London: Commission for Social Care Inspection

11 Commission for Social Care Inspection (2008) *Rights, risks and restraints – an exploration into the use of restraint in the care of older people.* London: Commission for Social Care Inspection

2.4 How much abuse of adults takes place?

This study is not designed to focus on the prevalence of abuse but it is useful to summarise recent findings to indicate the scale of the problem:

- A survey[12] has estimated that 227,000 older people have experienced neglect or abuse by persons they should have been able to trust. Sharp rises in the number of people who are over 85 years old would suggest this figure might rise and indeed, given the numbers of very elderly people with conditions such as dementia who often find it more difficult to report abuse, might well be an underestimate.
- Whilst older people who used a range of social care services (including lunch clubs, day care and meals on wheels as well as regulated services) were more likely to experience abuse than those who did not, only 13% of 'mistreatment' of older people overall involved care staff. Fifty-one per cent of mistreatment involved the person's partner and 49% involved other family members. Thus, the majority of abuse reported in the survey took place in a family context, which is more difficult for other people, and often the person themselves, to report. However, it should be noted that only 21% of the older people responding to the survey used any social care services, so who the perpetrator is, and the prevalence of abuse, may be different for people living in care homes or using home care. Further research is being carried out into prevalence of abuse of older people in care homes and hospital settings[13].
- A recent audit report by the Healthcare Commission[14] as well as the Commission's joint inquiry with the Healthcare Commission about Cornwall partnership NHS Trust[15] found widespread and significant failings in institutions providing care for people with learning disabilities, including insufficient attention being paid to keeping people safe.
- Survey-based[16] research suggests that only a small minority of people reporting abuse are being supported through council safeguarding arrangements.

12 O' Keeffe M, Hills A, Doyle M, McCreadie C, Scholes S, Constantine R, Tinker A, Manthorpe J, Biggs S and Erens B (2007) *UK study of abuse and neglect of older people: prevalence survey report.* Completed for Comic Relief and the Department of Health. London: National Centre for Social Research

13 Joint work between the Department of Health and Comic Relief, likely to report in April 2011.

14 Healthcare Commission (2007) *A life like no other: a national audit of specialist inpatient healthcare services for people with learning disabilities in England*. London: Healthcare Commission

15 Commission for Social Care Inspection and the Healthcare Commission (2006) *Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust.* London: Commission for Healthcare Audit and Inspection

16 O'Keefe et al (2007), *ibid*

2.5 Legislative and policy context

Powers to act in response to physical and sexual assault or theft are well established, but it has been recognised that these arrangements on their own have proved ineffective in safeguarding adults in vulnerable circumstances, especially where someone is judged to lack capacity in the eyes of the police.

The *No secrets* guidance[17] replaced piecemeal guidance and gave the leadership and co-ordinating role in respect of arrangements to protect people from abuse to social services, whilst specifying the responsibilities of police and health bodies. The guidance required local multi-agency codes of practice to be developed that spelt out the roles of each agency and procedures to respond to allegations and information sharing. Plans to develop better services for people who experience abuse, information and staff training were seen as crucial to local strategies.

Whilst progress has been made in establishing these local multi-agency arrangements, their effectiveness has been questioned[18]. The effective dissemination of information to the wider public has also been highlighted as an area that requires much more attention by councils.

The Human Rights Act, 1998 has influenced thinking in respect of the arrangements for adult protection and although *No secrets* has been widely applauded for setting up a clear framework for intervention, there have been increasing calls for a firmer legislative base, a more citizen-based context, and greater emphasis on prevention. A consultation process is currently under way on the *No secrets* guidance, to which this study is designed to make a contribution.

17 Department of Health (2000) *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse,* London: Department of Health

18 Sumner K (2004) 'Social services' progress in implementing 'No secrets': an analysis of codes of practice'. *Journal of Adult Protection* 6(1): 4-11

A number of the other most significant policies and laws relating to safeguarding are shown in the box below:

- **The Domestic Violence, Crime and Victims Act 2004** explicitly states that it is a criminal offence to physically or sexually abuse, harm or cause deliberate cruelty by neglect of a child or an adult. This legislation was introduced, in part, to emphasise the crime of abuse between partners within the home.
- A new **Independent Safeguarding Authority**[19] is to replace the Protection of Vulnerable Adults (POVA) scheme with a more comprehensive system and ensure a safe workforce for those who work with vulnerable adults.
- The **Mental Capacity Act 2005** and ***Achieving best evidence in criminal proceedings: guidance for vulnerable or intimidated witnesses***[20] both aim to empower and protect vulnerable people and enable better access to justice, including the introduction of a new criminal offence of wilful neglect or mistreatment.
- The White Paper ***Our health, our care, our say***[21] emphasises the importance of people having more control over their lives and access to responsive, preventative services, equally applying to those people who have experienced abuse or who need safeguarding from a risk of abuse.
- ***Valuing people*** and the consultation document ***Valuing people now***[22] has four underlying principles for policy on people with learning disabilities: rights, independence, choice and inclusion. Any intervention aimed at safeguarding people must respect and strengthen an individual's rights and freedoms.
- The **Care Standards Act 2000** and associated regulations required care providers to ensure they had in place proper arrangements to protect people in their care from the risk of harm or abuse.

19 The Safeguarding Vulnerable Groups Act 2006 recognised the need for a single agency to vet all individuals who want to work with children and adults. The Independent Safeguarding Authority was created to fulfil this role across England, Wales and Northern Ireland.

20 Home Office (2006) *Achieving best evidence in criminal proceedings: guidance for vulnerable or intimidated witnesses*. London: Home Office

21 Department of Health (2006) *Our health, our care, our say. London: Department of Health*

22 Department of Health (2007) *Valuing people now.* London: Department of Health

2.6 A call for new legislation

There is a growing lobby[23] seeking to secure a stronger legislative basis to underpin arrangements for safeguarding adults in order to raise its status, attract more resources and serve to better hold agencies to account. It is argued that a new statutory framework would bring together various strands of current law, guidance and support a more coherent, standardised response at local level as well as raise the profile of the issue with the wider public. The new powers being called for in some quarters include:

- a formal duty on statutory bodies to co-operate with each other, share information and take action in response to individual people who are at risk of abuse
- powers to access premises to assess and safeguard an individual
- powers to respond to concerns via removal to a place of safety or by directing the perpetrator to leave.

It is recognised that exercising such powers may risk flouting an individual's right to self-determination so checks and balances would need to be put in place.

2.7 Strengthening partnerships

From the outset it has been recognised that a partnership and multi-agency approach to safeguarding people is essential for arrangements to be effective. The benefits in terms of information sharing, pooling expertise and the co-ordination of interventions are well known. Despite such consensus, evidence from research to date[24] suggests that, in practice, all is far from plain sailing.

Developing working protocols across agencies can be helpful. In 2006, The Commission published its own *Safeguarding adults protocol and guidance* together with the Association of Directors of Adult Social Services and the Association of Chief Police Officers.

23 Action on Elder Abuse had led an alliance of organisations arguing the case for adult protection legislation in England, Wales and Northern Ireland. It published a consultation paper on the issues involved in 2007. ADASS also released a position statement calling for changes to the law.

24 Penhale B, Perkins N, Pinkney L, Reid D, Hussein N and Manthorpe J (2007). *Partnership and regulation in adult protection: the effectiveness of multi-agency working and the regulatory framework in adult protection*. London: Department of Health

The intended outcome of the protocol is to ensure that the Commission's working practices support effective safeguarding and contribute to a reduced risk of abuse for people who use services. This will be achieved by:

a) Establishing a consistent approach within CSCI to the identification, decision making, recording and management of safeguarding cases within regulated services.
b) Promoting a clear understanding of the role of the regulator within the multi-agency safeguarding procedures that is agreed amongst co-signatories to the protocol.
c) Ensuring that appropriate data is collected about safeguarding adults activity in a way which supports our regulatory role and our performance assessment of local councils.

From Commission for Social Care Inspection, *Safeguarding adults protocol and guidance*[25]

Debate about how to strengthen joint working has focused on inter-agency teams and training; widening the membership of partnerships, for example, to include community safety and independent sector providers; and new legal 'duties to co-operate' to shift safeguarding from what may be perceived as a 'may do' to a 'must do'.

It is also generally agreed that attention must be paid to raising the profile of the issue in the public's eye. It is only by shifting the wider culture that abuse of adults ceases to be tolerated and overlooked and becomes everyone's issue.

2.8 Summary of contemporary issues

The box below summaries these key contemporary issues in safeguarding people from abuse. The following chapters of this report present our findings on current arrangements and assess progress on addressing these issues.

25 Commission for Social Care Inspection (2007) *Safeguarding adults protocol and guidance* London: Commission for Social Care Inspection

Key messages from the CSCI seminar Raising voices[26]

- Enabling individuals to exercise choice and control over their own lives is crucial. Safeguarding should not result in over-protection and paternalism.
- National and local leaders need to articulate a clear, holistic approach to safeguarding policies, systems and practice and balance the rights of individuals against the role of the State.
- A whole-system approach needs to develop in relation to prevention and early intervention without detracting from robust investigation.
- Guidance needs to give added clarity to issues of information sharing, definitions, roles and accountabilities.
- Assuring good practice would benefit from more explicit performance measures and a more skilled workforce.
- Regulators as well as policy makers and local agencies needed to work together more effectively.
- The value of having additional powers and duties needs to be robustly examined.
- More needs to be done to raise awareness of safeguarding issues in communities.

26 Commission for Social Care Inspection (2008) *Raising voices: views on safeguarding adults* London: Commission for Social Care Inspection

3

People's experiences of arrangements to safeguard them from abuse

Key findings

- On average, councils have reported increases in safeguarding referrals of 36% from last year, indicating that there is some success in raising the profile of safeguarding adults. However, in councils taking part in this study, annual increases in referrals ranged from 10–150%, reflecting (in part) varied practice in raising awareness of abuse and the steps to take.
- Information is being targeted at older and disabled people, but is not always reaching people with mental health needs, those who misuse drugs or alcohol, people from black and minority ethnic communities and people funding their own care.
- Once an alert reaches the council, people are generally responded to promptly, although out of hours responses tend to be less consistent. But some people, who councils are trying to safeguard, say that once 'in the safeguarding system', they can feel carried along by the process and lose or lack control.
- People value advocacy support but 58% of councils inspected noted shortfalls in advocacy. There are examples of people successfully being helped by independent mental capacity advocates but the service is still at very early stages.
- Councils are beginning to provide options to help prevent abuse for people who direct their own support but the evidence indicates that no council yet has a systematic approach in place.
- In 20% of services, no one using the service interviewed for this study could remember receiving and understanding information about what do to if they have concerns about abuse. This highlights the challenge for care providers in ensuring people know and retain information about channels of help. However, services with high quality ratings seemed able to tackle this more effectively.
- In 82% of care services, everyone interviewed for this study felt that they could speak to a staff member or manager if they felt unsafe but in only 61% of services did they feel confident that the concerns that they raised with their service provider would be acted on.

3.1 Introduction

People have a basic human right to live free from abuse and neglect, so they need information about what constitutes abuse and to get appropriate help if they experience it. People want:

- information they can easily understand
- simple and straightforward ways to report their concerns
- to be taken seriously and to have their views considered at every stage
- independent support through the process
- to be able to make informed choices about risks and to be supported to manage those risks.

In assessing their performance the Commission would expect higher-rated councils and care services to focus on the issues set out below.

a) Councils need to:

- provide (and promote the availability of) clear and easily accessible information for the public about people's rights to live free from abuse and where to get help
- specifically target such information at people covered by safeguarding procedures, including older and disabled people who are not using services and those who are paying for services themselves
- provide easy ways for people to report abuse
- take people's initial report seriously and respond promptly
- provide the person experiencing abuse with appropriate independent support, including offering advocacy
- recognise people's rights to make choices about their lives, and provide support for this
- involve people in their own protection plans and ensure those plans are centred on their wishes
- enable people directing their own support to have access to the same level of safeguards as people using other services – and tailor safeguards to their needs.

b) Care providers need to:

- make people aware of what abuse is and the safeguards available to them
- provide people with a copy of procedures people can use if they are concerned about abuse, in a form the person can understand
- have an open culture where people feel safe and supported to raise concerns; and where visitors and outside contacts are encouraged
- ensure that special attention is paid to the wellbeing of people who cannot communicate verbally

- know when to report a concern to the council, under the local procedures
- provide support and keep the person who has raised the concern updated
- ensure staff know who in the organisation they need to contact if someone has disclosed abuse to them.

3.2 People's experiences of council arrangements

Awareness of abuse and knowing where to go for help

Some councils are successfully raising the profile of safeguarding and there were some good examples in the study of high profile public campaigns to raise awareness of abuse and what can be done about it. In one council a mail-shot to 90,000 households was used as a means of getting safeguarding into the public eye. This may partly explain the national picture reported by councils that in 2007-08 the average number of referrals was up by 36% from the previous year.

However, there was a marked difference in the rise in the number of people seeking help across all the councils involved in this study, with year-on-year increases of between 10–150% reported by the councils in the study sites. Whilst there can be a number of explanatory factors for this large differential, the study found varied practice in raising public awareness which may account for this; for example many council websites have very limited information on local arrangements to safeguard people.

