

## CSIP Report Template

**Aim:** To facilitate a workshop, discussion or event for the consultation on the review of No Secrets. To engage with all citizens and organisations to gain views, suggestions and best practice examples on the questions and issues raised within the document. We want people to be able to contribute to the discussions equally and for the facilitators to be able to keep the discussions focussed on the themes chosen for this session.

**Objectives:** The following guidelines are suggested to record the event:

- Identify a 'Facilitator' to state the question to be answered and keep the discussion group focussed on the current topic, and a 'Scribe' to record the discussion points.
- Ensure that the facilitators and scribes are fully briefed on the themes for discussion, discussion prompts and time allocated for each theme.
- Record numbers of attendees at each table and document where the attendees have come from, e.g. a nurse from a care home will be recorded as 'Care Home', a manager from social services will be recorded as 'Social Services'.
- Complete each section with the key points summarised from the discussions.
- Take details where appropriate of contacts for tools and/or best practice examples.
- **Please complete and return this template to the event organiser or your CSIP Regional Lead as follows:  
[alison.blight@csip.org.uk]**

<b>Lead:</b> Zoë Johnstone – Head of Adults and Commissioning	<b>Bracknell Forest Borough Council</b>
<b>Date/s of Event:</b>  <ol style="list-style-type: none"> <li>1. 14<sup>th</sup> October</li> <li>2. 19<sup>th</sup> November</li> <li>3. 9<sup>th</sup> December</li> <li>4. 11<sup>th</sup> December</li> <li>5. 9<sup>th</sup> January</li> <li>6. 14<sup>th</sup> January</li> </ol>	<b>Type/s of Event:</b>  <ol style="list-style-type: none"> <li>1. Learning Disability Partnership Board</li> <li>2. Safeguarding Adults Forum</li> <li>3. Legal team</li> <li>4. Crime and Disorder Reduction Partnership</li> <li>5. Operational Teams</li> <li>6. Adult Management Team</li> </ol>
<b>No. of Attendees:</b>  <ol style="list-style-type: none"> <li>1. 10 attendees</li> <li>2. 20 attendees</li> </ol>	<b>Types of Attendees (e.g. employer source):</b>  <ol style="list-style-type: none"> <li>1. Advocates Learning Disability Development Managers People using support and services Self advocacy group Administrative staff Social workers Representative from Men Cap</li> <li>2. Domiciliary Care Providers Care Home Providers CSCI area representative Community Safety Manager Advocacy Groups Assistant Team Manager Older People and Long Term Conditions Team Transforming Adult Social Care Project Manager Policy &amp; Commissioning Officer Safeguarding Adults Co-ordinator</li> </ol>

<p><b>3. 1 attendee</b></p> <p><b>4. 10 attendees</b></p> <p><b>5. 15 attendees</b></p> <p><b>6. 8 attendees</b></p>	<p><b>3. Bracknell Forest Council Solicitor</b></p> <p><b>4. Environmental Health Leisure Services Children’s Services Youth Offending Service Area Police Chief Inspector Primary Care Trust</b></p> <p><b>5. Older People &amp; Long Term Conditions Team Community response and Reablement Community Mental Health Team (Older Adults) Community Mental Health Team Community Team for People with Learning Disabilities</b></p> <p><b>6. Chief Officer Adult Social Care Head of Older people and Long Term Conditions Head of Adults and Commissioning Head of Learning Disability Services Locality Manager for Mental Health Services Head of Community Response &amp; Re-ablement Head of Performance Management</b></p>
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**Bullet Point Responses/Main Themes**