Good Practice In one council where there was some concern about low referral rates, new efforts at awareness raising via the website and the local media were being evaluated through an equalities impact assessment. People who use social care services were involved in the assessment and areas for further improvement had been identified and an action plan put in place.

There is an increasing range and availability of information about safeguarding targeted at older and disabled people. Particularly good work is being carried out in some councils to communicate with people with learning disabilities who live in the community, as illustrated below (Chart 1). Most people with learning disabilities living in the community who took part in meetings for this study were confident and knowledgeable about what to do if they had concerns about how they were being treated.

However the evidence from the investigation of the murder of Stephen Hoskin

and the Cornwall inquiry[27] suggests that people with learning disabilities living in care or with little contact with services may still lack information and people with more significant cognitive or communication impairments may have fewer opportunities to express concerns about their safety. Service inspections also indicate that councils are not confident that information about safeguarding is reaching people from black and minority ethnic communities and few councils had developed ways of reaching people funding their own care, though some had plans to do this.

Chart 1: Some of the methods used to inform people with learning disabilities how to get help if they are experiencing abuse

Good Practice A 'keep safe' card initiative in one part of a council area aimed to reduce the risk of people with a learning disability being unable to summon assistance when faced with a risky situation. A card with the cardholder's details, including medication and communication difficulties, and who to contact in an emergency was carried. It has been a great success and extended across the council to anyone who wanted to carry one.

27 Commission for Social Care Inspection and the Healthcare Commission (2006), *Ibid.*

In many areas, better targeted information is needed for people using mental health services or those who misuse drugs or alcohol who live in the community. If integrated mental health services take an approach based more on health than social care, people using these services may be missed from work carried out to inform people using adult social care about abuse.

In one council a targeted campaign in the local accident and emergency unit raised the number of referrals from this group of people quite markedly.

3.3 Seeking help

People's experiences of getting help varied and much depended on the type of response and who offered it. Seeking help is not easy for people. Knowing where to go is important but fear of the consequences, communication impairments, frailty or poor self–confidence can also affect an individual's ability to voice concerns. Older people living in their own homes particularly valued helplines offering advice and support on safeguarding, usually run by voluntary organisations, as one woman commented:

> "I got in touch with the Age Concern, they helped me through it all."

This seems to reflect the caution and anxiety felt by many older people in getting in touch with those in authority, although for some, automated phone systems were also a practical deterrent to getting in touch with the council. One council of the 23 inspected was planning a 24-hour staffed helpline in order to improve access to support. Action on Elder Abuse run a national helpline which has shown a year-on-year increase in the number of calls and complexity of situations faced by older people[28].

Whilst most people, once they had reported a concern, felt that it was dealt with seriously, the study found that sometimes people using mental health services are not believed or their concern is put down to a symptom of their mental health status or drug/alcohol problem.

28 Action on Elder Abuse (2007) *Annual report of the trustees*. London: Action on Elder Abuse

"When I rang the police and said two lads were harassing me and asking for protection money, they asked if I had been taking my medication. How can a paranoid schizophrenic report abuse?" (A person with mental health issues)

How people are treated is crucial to achieving the best possible outcomes (See Example 1).

Example 1

Mr B is a 59-year-old man who lives in supported housing. He has a mental health issue and has attempted suicide. His mental health care co-ordinator recognised that Mr B had some concerns about a member of staff in the supported housing when he was explaining why he was going to find a new place to live. Although Mr B found it difficult to communicate his concerns directly, the care co-ordinator was confident there was an issue that needed investigating further but proceeded with sensitivity and at a pace comfortable to Mr B Eventually, an investigation was conducted independently of the service and it emerged that a number of tenants had problems with this member of staff's behaviour, which was bullying and humiliating. The staff member was suspended, then dismissed and subsequently lost his case at an employment tribunal.

The practitioner was concerned Mr B's mental health would be affected by the protracted nature of proceedings, but on the contrary, the experience has given him confidence and he feels he has helped others too.

Supporting people who have raised a concern about abuse

Once an alert reaches the council, service inspections show that people are generally responded to promptly, although out-of-hours responses tend to be less consistent, for example in the availability of out-of-hours assessments or capacity for support staff to respond to urgent situations in the evening or at night time.

From the perspective of the person concerned, once 'in the safeguarding system', individuals often felt carried along by the process, sometimes resulting in a sense of loss of control (see Example 2).

Example 2

Mr C has severe physical and communication impairments. He lives in a care home but remains in close touch with his wife who is a health professional. He communicated to her that he had been given medication he did not want and had made it clear to the staff concerned he did not want it. He was clear he did not want to get anyone in trouble but he also did not want it to happen again. His wife sought advice from a colleague about what to do. Her instinct was to sort it out with the home, but she was advised to go to social services, which she did.

From then on, she and her husband felt events got completely taken out of their hands and they were both still unclear about what had happened. The staff members disappeared. Mr C felt guilty that the outcome was not what he wanted and his wife felt she had not represented her husband's wishes well and had lost control of events.

They recognised that when care staff are involved, potential risks to other people receiving care also have to be considered. However, Mr and Mrs C expected to be given information about what was going on and to have their views heard.

In tracking people's experiences, it was evident that support from a trusted friend, relative or advocate made a significant difference to the outcomes for people.

"My advocate helped me through it – I would have been lost without her." (A person with learning disabilities)

However advocacy support is not offered consistently, nor is there adequate provision to meet demand. In 58% of the council inspections, reference was made to inadequate access to advocacy support.

Good Practice In one council, two voluntary groups work in co-operation to provide advocacy support to people with learning disabilities. One promotes self-advocacy, enhancing self-esteem, assertiveness and awareness of rights. The aim was for individuals to be well-equipped to understand what was happening to them, feel confident to challenge anything they didn't like and know how to enlist the help of others. This was likely to prevent abuse in the first place but also ensure the right action in the event of a safeguarding incident. The second voluntary group provides individual advocacy and also has the contract for the Independent Mental Capacity Advocate service.

There is evidence that the Independent Mental Capacity Advocate (IMCA) service is starting to benefit people deemed to lack capacity as the two examples below show:

- *Staff in a care home wanted to stop an older man having a particular visitor because they suspected the visitor was exploiting the man's finances, although there was no evidence of this. The family agreed and it was decided to employ an IMCA to assess the man's understanding of the friendship and his capacity to make decisions in this regard. It was concluded the man was capable and he was clear he wanted to continue with the friendship.*
- *A very elderly woman with dementia was removed from her home following physical abuse by her family. An IMCA challenged the powers that had been used to move her and the woman's understanding of this.*

However the IMCA service is still in its infancy. Six hundred and eighty-one (681) people benefited from having an IMCA in adult protection cases in the service's first year[29]. IMCAs reported that adult protection referrals were some of the most complicated situations they faced, particularly where it was:

- not always clear where the IMCA role should start or finish
- difficult to balance collection of evidence with supporting the person
- challenging to work with families who may be involved in the alleged abuse.

Members of the IMCA service contacted as part of this study generally felt they were being used appropriately, although they recognised that more training about their role was needed, particularly for council staff calling upon

29 Department of Health (2008) *The first annual report of the Independent Mental Capacity Advocacy Service*. London: Department of Health

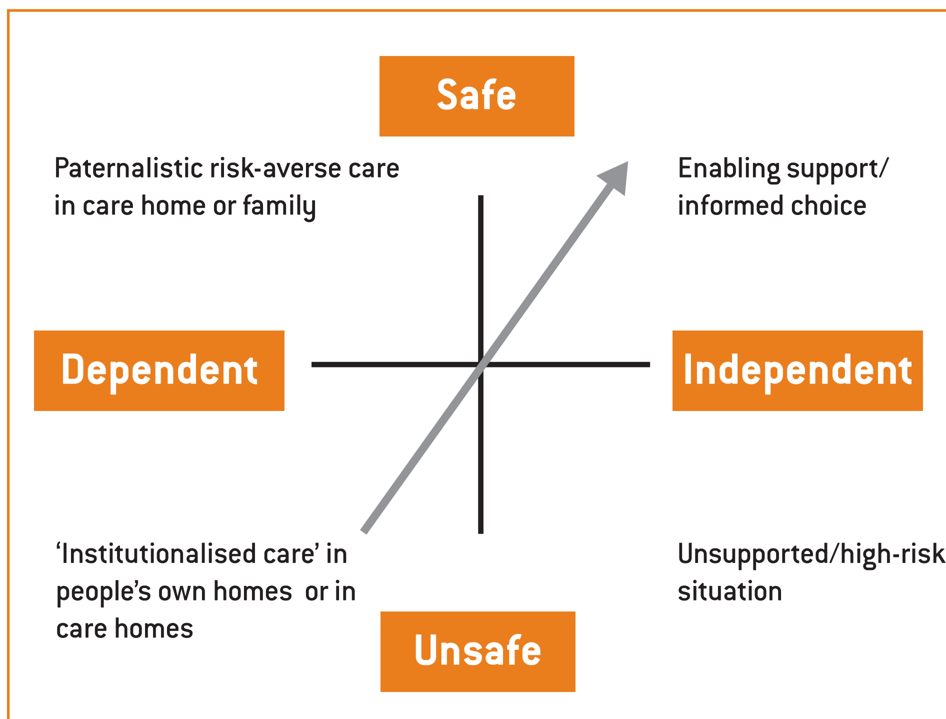
the service. Some councils have linked up to provide this service together which has the benefit of establishing a network of support and training.

Where someone deemed to lack capacity has family or friends to act for them, councils only have a power, not a duty, to appoint an IMCA following an allegation of abuse. ADASS has issued a national policy statement on the types of adult protection situations where appointing an IMCA may be most useful[30], for example where there is a conflict of views by decision makers on the person's best interests or a reasonable belief that family or friends would not have the person's best interests at heart. At this early stage, there is little evidence to assess whether different councils are applying this policy consistently.

Promoting independence and keeping people safe

People are at greater risk of abuse if they receive inadequate support in their daily lives. However, support should not be geared purely towards protecting people as this can then lead to restrictions on people's freedom to make choices and take considered risks. The experiences of people in this study reinforced that support needs to be geared to managing risk and independence as opposed to purely avoiding abuse (see Chart 2).

Chart 2: Independence and safety from abuse



30 Association of Directors of Adult Social Services (2007) *Practice guidance – criteria for the use of IMCAs in safeguarding adults cases.* London: ADASS

Risks can be exacerbated if a change from a protective to more independent style of living has not been well planned, as the following example illustrates.

Example 3

D is a young man with moderate learning disabilities. He lives in supported housing and attends a local college. D was thought to need very little support although previously he had lived in a very protective environment. He soon started to get into trouble. Problems occurred as a consequence of D's excessive use of alcohol, encouraged by the other tenants. After a safeguarding alert a greatly increased package of support was put in place.

Safeguarding people who are directing their own support

The potential risks of abuse for the increasing number of people directing their own care are starting to be addressed by councils. However, there is evidence from this (and other studies) that sometimes managers leading on safeguarding are not centrally involved in the development of self-directed services, such as the introduction of Individual Budgets[31].

A Direct Payment is a cash payments made in lieu of social services support, to people who are eligible for support from council social services. The person manages the money themselves.

A Personal Budget is an amount of money allocated by social services to someone for their support. The person chooses their package of support – they may choose to manage the money directly, as in a Direct Payment, purchase services through social services from their individual support budget, use other methods such as a trust fund or a mix of these approaches.

An Individual Budget is similar to a personal budget except that it combines a number of sources of funding or support that the person is entitled to, beyond the budget from social services. These include Access to Work, Supporting People and the Independent Living Fund.

31 Manthorpe J, Stevens M, Rapaport J, Harris J, Jacobs S, Challis D, Netten A, Knapp M, Wilberforce M and Glendinning C (2008) 'Safeguarding and system change: early perceptions of the implications for adult protection services of the English individual budgets pilots – a qualitative study'. *British Journal of Social Work*, September 2008

Some disabled people maintain that as the purpose of self-directed support is to put the disabled person in control, that person should therefore have the right to choose what safeguards they want in place, without having requirements imposed by councils, national guidance or legislation. In this study, some council staff expressed concern about the ease with which people using Direct Payments could become targets for intentional abuse from workers who thought that the abuse of people employing their own personal assistants was less likely to be detected than abuse of people in more traditional services. They feared that if employment checks are voluntary, people with criminal records may be able to persuade the person employing them that checks are not necessary. There is also concern that the increasing number of people having Individual Budgets or Direct Payments managed by family members could leave some people open to financial abuse. One older person commented:

"Some older people put up with financial abuse from their relatives or 'friends' in exchange for companionship and because they don't know how to deal with it without causing a lot of trouble."

There is also a debate about the role of regulation in relation to self-directed services and how best to balance interventions to ensure that people directing their own support are protected from abuse with people having control and choice over their own support.

Councils are offering some straightforward options to people that help to prevent abuse and minimise risk without undermining choice and independence, tailoring arrangements to individual circumstances. The following are some of the options offered to people directing their own support, although none of the councils receiving a service inspection yet had a systematic approach in place:

- good information on safeguarding in card form
- obtaining CRB and career history checks and references for personal assistants
- recruitment support from a third party
- training and support on financial and employment issues and potential abuses for people directing their own support
- routine council checks on progress through care plan reviews
- organising forums of people directing their own support to share experience and good practice.

3.4 Conclusions on councils' arrangements to inform and support people

Overall, councils need to do more to raise the profile of every citizen's right to be free from abuse, as well as explaining how to get help, by using a range of ways to reach people through popular media and universal services. Councils are improving information for older and disabled people about safeguarding but most need to develop ways of reaching others including black and minority ethnic people, people using mental health services and those funding their own care.

Councils also need to ensure that ways for people to report abuse are easy to use and that people are supported if they have fears about the consequences. All agencies that may receive initial concerns about abuse from people should train front-line staff to respond appropriately, particularly to people with mental health needs or substance misuse problems.

Whilst councils generally respond promptly to alerts about abuse, some service inspectors found that improvements could be made to out-of-hours services. Councils need to ensure that people experiencing abuse maintain as much control over their situation as possible and that their views are adequately heard. Increasing people's access to independent support and advocacy is important. The IMCA service is improving outcomes for people who qualify for this service but there needs to be greater clarity about the IMCA's role and some monitoring of equity of access for people experiencing abuse.

There is some way to go before people directing their own support are consistently offered a range of options to support them in keeping safe from abuse, irrespective of the arguments about whether this should be mandatory.

3.5 People's experiences of arrangements by care services

Awareness of rights and knowing who to go to in order to report abuse

In the thematic inspections, staff in care homes and home care agencies said they use a range of ways of communicating information to people about their rights and what to do if they felt unsafe, with some services using a wide spectrum of approaches (see Tables 1 and 2). Less than 1 in 20 services said that they did not inform people of their rights or what to do if they experience abuse.

Despite this, there were wide variations in approach across the country. Care homes for older people, in particular, were much more likely to rely on written guides and much less likely to use individual assessment and review meetings as a way of sharing information. This might seriously limit information reaching people who are frail or those with dementia. Verbal information, if not regularly reinforced, may be forgotten by the time that it is needed.

Table 1: Thematic inspection question: How do you (managers of services) make sure the people who use services know about their rights?

	% of services using this method
By written guides	67
By talking to people	56
Residents' meetings (not home care services)	48
Via advocates	28
Via relatives	23
Assessment and review meetings	22

In the services with the highest CSCI quality ratings there was much greater consistency of response between managers and staff than in lower-rated services, suggestive of a more managed approach.

Table 2: Thematic inspection question: How do you (managers of services) make sure people who use the service know what to do if they experience abuse or witness an incident?

	% of services using this method
Via staff	71
Written guides	34
Residents' meetings (not home care services)	24
Advocacy	15
Assessment and review meetings	14
Relatives	12

Yet when people using these services were asked about this, a much lower proportion remembered receiving information; in 20% of services everyone

interviewed said they had been given no guidance about what to do if they felt unsafe. The quote below, from an older person speaking to a CSCI 'expert by experience'[32] during the inspection, is fairly common:

"I don't remember, my son dealt with all the paperwork."

When information was given, only a minority of people said they understood it (see Table 3) with numbers particularly low in care homes for older people. Sometimes, there was a basic failure to provide accessible information:

"I would recommend that they record all documents onto audiotape, so the person can listen to it without asking staff [to read for them]." (Expert by experience report – thematic inspection of a care home for people with learning disabilities)

The overall low numbers of people who remember receiving and understanding information does indicate the challenge for providers in ensuring that people know and retain information about channels of help. However, higher-rated services seemed able to tackle this more effectively (see Table 3).

Given these difficulties, advocacy and other support to ensure people know their rights is important, but access to advocates was variable. Inspections of 250 services showed a greater use of advocacy in care homes for younger adults (23% of services) than in care homes for older people (10%) or home care services (3%).

Despite people's uncertainty about formal reporting processes if they felt unsafe, the vast majority felt able to raise an issue of safety informally with the staff or manager of the service they were using. In 82% of services, everyone interviewed as part of this study felt that they could speak to a staff member or manager, although this was somewhat lower (71%) in respect of older people living in care homes. People were much more likely to have confidence in speaking to the manager of their service about possible abuse where the service was highly rated (see Table 3).

32 'Experts by experience' are people whose knowledge about social care services comes directly from using social care services. In this thematic inspection, experts by experience mainly asked questions to people using the service.

Table 3: Thematic inspection question to people living in care homes or using home care: Did you understand the information/Do you know who to speak to if you don't feel safe?

Quality rating of service	0 star	1 star	2 star	3 star
% of services where everyone received information and understood it	0	18	22	25
% of services where all people interviewed said they would speak to manager[33]	50	59	83	100

However, some people can find it very difficult to get help without the support of a third party. In the event of lack of confidence in people providing the services, people were most likely to turn to family and friends (78%) or other professionals, such as social workers (58%), although 20% of people said they would tell the care regulator, the Commission for Social Care Inspection.

Fear, isolation, lack of confidence, poor self-esteem or communication impairments may mean that individuals are dependent on others to recognise the signs and symptoms of abuse and respond to them. The 'others' might be family, staff, visiting professionals or advocates. It is easy to conclude that isolated people, with few or no visitors, are at greater risk, especially where *staff providing a service perpetrate the abuse.*

"A relative expressed concern about people living in the home with no relatives or friends visiting them. Many people stay in their room most of the time, if there was an incident of any kind, he thought it would not be easy for them to report it to another member of staff." (Expert by experience report – thematic inspection of an older people's care home)

There are a number of reasons why people may withdraw from social interaction whether they live in care homes or receive increasing levels of support in their own homes, from paid services or family carers. This can lead to people who provide care treating such individuals in a dehumanising manner and increases the risk of abuse. This was illustrated in the Commission's 2008 report[34] on

33 This was an open question, but inspectors were able to prompt to ask whether people would approach the manager, staff who support them or anyone else.

34 Commission for Social Care Inspection (2008) *See me, not the dementia.* London: Commission for Social Care inspection

the experience of people with dementia living in care homes. While many homes were offering personalised, warm care in a stimulating environment, other places delivered very task–orientated care in an emotionless manner, contributing to even greater isolation and withdrawal for the individuals concerned. The study found that these 'neutral' task-orientated interactions with people were strongly related to low levels of well-being in people with dementia.

For people living in care homes, the wider the range and mix of people taking part in the daily life of the home, the more likely poor practice and abuse will be picked up or prevented in the first place.

"Staff said that they could tell if people were stressed by their expressions and behaviour and could use this to stop bad things from happening. I think it is really important that they have independent advocates, either family or paid, to make sure that they are safe." (Expert by experience – thematic inspection of care home for people with learning disabilities)

However, care providers reported that it was often difficult to obtain independent advocacy for people using their services.

Supporting people who have reported abuse

In only 61% of services was everyone interviewed (as part of the thematic inspection) confident that concerns that they raised with their service provider would be acted on. This is despite over 90% of managers of these services being clear that they would initiate a safeguarding alert in respond to an incident being reported, and over 80% of staff saying they would report such an incident to their manager.

However, managers and staff were much less confident about what other action they would take to support and protect the person concerned, and others who might be at risk, suggesting that there is a focus on getting the process right, rather than a more comprehensive approach to support the person who may be being abused (see Tables 4 and 5).

Table 4: Thematic inspection question: What would you [a service manager] do if a safe-guarding incident was reported to you?

	%
Initiate a safeguarding alert	91
Consider suspension of staff concerned	37
Make a record	27
Ensure safety of individual and others	12
Assessment and review meetings	14

Table 5: Thematic inspection question: How would you [staff] support the person raising safeguarding concerns?

	%
Reassure about safety	12
Reassure about confidentiality	8
Tell what will happen next	3

3.6 Conclusions on care providers' actions to inform and support people

Managers and staff in care homes and home care services are generally seen by people using services as approachable on an informal basis if problems arise. However, they need to do more to ensure people are aware of the rights to be free from abuse; know what to do if they experience or witness abuse or neglect; and where to obtain independent sources of support. This information needs to be reinforced regularly and provided in ways that people can readily understand.

Particular attention needs to be given to ensuring there is independent support for older and disabled people who want to report abuse and to people using services who have few visitors, or who have communication impairments or high support needs.

Care services were generally competent at reporting safeguarding concerns, though 1 in 5 staff would not always report a concern to their manager and 1 in 10 managers would not always report a concern under local procedures. However, most services need to consider a more comprehensive approach to supporting people, beyond the formal reporting procedures.

4

The quality of support and care practice to keep people safe from abuse

Key findings

- In almost three-quarters of council inspections unacceptable variability was found in the standard of practice when supporting someone who has experienced abuse in at least two of the following: a clear chronology of events and core information; risk assessment; protection plans; and case recording. Evidence of this poor (as well as less frequent good) practice was also found by tracking individuals' actual experiences.
- Some councils are providing more specific guidance to staff to distinguish between allegations that should be investigated through safeguarding procedures and concerns that should be dealt with in other ways. The best arrangements appear to be where there is a broad and inclusive definition of safeguarding but a number of options regarding the approach to take, dependent on the circumstances of the abuse.
- Councils' protocols for information sharing were found to be good in 83% of service inspections. However, difficulties were reported in respect of GPs' and hospitals' understanding of confidentiality and information-sharing protocols, particularly mental health services. Information sharing with care providers can also be problematic for councils.
- The support provided to people after they experience abuse is variable. The best councils had a wide menu of both short- and long-term support to draw on which could be tailored to personal needs.
- Intervention from councils to support people who experience abuse in residential settings needs strengthening.
- The use of legal powers to protect individuals from perpetrators is very patchy and appropriate actions not widely understood by front-line staff.
- Training about safeguarding has risen from 71% of relevant council staff in 2006-07 to 81% in 2007-08[35]. But councils report that only 46% of independent sector staff have had council-commissioned training – this needs to improve to ensure that staff from all sectors are equally informed about local arrangements for protecting people from abuse.

35 From the self-assessment survey of council adult social services.

There is a correlation between the quality rating of the service and the likelihood of the Commission receiving a safeguarding alert about the service – in a seven-month period in 2007-08, the Commission received alerts in respect of 6.3% of poor services and 2.9% of adequate services, compared to 1.9% of good services and 1.0% of excellent services. Alerts were received about a higher proportion of privately run services than council or voluntary services:

- The proportion of regulated services meeting the National Minimum Standards (NMS) on protection from abuse has risen substantially over the past five years, with 78% of care homes for older people and 77% of care homes for younger adults meeting the standard in 2006-07. This is up from 46% and 47% respectively in 2002-03, the year the NMS were introduced. For home care agencies the figure was also 77% in 2006-07, up from 55% in 2004-05 when they first came into regulation. Private sector services are least likely to meet the standard, across all types of service.
- Whilst this progress is to be welcomed, and many of the shortfalls in 2006-07 in meeting the NMS assessed by inspectors were relatively minor, it remains unacceptable in the context of such an important standard – five years after it was introduced for most services – that even minor deficiencies are still present. Moreover, the thematic inspections of care services suggest that the picture is somewhat worse when the standard is examined in closer detail.
- The most common shortfalls in regulated services are inadequate staff training, written documentation such as safeguarding policies and procedures and recruitment practices.
- Seventy-three per cent of the managers of regulated services interviewed for this study said they understood the process for making a safeguarding referral although there were marked variations in different areas. It was noticeable that managers of regulated services in the areas of the higher-performing councils had a better understanding than those in the areas of the lower-performing councils.
- Understanding of the local procedures by managers in regulated services can be hampered if the provider's policy on safeguarding does not dovetail with the local council multi-agency procedures. In 5% of inspections of regulated care services during a two-week period, it was noted that the provider's policy and the council policy were incompatible. This may be an underestimate as this was not a specific issue on which inspectors were asked to report.
- Nearly all managers of regulated services who were interviewed said that they were carrying out Criminal Records Bureau checks at the point

of recruitment but there was less confidence about the range of other checks. Over 40% of managers could not explain the role of the Protection of Vulnerable Adults (POVA) list adequately and 19% admitted they did not know about the POVA list and how to use it.
- There appears to be a correlation between staff training on safeguarding and quality rating, with only 40% of the lowest-rated services indicating all staff had had training to 100% in the highest-rated services.
- Despite the effort and resources going into developing the workforce, training and its implementation in practice still topped the list of statutory requirements placed on providers in the thematic inspection of regulated services.

4.1 Introduction

This chapter assesses the quality of care practice, the range and extent of support services offered to people and the skills of the workforce to keep individual people safe from abuse.

In assessing their performance the Commission would expect higher-rated councils and care services to focus on the issues set out below.

a) Councils need to:
- assess any risks of abuse whenever they are undertaking care planning with individuals
- have guidance for staff that clearly distinguishes which situations are to be handled under safeguarding arrangements
- ensure allegations are investigated by the appropriate agency
- undertake a thorough assessment of needs, risks and possible actions where someone is experiencing abuse
- have effective information-sharing procedures with other agencies
- offer people experiencing abuse options for support both in the immediate term to keep safe, and in the longer term to help them recover
- develop and agree person-centred protection plans with people experiencing abuse
- assist people to have access to the justice system by using a range of legal powers
- review protection plans and care plans, including those for people using care services that the council have commissioned or for people directing their own support
- communicate their procedures for safeguarding adults to other agencies and providers
- resource a workforce development and training strategy for safeguarding that ensures relevant council staff have training in safeguarding, including

specialist training; and offers training on the local procedures to care providers from all sectors.

b) Care providers need to:

- assess any risks of abuse whenever they are undertaking care planning or reviews with individuals
- promote access to advocates or other external agencies, including when care plans are reviewed
- ensure that their policies on safeguarding people align with the local council policies
- ensure managers and staff understand policies on safeguarding and whistle-blowing
- co-operate with investigations of abuse
- have a clear recruitment staff procedure which is always followed and includes adequate pre-employment checks in line with the regulations
- take appropriate action to protect people where staff are alleged to have perpetrated abuse, including use of disciplinary processes and POVA list
- ensure staff are trained on how to safeguard people and that this is reinforced through team meetings and supervision.

4.2 Council arrangements to keep people safe from abuse

Preventing abuse happening to individual people

Prevention of abuse is obviously preferable to supporting people after abuse has taken place. Care planning with all people who may need to use services needs to consider potential risks of abuse. The following example from this study shows the dangers of poor understanding and a lack of comprehensive risk assessment (Example 4).

Example 4

Ms F has learning disabilities and attends a day centre. She has very limited communication. On one occasion she was found in a room with a young man who also attended the centre. The clothing of both of them was in disarray, suggesting sexual activity. Ms F showed some distress. No comprehensive risk assessment on either young person had been completed prior to this situation, which should have informed protection plans, and could have avoided the incident.

Inadequate initial assessments of an individual's needs that fail to ensure support is properly tailored to their circumstances have the potential to result in discriminatory abuse as the following example shows (Example 5).

Example 5

Ms H is an older woman of Indian heritage. She moved to live in a care home, chosen to reflect her culture and language, as she spoke little English. After several months there, her family, who remained close, were concerned that Ms H was being discriminated against because she was Christian rather than Hindu. She felt excluded from many activities of the home. A number of falls had also not been dealt with well, in the family's view. An investigation was inconclusive, but did consider that Ms H did not fit in and was viewed as an outsider. A new home was sought. Here Ms H is the only non-white person but she is content she can go to church and her English is now very good. Assumptions appear to have been made about Ms H's needs without a full understanding of what she saw as her priority.

Recognising abuse and when safeguarding arrangements are best used

- ***Identifying institutional abuse***

Collective poor practice in communal settings, such as care homes, can amount to an institutionalised form of abuse (Example 6). This study found councils vary in how they define and record institutional abuse, which makes comparisons difficult. In the five study sites, reported institutional abuse ranged from 30% of referrals to less than 1%.

Example 6

Ms I lives in a care home. At a review it was noted she was falling from her chair. The reviewer sought the advice of the occupational therapist. Three months later it was noted Ms I had fallen a further three times. It emerged the advice of the OT had been ignored and ultimately a new chair solved the problem. As a result further inquiries into practices into this home identified concerns about the overall quality of care and management amounting to institutional abuse. Following investigation, there has been a change of the person in charge and standards have improved.

- ***Guidance on the application of safeguarding procedures***

Some councils are providing more specific guidance to staff to distinguish between allegations that should be investigated through safeguarding procedures and concerns that should be dealt with in other ways. The best arrangements appear to be where there is a broad and inclusive definition of safeguarding but a number of options regarding the approach to take, dependent on the circumstances of the abuse (Example 7). This example also illustrates how some quite straightforward proactive action can prevent the need for a safeguarding alert.

Example 7

Ms J is a young African woman who experiences mental ill health and needs to go into hospital regularly. During a recent spell in hospital the nursing staff observed a family member shouting and speaking abusively to Ms J. A safeguarding alert was made.
At the strategy meeting, it was established that the family was usually highly supportive of Ms J. However, problems develop when she has a relapse. It was agreed to focus on supporting the family to understand better the nature of Ms J's condition in order to engender a more helpful response when she became ill. It was agreed not to hold a formal investigation but a protection plan was built into the Ms J's overall care programme.

Quality of care practice with people experiencing abuse

In almost three-quarters of council inspections too much variability was found in the standard of practice relating to at least two of the following, when responding to people who have experienced abuse:

- a clear chronology of events and core information
- risk assessment
- protection and contingency plans
- case recording
- the need for advocacy support (see Chapter 3).

Gathering information

Councils' policies and protocols for information sharing were found to be good in 83% of service inspections although in some cases, recording practice was poor.

Information-sharing protocols across agencies are well established and appear to be working well in governing what can be shared with whom and when. However, difficulties were reported in respect of GPs' and hospitals' understanding of confidentiality and information-sharing protocols, particularly mental health services.

Information sharing with care providers can also be problematic. In this study, representatives of care providers expressed concerns about poor information sharing with managers of care services after they had reported an allegation of abuse in their service to the council, suggesting that in some instances managers were wrongly assumed to be complicit in the abuse.

- ***Comprehensive risk assessment and protection plans***

When assessments are carried out with a person who has experienced abuse, a focus only on the presenting abuse and a lack of an appropriate protection plan can sometimes make matters worse (Example 8).

Example 8

Ms K, a person with learning disabilities, had lived happily in her flat for years. A young man then began to taunt her. She did ask for help and ultimately the young man got an Anti Social Behaviour Order (ASBO) and was banned from coming near her flat. However, her overall needs, risks and circumstances were not addressed and no preventative protection plan was put in place. Unfortunately the young man's friends resented what had happened and started harassing Ms H even more. She complained she felt matters were worse than ever and wished she had not taken action.

However, in contrast to the example above, this study found some examples of good practice where council staff and other professionals from partner agencies worked well together with the person experiencing abuse. A thorough assessment of the person's needs and the risks that they faced resulted in positive outcomes for the person (Example 9).

Example 9

A serious incident involving a man with learning disabilities and mental ill health being assaulted by his wife raised an emergency alert about safeguarding the man. A team from health, social services and the police worked together on the investigation and undertook a fuller assessment of needs and risks. A joint protection plan was agreed, fully involving the man concerned, and resulting in the following actions:

- alerts to emergency services in the event of further calls from the address
- full information sharing across agencies
- initial risk plan for the man and professionals visiting the home
- providing an assessment of mental capacity and advocacy support
- daily visits to the man as part of a full risk management plan
- family respite supported by the team
- supporting the individual in his decision to become a witness
- a range of preventative advice to the man
- markers on records of main agencies relating to circumstances of the family.

- ***Case recording***

Case recording was criticised in over half of council inspections. When a number of staff or agencies are involved in supporting someone who has experienced abuse, good recording is necessary for continuity of support. This includes contemporaneous recording that clearly documents the views of the person being safeguarded and the progress on agreed actions by different agencies. It is also vital to have a good record of evidence if legal action is going to be considered. Good recording enables managers to oversee the support to individuals experiencing abuse.

Working with families and family carers

Councils report challenges in work with families, particularly in sharing information For example:

- A council realised that they had carried out interviews with a person thought to be at risk from financial abuse from a family member, with another family member present, who turned out also to be involved.
- Councils having difficulty in deciding when to involve family members in general decisions relating to care and support of their relative if the family is under investigation for abuse.

- Equally families and family carers report dissatisfaction with the way they are treated.
- A family felt very angry and pursued a complaint against a council, which had decided not to tell them about an abusive incident experienced by a relative in a care home because of previous allegations involving the family.
- Parent carers were dismayed at discovering that it had been recorded they were a risk to their disabled child after expressing despair at the closing of a respite service.

Providing support to people

The range of services offered to people after they experience abuse is variable. The best councils had a wide menu of both short- and long-term support to draw on, which could be tailored to personal needs.

There are some examples of crisis intervention to stop people experiencing further abuse. For example, fast-track responses to domestic violence incidents were referred to in around a third of council service inspection reports. Some councils provide people with emergency alarms or 'safe and well checks' in the evenings and at weekends, or give people who are directing their own support some extra temporary help to get over the crisis. People benefit from a protection plan that uses powers across a range of agencies.

"They gave me alarms and better security at home, a keep safe card and helped me get to the club for a while until I got back on my feet otherwise I would have given it up. The local bobby kept an eye on me. Some of them got an ASBO." (An older woman abused by youths in her neighbourhood)

A range of services was being offered in the best councils to provide longer-term support to help people recover from abuse. These include counselling and self-advocacy groups, home computers to enable people to be part of support networks, day care, leisure and learning opportunities.

Some councils consider the needs of people who would not usually be eligible for council social care support by providing targeted community-based prevention services. In a few councils, voluntary groups in black and minority ethnic communities are being used to disseminate information on safeguarding and provide social centres for older people to tackle isolation.

Carers who either experience abuse themselves or are in danger of abusing

the person they support because of stress are benefiting in some places from respite and other support services.

"They knew I was at the end of my tether – my personal counsellor and the respite was a god-send." (A carer who had confided in home care staff that sometimes he handled his wife "a bit roughly")

However, intervention from councils to support people who experience abuse in residential settings needs strengthening. In the study sites, there were good examples of interventions to investigate and secure the safety of individuals and others who may be at risk but few examples of sustained independent support to ensure longer-term recovery. A few councils make random checks following incidents but these tend to focus on standards in the home rather than on individual support.

In the study sites, council staff responsible for work on safeguarding emphasised that some councils are finding their ability to respond to the sharp increase in alerts about safeguarding a challenge. 'Lack of resources' topped the list of councils' concerns about implementing the *No secrets* guidance (see Chapter 6). As was experienced in child protection, there is a risk that resources become focused more on immediate protection after the event and less on prevention or long-term support.

Getting justice following abuse

The use of legal powers to protect individuals from perpetrators is very patchy. A few places demonstrated, for example, their use of civil injunctions, restraining orders and guardianship as protective tools of intervention. The understanding and applicability of these actions were not, however, widely understood by front-line staff.

Getting justice following abuse, via robust police investigations and court action, is not easy to achieve a is sometimes let down by inept intervention (See Example 10).

Example 10

Ms M has mild learning disabilities and lives independently. She became involved with a man on the internet who encouraged her to be involved in sexual activity she was not happy about, but she did not want to lose her boyfriend. Eventually Ms M told her mother who reported it to the police. Ms M was interviewed on her own by the police. The concerns were treated as allegations of rape. The police concluded there was no case to answer as sexual activity had been consensual. The case was later considered under safeguarding procedures but the police were reluctant to re-examine the case. It has affected Ms M's confidence and the potential risks posed to others by this man's behaviour have not been considered.

People in the study sites reported more is being done to promote equal access to justice but that the numbers of cases getting to court are still only a very small percentage of total referrals. The national picture from service inspections shows that where safeguarding arrangements are poor, relationships with the police are often underdeveloped, at both an operational and a strategic level.

A combination of dedicated, specialist police units, joint investigatory training and improvements to the support given to vulnerable witnesses in court is making a positive difference in some areas. However, the recording of information on safeguarding cases in social services, which could contain important evidential information, was criticised in over half of the council service inspections.

Addressing financial abuse

Issues relating to financial abuse are proving to be a big challenge for safeguarding services. There appeared to be a wide-ranging number of reasons for this:

- lack of knowledge in council staff of how to approach and navigate financial institutions, such as obtaining information about transactions from bank accounts
- lack of understanding of the powers and options available to address financial abuse
- shortage of training in investigative skills on financial issues
- older people's reluctance to pursue concerns if family members are the alleged perpetrators, for fear of losing contact with their family.

Good Practice One council has created the role of corporate appointee to help people manage their financial affairs by accepting appointee-ships and receivership via the Court of Protection. The role helps to protect people from financial abuse through an online corporate banking system monitored by the appointee. Approval to make applications of this kind is taken by a high-level panel including the director of adult social services.

Checking progress

Only a minority of councils were using care plan and protection plan reviews as an important component of their approach to safeguarding. These few councils had adopted a range of approaches:

- Designated liaison workers who had developed expertise on safeguarding and who linked to a number of care homes. This helped to build up a level of expertise about individuals and homes via the review process and was particularly useful where there were concerns about overall care practices at the home.
- Designated specialist reviewers for people who have experienced abuse operating across all adult services.
- A system of protection plan review according to assessed risks. People at low risk can have their plans reviewed by any agency whilst plans for people at a high risk have to be monitored by health and social care jointly.

These councils were confident of the benefit of these specialist arrangements to both detect abuse and oversee existing protection plans.

> "The review officers keep a tight rein on what's going on. In generic teams reviews are the first thing to go when under pressure. This way we ensure they get done properly." (An adult services co-ordinator)

The value of reviews in respect of people directing their own care has also only been recognised in a few councils, yet it provides a valuable opportunity to check how things are going.

> "The financial abuse by the personal assistant was picked up at the review. Goodness knows when it would have come to light otherwise." (An adult services co-ordinator)

Ensuring staff are well informed about safeguarding

In 2005-06, on average, 51% of relevant council staff had received training to identify and assess risks to vulnerable adults. By 2006-07, this figure had risen to 71% and to 81% by 2007-08[36].

Most local adult safeguarding boards had training strategies and a minority had full-time training co-ordinators. Inspections found that where there was some dedicated resource for overseeing training, not only was more training delivered, but it was also better organised, recorded and better linked to need, competencies and performance systems. Awareness raising and refresher-type training was extensive and usually multi-disciplinary.

More bespoke and specialist training was also being included in training programmes, with an emphasis on:

- investigations, where some of the training was jointly undertaken with the police (although this was less common) and some specially designed for provider services
- chairing and minute-taking for individual adult safeguarding strategy meetings
- achieving the best standards of evidence collection for legal purposes.

There was universal support for joint training as a vehicle for improving joint working, especially covering the investigation and assessment of abuse. A few considered mandatory joint training was required.

However, not all councils are making progress:

- In 2007-08, in 11% of councils less than half the relevant staff had received training
- In 2006-07, 16% of councils had a smaller percentage of their workforce trained in safeguarding than the previous year, and
- Forty-three per cent of councils failed to achieve their planned target on training.

Councils are also trying to improve the training on safeguarding for staff in services they commission from the independent sector. In 2006-07, it was estimated that only 31% of these staff had received training funded or commissioned by the council; this rose to 46% in 2007-08. There is wide variation between individual councils, with 31 councils having trained less than a quarter of independent sector staff[37]. This leaves many of those people with the greatest needs being supported by workers with limited access to council training on safeguarding, the very training most likely to give staff accurate guidance on local procedures.

36 From the self-assessment survey of council adult social services.

37 From the self-assessment survey of adult social services.

4.3 Conclusions on councils' arrangements to keep people safe from abuse

Assessments and care planning with people does not consistently identify risks of abuse.

Once councils have received a safeguarding alert, staff may have difficulty in deciding which situations should be handled through safeguarding procedures. The best arrangements appear to be where there is a broad and inclusive definition of safeguarding but a number of options regarding the approach to take, dependent on the circumstances of the abuse.

For people who experience abuse, assessments, planning processes, options available for support and reviews of progress are too variable, although there is some good practice developing. This means that some people may not be protected from further abuse or helped to recover in the best way, particularly those people who have experienced institutional abuse in care settings. Support needs to be more consistently available for all people experiencing abuse, including those who would otherwise be ineligible for council-funded care services.

Information sharing between agencies is generally working well, though there are some difficulties with sharing information with health services and independent providers.

Communication with families needs to improve, and assessments should be undertaken of carers' needs and a range of support services made available locally, including opportunities for a break.

Access to legal redress for people experiencing abuse is complex and can be problematic; training and support is needed for council staff to understand the range of legal remedies available and how best to address financial abuse.

Councils are improving training on safeguarding across their localities, with more and better quality training for council staff, though some areas lag behind. The availability of council-commissioned training for independent sector providers still needs to improve to ensure that staff from all sectors have equal access to training on local arrangements for protecting people from abuse.

4.4 Care services' arrangements to keep people safe from abuse

Alerts about abuse in care services

In September 2007, the Commission introduced a new system for monitoring safeguarding alerts . An analysis of the 615 alerts recorded in the first seven months of this system shows that the largest numbers of alerts were received from staff working in services (40%), followed by social services (25%) and providers themselves (12%). Alerts from the person themselves, family, friends or other people using services on behalf of someone else were 10% of the alerts.

Five hundred and eighty-nine alerts were traceable to 441 specific regulated services. These overall numbers need to be treated with caution, as research shows that abuse is likely to be under-reported,[38] there was an uneven distribution of alerts between regions, suggesting some alerts may not be logged by staff and some abuse in care services may be reported to other bodies, such as councils, but not to the Commission. However, there is a correlation between quality rating and the likelihood of an alert being received about the service (Table 6).

Table 6: Safeguarding alerts to the Commission from September 2007 to April 2008, by quality rating

Quality rating of service	0 star	1 star	2 star	3 star
Percentage of services where a safeguarding alert was received	6.3	2.9	1.9	1.0

Alerts were received about a higher percentage of privately owned services (2.0% of services) than council services (1.6%) or voluntary sector services (1.3%).

Meeting the National Minimum Standards

An important measure of performance in safeguarding people from abuse for regulated care services is whether the service meets the National Minimum Standard on 'protection' (see Appendix 2).

38 O' Keeffe M, Hills A, Doyle M, McCreadie C, Scholes S, Constantine R, Tinker A, Manthorpe J, Biggs S and Erens B (2007) *UK study of abuse and neglect of older people: prevalence survey report.* Completed for Comic Relief and the Department of Health. London: National Centre for Social Research

- The proportion of regulated services meeting the National Minimum Standards (NMS) on protection from abuse has risen substantially over the past five years, with 78% of care homes for older people and 77% of care homes for younger adults meeting the standard in 2006-07. This is up from 46% and 47% respectively in 2002-03, the year the NMS were introduced. For home care agencies the figure was also 77% in 2006-07, up from 55% in 2004-05 when they first came into regulation. Private sector services are least likely to meet the standard, across all types of service.
- Whilst this progress is to be welcomed, and many of the shortfalls in 2006-07 in meeting the NMS assessed by inspectors were relatively minor, it remains unacceptable in the context of such an important standard – five years after it was introduced for most services – that even minor deficiencies are still present. Moreover, the thematic inspections of care services suggest that the picture is somewhat worse when the standard is examined in closer detail.
- In all types of services, privately run services were the most likely to fail to meet the standard. The largest difference is in older people's homes where 76% of privately run homes met the standard, compared to 84% of voluntary sector and 86% of council-run homes.
- All sectors and service types have improved in meeting the standard over the last few years. However, improvement in respect of care homes, including care homes with nursing, appears to have stalled over recent years, with only 3–4% more services meeting the standard over the past two years.
- Moreover, in-depth thematic inspections of a smaller sample of services suggest a somewhat worse picture.

The range of statutory requirements and recommendations[39] made to the regulated services as a result of the thematic inspection on safeguarding is highlighted in Table 7. Inadequate staff training, written documentation – such as safeguarding policies and procedures – and recruitment practices were the most common shortfalls. There were also a large number of recommendations, though fewer requirements, about information to people on their rights to be safe and how to report any concerns.

39 Statutory requirements are actions the care services must take by law in order to comply with the regulations within a reasonable time. Recommendations for improvements are based on the National Minimum Standards. These are not required by law but are considered as good practice by the Commission for the service provider to consider carrying out.

Table 7: Recommendations and requirements from the thematic inspection of 94 care homes, home care services and adult placement schemes

Issue/shortfall	Number of requirements made	Number of recommendations made
Training and implementation of training	15	37
Safeguarding policy	11	24
Recruitment of staff	10	11
Record keeping	9	27
Procedures	7	19
Care plans	5	8
Medication	3	4
Complaints	2	2
Information	1	19
Environment	1	6
Supervision of staff	1	4
Other	2	9

Understanding people's needs and risks

Evidence from a previous Commission study[40] suggests that risk management is not yet well understood in regulated services. There is confusion about whether it is about health and safety, risk of abuse or risk to staff. At its best risk management supports choices and rights and enhances the capacity of the individuals to exercise these to the full. Risk management appears to be least robust in respect of older people and strongest in respect of younger adults.

The Commission's study on supporting people using regulated care services with their finances found that risk management in relation to financial abuse is under-developed[41].

40 Commission for Social Care Inspection (2006) *In Focus – Quality Issues in Social Care: better safe than sorry*. London: Commission for Social Care Inspection

41 Commission for Social Care Inspection (2007) In safe keeping: supporting people who use regul*ated care services with their finances.* London: Commission for Social Care Inspection

Care plan reviews are one way to ensure that risks for a person are reviewed regularly. Provider-led reviews are commonplace, but have distinct disadvantages as they do not allow an objective person to reassess risk, review progress and adjust the plan accordingly and do not give the individual an opportunity to speak to an independent person about their concerns.

"The dominance of provider-led reviews meant that some changed circumstances were not recognised and new risks were not assessed." (Quote from a service inspection report)

Service providers should welcome and encourage the involvement of independent people in reviews. It is important that people using services and their relatives have an independent route to challenge poor practice in services. The Commission welcomes the extension of the role of the Local Government Ombudsman to adjudicate on second-stage complaints about care providers from people funding their own care.

Using the procedures to safeguard people

Of the managers of regulated services spoken to as part of this study, 73% said they understood the process for making a safeguarding referral although there were marked variations in different areas. It was noticeable that managers of regulated services in the areas of the higher-performing councils had a better understanding than managers in the areas of the lower-performing councils, indicating better communication and liaison between care providers and councils in the best performing councils.

Understanding of the local procedures by managers in regulated services can be hampered if the provider's policy on safeguarding does not dovetail with the local council multi-agency procedures. This can happen where the provider organisation operates in a number of council areas and a generic safeguarding policy is used. In 5% of inspections of regulated care services during a two-week period, it was noted that the provider's policy and the council policy were incompatible. As inspectors were not specifically asked to report on this, actual figures may be higher. All the services reported to have incompatible policies were run by the private sector and there was a relationship between the service's overall quality rating and whether an incompatible policy was being used, with the poorest services performing worst – 11% of poor providers were using incompatible policies.

Confusion may also arise if councils do not alert providers when policies are updated, as an independent provider commented:

"They update policies on the website and don't tell anyone. I tried a few council websites last night; two different versions come up on one council site... It is knowing where to find the information."

As well as understanding council procedures, it is important that the provider's own procedures are robust and clear. Improvements to safeguarding policies were the second most common requirement made in the thematic inspection; 11 requirements and 24 recommendations were made in relation to the safeguarding policies of 94 services.

Staff, as well as managers, need clear direction about what to do if they have abuse disclosed to them, or witness abuse themselves. Staff are generally protected from dismissal or victimisation by the Public Interest Disclosure Act 1998 if they report an allegation of abuse to their employer, the regulator or certain other bodies. This employment protection can increase their confidence in reporting abuse. The vast majority of managers of regulated services (85%) said they had a policy on whistle-blowing, 9% said they used the council's policy but 6% were not sure whether they had a policy or not.

Once a referral to the council has been made, a council may decide that it is most appropriate that the provider organisation carries out the investigation. This can be in line with national and local protocols, where it is agreed that the provider should investigate where the registered service is not directly implicated, taking into account information about the quality of the service and an expectation that the provider keeps the council informed of progress and the final outcome. In some council areas, providers report that they are not involved in investigations even if they are fit to do so. On the other hand, this study found that sometimes allegations are not adequately addressed by provider services, particularly if they have not sought advice from the council before dealing with the issue (Example 11).

Example 11

L is a young woman with learning disabilities who lives in supported housing. She also needs a special diet because of a physical condition. She declined to go on a trip with others in the home because of finding suitable food but was put under pressure to go so her key worker did not have to stay at home too. She felt bullied into going and ended up having dietary problems as a result. As there were other worries about the support she was getting from this worker L complained to her day centre who helped her to get advocacy support to make a complaint. The provider service investigated but did not uphold the complaint. As she was very dissatisfied with the outcome L was assisted to make a safeguarding alert. As a consequence of a more detailed independent investigation it came to light that there were more widespread concerns about the member of staff involving other residents, which warranted serious attention.

Ensuring suitable staff work in care services

There are improvements in the overall number of regulated services meeting National Minimum Standards on recruitment, although at least one quarter of services of each type still failed to meet the standard in 2006-07 (see Appendix 2). There are variations across council areas and types of service:

- In 2006-07 care homes for younger adults best met the standard (73% of homes) whereas care homes for older people did least well (69%). Home care agencies' compliance improved from 61% in 2005-06 to 72% in 2006-07.
- Voluntary sector home care agencies were more likely to meet the recruitment standard than agencies run by other types of provider (80% meeting the standard compared to 77% of council run services and 71% of privately run services).
- In relation to care homes for younger adults, voluntary sector services also best met the standard (78% compared to 72% of private and 70% of council care homes), but council-run homes performed better in relation to care homes for older people (78% met the standard, compared to 75% of voluntary sector and 68% of private sector care homes).
- Between 2005-06 and 2006-07, 94 councils showed improvements in the number of care homes for older people meeting recruitment standards in their area. More council areas showed an improvement in relation to home care services (114 councils) and fewer in respect of nursing homes (51 councils).

Nearly all managers of regulated services interviewed in the thematic inspection said that they were carrying out Criminal Records Bureau checks at the point of recruitment but there was less confidence about the range of other checks (see Table 8).

Table 8: What employment checks do you carry out (or were carried out on you) before starting work here?

	% managers mention this	% staff mention this
CRB checks	97	100
Take up references	69	94
POVA checks	67	45
Check previous work history	43	15
Interview before employment	30	32
Identity checks	30	26

Service providers have a responsibility to ensure that staff who abuse people using services are removed from the workforce. The uncertain knowledge of some managers about the role of the POVA list in this respect was confirmed by answers to a question on this topic in the thematic inspection, with over 40% judged to have offered an inadequate explanation of the term, and 19% saying they did not know about the POVA list and how to use it. This low level of understanding will need to be addressed by the new Independent Safeguarding Authority.

It is also questionable whether managers have an adequate understanding of human resources policies on suspension of staff members when allegations of abuse are made against them. Only 37% referred to considering this action if a safeguarding incident was reported to them. Representatives of service providers indicated that suspension of staff could cause problems for services, especially when police investigations took a number of weeks or months. Not only is there the cost to the provider of paying a suspended member of staff as well as replacement cover but, if the allegation was unfounded, it can be difficult for the staff member to then return to work after this period of time. If the police and councils carry out investigations in a timely manner, this can minimise the impact on services of staff suspensions.

There are also systems in place for alerting professional regulatory bodies when someone has perpetrated abuse. For example, the Commission has a protocol with the General Social Care Council on this.

Ensuring staff develop good practice in safeguarding people

Though nationally it is estimated that only 46% of care staff across all sectors have access to council training on safeguarding, when managers and staff of regulated services were asked about their access to training on safeguarding, a more encouraging picture emerged. This indicates that services are using a range of training sources, not only those commissioned by their council:

- 91% of managers of services said they had had training (although in one study site 21% had not)
- in 71% of services all staff had received some training, with the lowest level of training for those working in care homes for older people
- there were regional variations with London coming out best for training
- there appears to be a correlation between staff training in safeguarding and the overall quality rating of a service, with only 40% of the lowest-rated services indicating all staff had had training to 100% in the highest-rated services.

Despite the effort and resources going into developing the workforce, training and *its implementation in practice* still topped the list of statutory requirements placed on providers in the thematic inspection of regulated services. Training depth and quality appeared variable, ranging from watching a short DVD to attending courses that are supported by annual refresher training. In 32% of poor services inspected over a two-week period, although all the staff had received training on safeguarding, the understanding of some staff was weak when interviewed by an inspector. By contrast, this was the case in only 14% of good services.

When managers were asked how they made sure staff understood safeguarding policies, training topped the list of answers (see Table 9). Few managers were drawing on the full spectrum of approaches to informing staff about policies on safeguarding.

Table 9: What do you (service managers) do to make sure staff understand policies?

	%
Training	56
Supervision	52
Team meetings	46
Induction	44
Observing staff	17
Staff handbook	15

The value placed on training increased significantly with the quality rating of the service.

Similarly, when managers were asked about how they ensured training was put into practice, there was a spread of responses, but again, few people were using the full spectrum of approaches with their staff (see Table 10).

Table 10: How do you (service managers) make sure that training is put into practice?

	%
Through staff supervision	62
Observation of practice	54
In staff meetings	43

There was again variation across different parts of the country. Supervision was used most in the highest-rated services and least in the lowest-rated services.

"The manager believed from the feedback that I had given her that she would now reconsider how she knows that staff are putting training into practice – she was concerned that staff should have known more than they did." (Inspector's comment on a thematic inspection feedback form)

The best service providers place a high value on training their staff about safeguarding people and their managers regularly reinforce messages to ensure staff put these into practice.

4.5 Conclusions on care services' arrangements to keep people safe from abuse

The proportion of services that meet the National Minimum Standards on protection from abuse is improving, but more need to meet the standard to help ensure that everyone using care services is adequately protected from abuse.

Inadequate staff training, poor or inadequate written documentation such as safeguarding policies and procedures, and recruitment practices were the

most common shortfalls in services. Information to people about their rights to be safe and how to report concerns also needs improvement in many services.

Prevention of abuse is the best way to keep people safe in regulated care services but good risk assessments are not yet undertaken in every care service. Ensuring that the staff who work on a day-to-day basis with people are suitable is also critical. Although there has been improvement in pre-employment checks by providers, too many services still fail to meet the National Minimum Standards on employment and too many managers do not understand the POVA list processes for preventing staff who have abused people working again in a care position.

Training staff about safeguarding can also help prevent abuse occurring, as well as giving staff confidence in the procedures to follow if they report abuse. Access to good quality training and reinforcement of training in day-to-day practice is the area that needs most improvement in regulated services.

If abuse does happen, managers in services need to know how to work with the local council safeguarding procedures. Knowledge in this area was variable; not only were managers of higher-rated services generally better informed, but those in higher-rated council areas also knew more. Clearly both provider organisations and councils have a role to play in ensuring people using care services have good access to procedures if they experience abuse.

5

Checking that the arrangements work and making improvements

Key findings

- Over two-thirds of councils are failing to monitor safeguarding adequately, through appropriate management overview of both individual cases and the arrangements as a whole. At a casework level, over half of the councils inspected need to improve recording and supervision, and two-thirds to improve auditing processes.
- At a strategic level, councils are recording the number of people receiving support because of abuse, thereby providing a better measure of levels of activity in safeguarding work. However, most councils need to put systems in place to obtain feedback from people who have experienced abuse and monitor the outcomes for people in order to improve services.
- Councils vary in how well they commission services that have good arrangements for safeguarding people. However, the better-rated councils overall had more care homes in their area meeting the NMS protection standard. Accordingly, more than 8 out of 10 three-star councils have 90% or more of the care homes in their area meeting NMS protection standards. By contrast, only 7 out of 10 one-star councils achieved this.
- Only 38% of managers said they had used their experience from a safeguarding incident to improve practice. Only 16% of managers said that they were enabling people to give regular feedback on how the service could improve to make people feel safe. Higher-rated services are performing better in both learning from incidents and using feedback surveys to improve practice in safeguarding people.
- Some members of the public, staff in councils and in care services remain confused about the role of the regulator in respect of safeguarding; both in situations where individual people need support because they have experienced abuse and in the development of local safeguarding arrangements, for example through adult safeguarding boards.

5.1 Introduction

This chapter assesses the ways in which councils, care providers and the regulator check how well arrangements work to safeguard people from abuse and how they then make improvements.

In assessing their performance the Commission would expect higher-rated councils and care services to focus on the issues set out below.

a) Councils need to:

- assess the quality of practice to safeguard people
- carry out audits to ensure compliance with safeguarding procedures
- collect data to ensure trends in referrals, safeguarding issues and outcomes for people can be measured
- ensure that senior managers and safeguarding boards receive reports about performance in safeguarding so they can plan improvements
- use commissioning processes and contracts to ensure people are safeguarded in commissioned services.

b) Care providers need to:

- have processes in place to learn from safeguarding incidents and from the views of people using the service about their safety, in order to make improvements.

c) The regulator needs to:

- work with other agencies through local procedures to ensure that people in regulated services are adequately safeguarded
- use its powers to improve standards in regulated services so that everyone using these services is safeguarded from abuse
- use its powers to drive up performance of councils to ensure everyone in their local area is well served by the local safeguarding arrangements.

5.2 Councils' checking of arrangements to safeguard adults and make improvements

Significant shortfalls in performance management arrangements for safeguarding are highlighted in over two-thirds of councils' adult inspection reports. Some councils had some key elements of performance measurement and quality assurance in place but a few councils were lacking even the basics. Two quotes illustrate the ends of this spectrum:

> "There was close monitoring of the outcomes of adult safeguarding at all levels, with a strong focus on information, quality assurance and good management oversight..."
> "Management oversight and performance management were under-developed markedly... there was no system in place to check compliance... and management advice was often inaccurate – there were major information weaknesses and gaps." (Quotes from two service inspections of councils)

Few councils were comprehensively monitoring the quality of support to individuals. Case recording was criticised in over half of council inspections. Poor recording has the potential to undermine effective evidence gathering and also makes it difficult for managers to oversee practice.

Supervision and decision making by operational managers was often not evident in records, although in practice was probably better than indicated in the files. In only around a third of councils were routine audits of safeguarding casework undertaken, although more were doing random checks. Few councils had processes in place for people who had experienced abuse to give feedback on how well the arrangements worked for them.

Where councils had specialist mentors and champions in place, they were highly valued and were seen to have a positive impact on the quality of work with individual people experiencing abuse. They often brought practitioners together to learn from the experience and practice of each other.

Most places have arrangements in place to undertake serious case reviews and are learning from these and national inquiries.

At a more strategic level, some analysis of referrals, trends and benchmarking of these against similar councils was taking place. However, this tended to capture amounts of activity rather than quality and outcome and was not analysed alongside information from complaints and contract monitoring.

There was widespread recognition and acceptance in principle of the ADASS safeguarding standards by councils but only a few have used the standards to measure their current performance and to develop an improvement plan.

Safeguarding boards vary in how well they understand what is going on at the front line, the pressure points and outcomes achieved for individuals to keep them safe. Where reporting was poor, messages about the resources required to effectively respond to increases in referrals were not always reaching senior management.

Local politicians are very interested in how their council is performing in respect of safeguarding but to date have had limited ways of judging this. Scrutiny boards and local select committees are starting to establish a clearer role in respect of scrutinising performance in safeguarding but as yet this is very under-developed.

Few areas are meeting the challenge of integrating standards on safeguarding and priorities across agencies and mapping progress against them. Liaison with other performance management bodies such as those in health and the police also need to be strengthened to give an overall picture for the locality.

Chart 3 lists the range of challenges still to be met and managed by councils.

Challenges met by most councils	Challenges met by some councils	Challenges met by a few councils
Awareness-raising information and training in place for key professionals	Information tailored to specific professional and public audiences	Personalised approach to the management of risk – meeting needs of all community, including those directing their own support
Rights-based joint policies and guidance in place, linked to individual agency procedures	Clear, consistent routing of referrals	Safeguarding effectively built into commissioning standards and monitoring arrangements
Prompt response to safeguarding alerts	Good, integrated investigation, care management and risk assessment with specialist support	Integrated preventative measures
Some joint assessment and investigation	Access to advocacy support	Support for access to justice
Information-sharing protocols in place	Regular case reviews	independent reviews of protection plans
Specialist co-ordinators in post	Safeguarding profile strong but not integrated into wider provision of preventative support	Measurable, joint strategic objectives for safeguarding informed by the community
Access to some preventative support	Safeguarding has limited profile in commissioning and contracting	Integrated information, compliance and assurance checks
Safeguarding board in place	Effective strategic engagement across main agencies	Comprehensive, integrated training plan and a joint workforce strategy developing
Clear arrangements for CRB checks	Elements of data collection/analysis and performance management in place	Involving people in the design, monitoring and evaluation of safe services
	Full recruitment checks and specialist training needs addressed	

Promoting good practice in safeguarding – a specialist or mainstream activity?

There is a debate about the value of specialist versus mainstream activity to keep adults safe. On the one hand, it is argued, specialist practitioners develop expertise and ensure a higher, more consistent standard; on the other, some claim that safeguarding has to be located in mainstream adult social care in order to ensure a holistic, preventative focus on safety and independence. These are not mutually exclusive.

In the five study sites, safeguarding co-ordinators were valued in supporting the work of safeguarding boards and the development of the service, and 'safeguarding champions' in mainstream teams were an effective way of encouraging good practice. The evidence suggests such posts raise the priority of safeguarding and form an effective bridge from top-level strategies and policies to front-line practice.

While specialist operational teams might ensure a more consistent response, there was evidence of significant tensions around the boundary between poor practice and safeguarding. The allocation of individuals using services to specialist 'safeguarding teams' to keep them safe from abuse also has the potential to prevent them benefitting from the wider development of personalised services designed to support inclusion, choice and independence.

> "People who have experienced abuse should not be denied their right to social inclusion and participation; this might happen if safeguarding is dealt with separate to other adult services." (An advocate)

Procurement by councils to ensure safeguarding in services

The majority of councils are building quality measures about safeguarding into procurement. These go beyond formal contract clauses and include:

- a joint dignity in care strategy launched with a range of partners, setting standards to achieve a zero tolerance of abuse of older people
- a nursing standards group set up in response to concerns about standards in local nursing homes
- incentives and premiums in contracts to reward high quality
- liaison officers who have links to specific homes to build up knowledge and encourage higher standards especially in relation to safeguarding issues
- managers of care homes invited to 'clinics' about safeguarding to share experiences and learning.

There is some evidence that higher-performing councils are better at driving up standards in regulated services than lower-performing councils. Accordingly, more than 8 out of 10 three-star councils have 90% or more of the care homes in their area meeting NMS protection standards. By contrast, only 7 out of 10 one-star councils achieved this.

5.3 Conclusions on councils' checking arrangements to safeguard adults and making improvements

Over two-thirds of councils have significant shortfalls in their management of safeguarding arrangements. Improvements are needed at both an operational and a strategic level. In most councils better casework recording, supervision and audit is required to ensure that every person who experiences abuse receives an equally good response. Most councils also need to put mechanisms in place to get feedback from people who have experienced abuse and to use this to improve services.

Councils are recording the number of people receiving support because of abuse, which is giving a better measure of levels of activity in safeguarding work. However, there needs to be better monitoring of the quality of work and the outcomes for people in order to assess the resources required to deliver improvements, both for councils and for partner agencies.

Most councils are developing strategies to ensure that the services that they procure carry out good practice in safeguarding people but more needs to be done. There is some evidence that services are more likely to meet safeguarding standards in areas where councils are performing better.

5.4 Performance management by service providers

Only 38% of managers of services inspected said they had learned from their experience of keeping people safe from abuse (although 26% said they could not recall an incident). Around half of those responding could not describe adequately how they had used learning from an incident to improve their service:

- private sector services demonstrated the least capacity to learn (36%) and voluntary sector the most (47%)
- only 16% of 'poor' services learned from safeguarding incidents as opposed to 60% of 'excellent' services.

There was a similar association with quality ratings in respect of the use of surveys as a means of gauging the 'customer' perspective on whether people are kept safe:

- only 16% of services said that they used surveys to give people using services an opportunity to express views about their safety
- these surveys were least commonly used in the private sector and most commonly in the voluntary sector
- no 'poor' services mentioned using surveys for this purpose whereas 40% of 'excellent' services did so.

5.5 Conclusions on care services' checking arrangements to safeguard adults and making improvements

Managers in services need to ensure that processes are in place to learn from safeguarding incidents and to enable people using services to give regular feedback on how the service could improve in terms of people feeling safe.

5.6 The role of the regulator in quality assurance and improvement

During this study it was evident that there remains some confusion about the role of the Commission in respect of safeguarding. Issues raised by multi-agency partners in the study sites included:

- The circumstances where the Commission might attend strategy meetings about incidents in regulated services: *"sometimes they come – sometimes they don't".*
- The role of the Commission on local safeguarding boards: *"when they come they are silent".* This may relate to the period when Commission staff members had observer status on some safeguarding boards.
- Owners of care homes expressed a wish for greater clarity between the role of the council and the role of the Commission when an incident takes place.
- Misunderstandings and unease felt by family carers who raise concerns or complaints with the Commission only to find them directed back to the care home to deal with, even when this has already been tried. This indicates some remaining public confusion over the role of the Commission.

The Commission has taken a number of actions on safeguarding including:

- The introduction of a protocol involving the Commission, the Association of Directors of Adult Social Services and the Association of Chief Police Officers, first published in February 2007, to ensure that the Commission's working practices support effective safeguarding and contribute to a reduced risk of abuse for people who use services (see Chapter 2).
- The development of a concerns, complaints and allegation policy that defines the difference between a complaint and an allegation of abuse. An

allegation of abuse to the Commission triggers action under local multi-agency arrangements. The Commission has no powers under the relevant legislation to investigate an individual *complaint* to get redress for an individual but will consider whether the provider's complaints process is fit for purpose and may consider whether the content of complaints requires regulatory action to improve the service overall. Often, information about and from complaints triggers further regulatory activity including enforcement action.
- Development of the regulatory process for regulated services to target inspection activity towards services that need closer monitoring, including giving a high priority to monitoring services that fail to meet standards on complaints and protection.
- Introduction of a new Key Threshold into councils' star ratings for 2007-08. Failure to deliver at least 'adequate' outcomes to safeguard people who are vulnerable affects the council's overall star rating.

The Commission welcomes the extension of the role of the Local Government Ombudsman to investigate second-stage complaints about care services from people who are funding their own care. This provides a new way for individuals to get redress for complaints of poor practice, but it may need promotion to the general public to increase awareness of this new remedy.

This study suggests that future actions required by the regulator include to:

- further communicate the role of the regulator in relation to safeguarding individual adults from abuse
- ensure that the new regulatory compliance criteria used by the Commission's successor, the Care Quality Commission, are used to drive up standards in safeguarding in regulated services
- ensure that the contribution of the Care Quality Commission in assessing and reporting on the performance of councils for 'people who are vulnerable' in the Comprehensive Area Assessment is in the context of safeguarding outcomes.

6

Local strategic work to safeguard people

Key findings

- There is variation in the degree of priority shown to safeguarding adults within and across council areas.
- Only about a half of safeguarding boards were judged to be working effectively according to council service inspections.
- All boards had representation from the key statutory agencies, although not always of the appropriate level of seniority. GPs, housing and probation services were the least involved.
- Most safeguarding boards are struggling to find practical ways of engaging people who use services and other local people to inform decision making about strategic development or service design in respect of safeguarding.
- A minority of councils considered safeguarding as a matter of course in all their strategies on health and well-being, crime and disorder, domestic violence and regeneration. A majority of councils were developing some strategic work on safeguarding but this was not a theme that ran through all strategies and few outcomes were yet evident.
- Councils were at different stages in explicitly including safeguarding in their core commissioning strategies for both universal and specialist services.

6.1 Introduction

This chapter looks at the ways in which councils respond to and prevent abuse at a strategic level including the priority given to this work, underlying principles, prevention and partnership working.

In assessing their performance the Commission would expect higher-rated councils and care services to focus on the issues set out below.

Councils need to:

- give sufficient priority and resources to the development and review of safeguarding strategies and multi-agency procedures
- have a safeguarding board which drives the work, with members from key agencies of appropriate seniority, and operates effectively, for example through proper governance

- involve older people, disabled people and others covered by the safeguarding arrangements in strategic work
- co-ordinate partnership working between key agencies at an operational level, ensuring agencies implement the procedures
- and at a strategic level, for example in the development of joint training
- ensure that preventative work is developed through other council strategies, for example community safety.

6.2 Making safeguarding a priority

There is variation in the degree of priority shown to safeguarding adults within and across council areas. The way budgets are organised does not make it easy to demonstrate this variation in terms of comparative spending on safeguarding, but evidence of differing priorities is shown by:

- marked variations in the annual increase in the number of safeguarding alerts of between 10 and 150%, and across different groups of people within councils
- some front-line teams are trying to handle massive increases in referrals without increased resources or support
- differing profiles given to safeguarding in commissioning and monitoring of services and in key preventative strategies
- the varying seniority of staff represented on local safeguarding boards and the resources made available to these boards.

The priority given to safeguarding does not depend on the council alone, but also on key partners in health and police services who have numerous other responsibilities and priorities set by government. Negotiating a high priority for safeguarding adults in this context is not always easy. For example, some councils had difficulty in securing dedicated attention to safeguarding in the local police force. In only 17% of councils inspected was their performance in safeguarding rated higher than their overall performance across all their functions. Difficulty in engaging strategic partners was one of the major reasons for this generally lower performance.

Where there is a political champion for safeguarding and the chief executive of a council and the director of adult social services are actively involved in raising the profile of safeguarding, there is a greater likelihood of engaging other major players in primary care trusts, hospitals and police authorities.

"Leadership and championing of safeguarding were strong... partners had a good record of identifying shared goals and priorities on safeguarding and achieving these by sharing resources, both money and personnel." (Quote from a council inspection report)

6.3 The effectiveness of safeguarding boards in driving strategic work

The study found a mixed picture of the effectiveness of local adult safeguarding boards. Most places considered their board was making progress, but only about half were judged by service inspectors to be working effectively. Some had recently been re-launched in order to become more effective and it was too early to judge impact. A few were far from operating at the level required.

"The board acted more like a special interest group of like-minded professionals than as an inter-agency strategic lead forum." (Quote from a council service inspection report)

All boards had representation from the key statutory agencies, although not always of the appropriate level of seniority or continuity. GPs, housing and probation were the least involved. Links with children's safeguarding boards were usually made.

Most safeguarding boards are struggling to find a practical way of engaging local people in order to inform board decision making about strategic development or service design in respect of safeguarding. A few are drawing on existing networks of people who use services and carers' forums but this does not reach more marginalised groups or citizens. This bears out recent research into *Partnership and Regulation in Adult Protection*[42] which found that only 29% of safeguarding boards had representation from people using services or family carers.

Some boards are uncertain about whether to include representatives of

42 Penhale B, Perkins N, Pinkney L, Reid D, Hussein N and Manthorpe J (2007) *Partnership and regulation in adult protection: the effectiveness of multi-agency working and the regulatory framework in adult protection.* London: Department of Health

the independent provider sector. This uncertainty is also reflected in the *Partnership and Regulation in Adult Protection* study[43] which showed that whilst 65% of safeguarding boards had voluntary sector representatives, only 34% had representatives from the independent sector. Independent sector representatives taking part in this study saw their main concerns as improving co-operation at an operational level, although they could see the benefit of being involved on safeguarding boards to influence reviews of local procedures and resource decisions, for example around training plans.

As with other strategic partnerships, the following factors appear to be linked to a successful board:

- getting the right people at the right level of seniority *consistently* round the table
- having a shared view of key priorities and how each organisation contributes to their achievement, by pooling people and finances
- showing leadership on safeguarding within and across organisations
- being clear how the board relates to the governance of the constituent organisations, local strategic partnerships and scrutiny bodies
- having co-ordinator and administrative support to ensure things happen
- getting organised via business plans and sub-groups on issues such as training, performance, policies, procedures, and serious case reviews.

6.4 Working together to prevent abuse

Almost all localities thought partnership working in respect of adult safeguarding was getting better; it was not as structured and as well established as child protection but improving all the same. There were regional variations; in London more difficulties were highlighted in partnership working than in the rest of England[44] (see box).

43 Penhale B et al, *ibid*

44 from the self-assessment survey of council adult social services, March 2007.

Councils' responses about remaining difficulties in embedding a robust, multi-agency approach to vulnerable adults following *No secrets*

Over half of councils reported no difficulties. 65% of London councils reported some remaining problems compared with only 48% of unitary councils.

73% of London councils reported difficulty in relationships compared with only 24% of unitary councils.

Most difficulties were said to relate to lack of resources (a third of councils). This was followed by problems related to lack of legislative powers. Lack of commitment by GPs came third.

London councils were much more likely to report difficulties with the police and least likely to report difficulties in training. County councils were most likely to report difficulties with health bodies and with training.

In the discussions in study sites, staff from many statutory agencies agreed that the *No secrets* guidance had been the main impetus in bringing about improvement. However, many also thought that the rather 'permissive' nature of guidance on safeguarding adults, especially as applied to health and police, resulted in variable commitment and left partnership working relying too much on local negotiation rather than statutory duties. There was recognition that universal services, particularly health and police, faced competing priorities but there were mixed views as to whether placing adult safeguarding on a firmer legislative footing would, in practice, push it up their agenda.

Strategic partnerships and commissioning services to improve safeguarding

Councils have responsibilities for community leadership and the promotion of well-being. This includes endeavouring to ensure that services designed to prevent abuse happening in the first place are promoted in key local strategic partnerships, and that work to keep people safe from abuse is a coherent theme across a number of strategies (see Chart 4).

A majority of councils were developing some strategic work on safeguarding but this was not a theme that ran through all strategies. A minority of councils considered safeguarding as a matter of course in all their strategies on health and well-being, crime and disorder, domestic violence and regeneration.

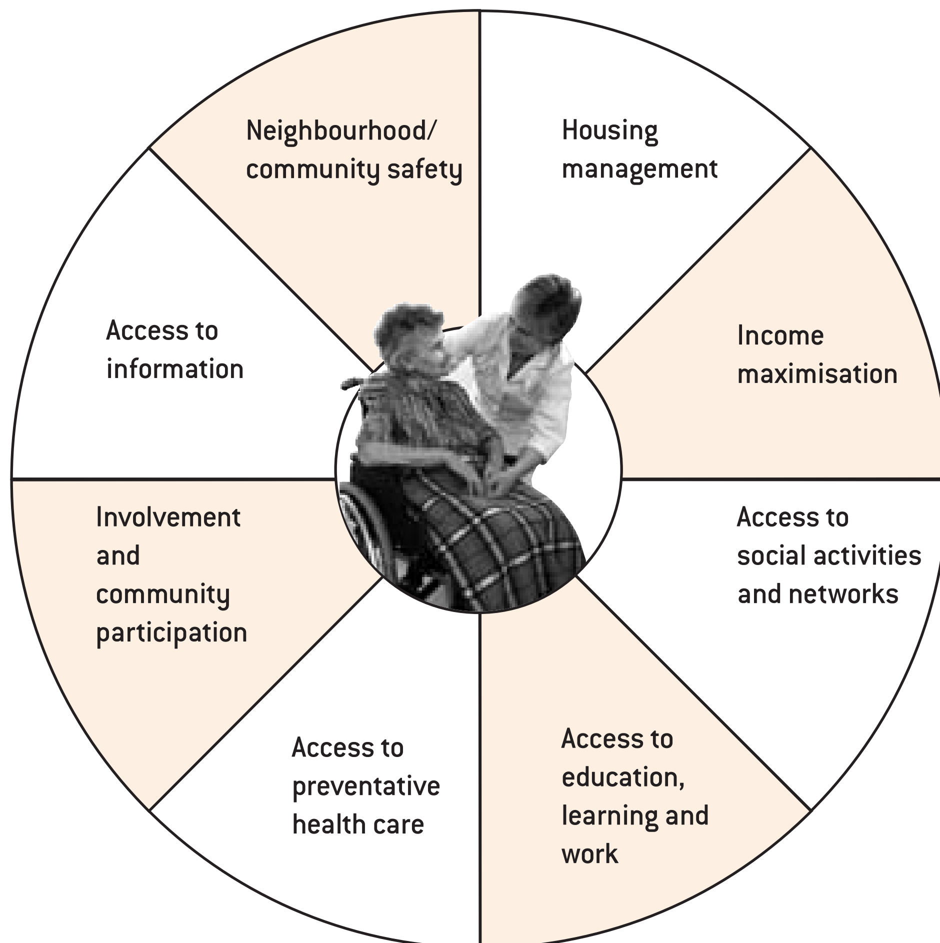
As a result, on-the-ground initiatives tackling rogue traders, doorstop crime, and domestic violence in old age were developing. One community safety partnership included initiatives aimed at particular local issues to keep people safe that were informed by work on safeguarding, such as the harassment and bullying of people with learning disabilities and the role of community wardens in keeping people safe from abuse.

However, for many councils, this strategic prevention work was only just beginning to happen and no visible outcomes were evident.

Having named safeguarding champions at a senior level seems to help raise the profile of safeguarding at this level.

Where councils are investing in services which are accessible to all and enable people to receive support whilst maintaining their independence, in the long term it could be argued that there will be fewer incidents and less pressure on resources to address the aftermath of abusive incidents.

Chart 4: Community strategies that contribute to the prevention of abuse



Councils were at different stages in explicitly including safeguarding in their core commissioning strategies for both universal and specialist services, as these quotes show from the inspection reports of two councils at different stages in the development of their safeguarding services:

> "...Strategic development work to address the inclusion of safeguarding in both the commissioning strategy and commissioning activity has only just begun..."
> "...Safeguarding has been accepted as a core responsibility of the whole council and by the wider strategic partnership and this is carried through to the services commissioned..."

6.5 Conclusions on local strategic arrangements to safeguard people from abuse

Although the priority of work to safeguard adults from abuse has generally increased over recent years, there is significant variation in the degree of priority shown within and across council areas. Effective leadership from the chief executive and director of adult social services and senior 'safeguarding champions' help to secure the partnership working necessary from key agencies at a strategic level, where competing priorities in universal services can be a hindrance to the development of safeguarding work. These champions can also influence wider council strategies such as community safety, which will lead to the development of services more likely to prevent abuse or enable early intervention when people have experienced abuse.

Safeguarding boards need to consider their membership, particularly of people using services and independent providers, also in term of continuity and seniority of representatives.

7

Concluding remarks and key messages

Conclusions

This study confirms the rising profile of work to safeguard adults from abuse across the country. Arrangements put in place by councils and care services are resulting in more people being better informed about sources of help if they are being abused, or suspect that others are being abused, and getting the help they need. But the overall picture is not consistent.

Uneven progress

Progress on establishing effective safeguarding arrangements is uneven both across and within council areas and between different service providers. Some groups in the community are still under-represented in referrals, including black and minority ethnic people and people using mental health services. More needs to be done to ensure people with high support needs or without support from trusted family or friends get help that truly results in better outcomes for them.

Variations in quality of support and care practice

Good councils are assisting people in situations where they face abuse by drawing on the full range of universal services and resources specifically for people needing support to be safe. Importantly, the evidence suggests that arrangements work best where the whole system is underpinned by shared objectives and a common human rights value system (see Chart 5 below).

But more often the quality of assessments and interventions to support people is variable and practice is not consistently monitored by councils.

Care services are generally competent at reporting safeguarding concerns but need to adopt a more comprehensive approach beyond formal reporting procedures, including supporting people who have experienced abuse and improving recruitment practice and staff development on safeguarding.

Individually tailored safeguards for people directing their own support

The increasing number of people managing their own support presents new challenges for safeguarding; but arrangements are not yet fully geared to

Chart 5: shared objectives and human rights values in safeguarding

the personalisation agenda. Risks need to be explicitly identified with people and addressed in a manner that enhances people's ability to make informed choices.

Variable action to help prevent abuse and achieve good outcomes

This study found that the building blocks of prevention and early intervention are not consistently in place in every council. These essential elements are:

- people being informed of the right to be free from abuse; and supported to exercise these rights, including having access to advocacy
- a well informed, competent and properly vetted workforce operating in a culture of zero tolerance of abuse
- a sound framework for confidentiality and information sharing across agencies
- good universal services targeted at older and disabled people that can reduce the risk of people experiencing abuse, for example community safety services or services that increase people's access to advice or maintain informal support networks
- thorough needs assessments supported by risk assessments where required to inform people's choices
- a range of options for support to keep safe from abuse that can be tailored to people's individual needs – both for people using care services and those directing their own support
- service provision which gives prominence to the need for sound safeguarding arrangements as well as the promotion of people's independence
- a public which is aware of – and alert to – these issues.

Leadership

Councils are in the driving seat on safeguarding in respect of community leadership, strategic partnership development and commissioning and as the lead care management and support agency. A council's performance is central to effective protection and prevention of abuse.

The best councils are providing active, visible leadership on safeguarding and building the local partnerships needed for success. But others are only just beginning to develop and implement joint local strategies. Safeguarding does not yet feature sufficiently prominently in existing cross-agency strategies, yet this is central to effective prevention. Safeguarding champions and specialist co-ordinators can help to translate strategies into front-line practice but it is also important to embed safeguarding securely into mainstream adult social care. Safeguarding work needs to be part of the overall shift towards more personalised services supporting independence and choice, not separate to it as this study frequently found.

New legislation and government action

The study has confirmed a lack of consensus about what, if any, new powers are needed to improve safeguarding work. No one saw legislation as the only solution to shortfalls in the existing service. Places with strong local partnerships were less inclined to see the need for new powers. Where there were concerns that some organisations were, to some extent, abdicating or minimising their responsibility for safeguarding, there was more enthusiasm for more explicit powers to give an impetus for change and to raise standards and consistency of response.

In summary:

- Some places were using existing powers to good effect. Sharing good practice in the form of guidance, about how existing powers can be deployed to best effect, could raise standards without changes to the law.
- The greatest consensus is around the need to have a specific duty to co-operate in reporting abuse, sharing information and investigating concerns.
- There was a common view that more explicit guidance and possibly new powers and guidance were needed to access information and to secure the co-operation of financial institutions where there were suspicions of financial abuse.
- Many people felt there were risks as well as advantages to additional powers to intervene to protect adults. Checks and balances would be essential. If people's right to self-determination is to be breached, except in the most extreme of circumstances or in the context of 'best interests' if someone is deemed to lack mental capacity, there is a risk of people refusing to seek

help in the first place or feeling further oppressed by the actions of the authorities.

- Many people using services saw value in a well publicised, single national helpline where people could get advice and support about safeguarding and where action could be triggered.
- Many people who experience abuse want the support of independent advocates but advocacy provision is currently very patchy and does not meet demand.

Messages for councils, care providers and the regulator

There are important messages for councils, care providers and the care services regulator to improve the current safeguarding arrangements.

For councils, there are messages not only about their leadership role to prioritise safeguarding but, as this study across the whole system shows, also about their commissioning and market development role. Services being commissioned by the council and developed for the whole community should have good safeguarding arrangements and be of a quality that would help prevent abuse occurring in the first place. It is clear that the area of those councils performing best over safeguarding contained a higher proportion of the better performing care services. It is also clear that there is a positive relationship between a care service's overall quality rating and its ability to safeguard adults from abuse.

Councils and care services need to ensure best practice in the recruitment of staff and their training, supervision and support around safeguarding people from abuse. Councils' training plans should extend to staff in the independent and voluntary sectors.

Care services need to ensure everyone using their service, particularly those with high support needs, are clear what to do if they have concerns, and to foster a culture that puts people first. Service providers also need to develop processes for improving their performance in safeguarding, particularly to learn from incidents and ensure that managers are conversant with national developments, such as the POVA list, as well as developments in their local council.

There are important messages for the regulator about communicating its role to work with other agencies to ensure people in regulated services are adequately safeguarded and to help drive up standards in both safeguarding arrangements in councils and practice in services. There are opportunities for taking this forward in both the new regulatory compliance criteria and Comprehensive Area Assessments.

But more often the quality of assessments and interventions to support people is variable and practice is not consistently monitored by councils.

Care services are generally competent at reporting safeguarding concerns but need to adopt a more comprehensive approach beyond formal reporting procedures, including supporting people who have experienced abuse and improving recruitment practice and staff development on safeguarding.

Thematic inspections and probes

Thematic inspections

Thematic inspections are additional inspections of regulated services in order to:

- provide evidence about the quality of services in a particular area of provision
- inform the Commission's national reports
- add to the Commission's understanding of social care and to be an 'expert voice'.

Services for the safeguarding thematic inspection were chosen to give a good spread of service types, quality rating and ownership in seven study areas, one in each of the Commission regions.

Table 11: Services included in the thematic inspection

	Service Type			
	Care home for older people	**Care home – under 65**	**Home care agency**	**Adult placement scheme**
Number of services	34	30	26	4
%	36	32	28	4
	Ownership			
	Independent	**Voluntary**	**Council**	**Other**
Number of services	57	19	15	1
%	62	21	16	1
	Quality rating			
	0 star	**1 star**	**2 star**	**3 star**
Number of services	6	21	49	18
%	6	22	52	19

Inspectors carrying out the inspections used a range of evidence to look at the key themes of the study, in relation to the National Minimum Standards on protection and recruitment, to answer the following questions:

- Are people aware of their rights to be safe from abuse?
- What opportunities do people have to express their feelings about how safe they are?
- How well are the systems working for ensuring that safe staff work in adult social care services?
- How well is learning on safeguarding applied by organisations to ensure good outcomes for individuals and continuous improvement for the future?
- Is safeguarding given sufficient priority across all relevant agencies?

This evidence included:

- Pre-inspection work such as looking at past inspection reports, complaints or concerns raised.
- A short focused inspection:
  - asking specific questions to service managers, staff and some people using the service, usually three or four people)
  - scoring specific key standards on a feedback sheet
  - looking at records
  - looking at policies.
- Working with 'experts by experience' on the inspections. Experts by experience are people whose knowledge about social care services comes directly from using social care services. On this inspection, experts by experience mainly asked questions to people using the service.
- Writing a thematic inspection report, on which the service has an opportunity to comment before it is finalised and returning this with a feedback sheet, with answers to specific questions, to the team analysing results for this study.

Thematic probes

We used a thematic probe to gather additional information on safeguarding from scheduled key inspections of all services, except nursing agencies, between 5 and 16 May 2008. Inspectors scheduled to carry out these inspections were asked to:

- ask specific questions
- score specific key standards
- look at records
- look at policies
- record information you gather in a recording tool to answer the following questions:

1 Have staff had all pre-employment checks before starting work?
2 Does the quality assurance system include learning from safeguarding referrals/issues?
3 Do staff receive specific training on safeguarding?
4 Is the policy on safeguarding robust and put into practice (for example, does it detail the role of other organisations such as the local authority and the police, do staff know what to do, do people who use services know their rights, and when and how to report any concerns)?

Two hundred and fifty thematic inspections were carried out. Because CSCI inspects poorer services more frequently than better services, there will always be a higher proportion of 'poor' and 'adequate' services inspected in any two-week period than the proportion of 'good' and 'excellent' services inspected. In this study, we did not therefore use overall results from the thematic probe, but only the disaggregated results, to check key themes that emerged from the thematic inspection data, which was more representative across quality ratings.

Percentage of services for adults and older people meeting or exceeding individual National Minimum Standards relating to safeguarding[45]

Table A: Percentages of services meeting or exceeding individual NMS – younger adults' care homes

	Private					Council					Voluntary					All Services				
	02-03	03-04	04-05	05-06	06-07	02-03	03-04	04-05	05-06	06-07	02-03	03-04	04-05	05-06	06-07	02-03	03-04	04-05	05-06	06-07
Protection	41	63	71	72	75	66	69	74	79	78	55	71	76	77	80	47	66	73	74	77
Recruitment	45	55	63	69	72	29	42	55	64	70	50	54	63	70	78	47	54	62	69	73

Table B: Percentages of services meeting or exceeding individual NMS – older people's care homes

	Private					Council					Voluntary					All Services				
	02-03	03-04	04-05	05-06	06-07	02-03	03-04	04-05	05-06	06-07	02-03	03-04	04-05	05-06	06-07	02-03	03-04	04-05	05-06	06-07
Protection	40	63	70	72	75	64	69	73	80	78	54	71	76	76	80	47	66	73	74	77
Recruitment	45	55	63	69	72	29	42	55	64	70	49	54	63	71	78	47	54	62	69	74

Table C: Percentages of services meeting or exceeding individual NMS – home care agencies

	Private			Council			Voluntary			All Services		
	02-03	03-04	04-05	04-05	05-06	06-07	04-05	05-06	06-07	04-05	05-06	06-07
Protection	53	63	70	73	80	78	76	76	80	73	74	77
Recruitment	52	59	71	50	64	77	63	65	80	53	61	72

45 From CSCI (2008) *The state of social care in England 2006-07*. London: Commission for Social Care Inspection

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Tracking the experiences of people in five study sites

Thirty safeguarding cases were tracked. The profile of the individuals concerned was as follows:

- 16 were female
- 14 were male

- 5 people were from minority ethnic communities
- 9 people had learning disabilities
- 14 were older people, some of whom had mental health issues
- 4 people had a physical impairment
- 3 people had a mental health issue

- 7 people had experienced physical abuse
- 6 people had experienced neglect
- 7 people had experienced financial abuse
- 5 people had been subject to sexual abuse
- 2 people had experienced bullying
- 1 person had experienced institutional abuse
- 1 person had experienced discriminatory abuse

Notes

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How to contact CSCI

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www.csci.org.uk/professional

We want people to be able to access this information. If you would like a summary in a different format or language please contact our helpline or go to our website.

Get monthly updates on news from CSCI – sign up to our email newsletter www.csci.org.uk/professional.

From April 2009, a new Care Quality Commission will take over the work of CSCI, the Healthcare Commission and the Mental Health Act Commission.

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