**1. Leadership**

- The lead organisation should be the Commission for Quality Care as they are the regulatory body for both Health and Social Care. There needs to be a clearly defined lead role for the department of Health, this would need to include how cross departmental issues will be resolved.
- Clarification is needed regarding the difference between the leadership and co-ordinator roles.
- Local responsibility should rest with the Director of Adult Social Services. Best practice guidance on the role of the Director of Adult Social Services includes emphasis on supporting the wellbeing of vulnerable adults.
- There should be national guidelines so that the citizen is afforded the same level of support and protection no matter where they live. This should be linked to the human rights act.
- Safeguarding Adult Boards should have a statutory footing and be accountable to its local citizens. They should be attended by senior staff and should discuss serious case reviews. They should be ‘regulated’ by the Commission for Quality Care who should undertake reviews of the board and its functioning.
- The NHS should not have separate procedures; it should have to adopt the national procedures. Each NHS trust should have a suitable senior person appointed to be their safeguarding lead. This should be a dedicated role and not an addition to existing responsibilities. There needs to be a clear and unambiguous duty to co-operate in safeguarding work. Furthermore current guidance on patient confidentiality needs to be

reviewed to set out a clear duty to share information when it is thought a person is or may be at risk of harm.

- The responsibility should rest with every member of staff who works with vulnerable adults regardless of job role; however it should be the responsibility of the registered manager to ensure that there are robust procedures in place within care homes. Legislation/regulation should state this and give clear unambiguous guidance to registered managers as to what is expected of them.
- Legislation should state that persons with responsibility for adult safeguarding are senior enough within their organisation to commit financial and human resources as necessary.

## **2. Prevention**

- The previous guidance focused on dealing with harm the new guidance should also focus on prevention.
- There should be regular multi agency meetings to pre-empt volatile situations. Too often we only act when necessary. We should be sharing potential risk situations not just actual incidents. Electronic information systems are not geared up to exchange information between agencies. The NHS is often hindered in sharing information by patient confidentiality.
- Increase support for staff to enable people to remain in a 'risky' situation if this is their informed choice and to balance this with their duty of care.
- Concentrate our efforts within service delivery; ensure there are effective quality assurance arrangements, supervision and pre-employment checks etc. Make the workforce of privately employed personal assistants safer through training and a system of accreditation.
- Empower those who we support to know that they have real choices and that they do not have to accept poor services and poor quality means poor service.
- There is a need for a national prevention strategy this would focus the agenda and ensure that good practice recommendations are followed with same standards across the country. It is key that any such strategy is cross cutting and looks at the issues as a whole and not just in a social care context.
- Whistle blowing policies should be more robust with increased support for the individual from an independent source. Commitment is needed from all agencies to support someone reporting a situation.
- An example of good practice in Bracknell Forest is the Care Governance Board (multi-disciplinary) which meet monthly to exchange information and consider trends / changes in star ratings etc. and to agree on improvement plans.

## **3. Outcomes**

- An outcomes framework has to be introduced if this area of work is going to develop. Any such framework needs to balance rights and responsibilities. It also needs to focus on the outcomes for the individual.
- We need to develop post assessment research with those subjected to harm (with appropriate consent) in order to learn from people's experiences. We also need to ensure that the individual is at the heart of the 'process' so that their voice does not get lost within it. National guidance on this issue may help so that where good practice is already happening this can be shared.

- Annual reports should not just state what has happened it should look at trends, strengths and weakness and then what action is intended to achieve the necessary change. The annual report should also have to be shared with the regulator who will regulate the work of the statutory safeguarding boards. However safeguarding should be a key element of all training.
- There should be a national training set for Safeguarding Adults so that a consistent message is delivered and should be based on core competencies. This should fit into learning requirements for all relevant occupational groups' i.e. social care, health care, Commission for Quality Care staff etc.
- There should be a review of serious case reviews already undertaken to evaluate their effectiveness. If they are to be continued then national guidance is needed to ensure a consistent approach is taken setting out triggers and process for a serious case review, the executive summaries should be shared via a national database. The serious case reviews undertaken can form part of the inspection regime of the Safeguarding Board.
- The Police are relatively small players in adult safeguarding i.e. the number of occasions they are actively engaged in a concern. This would suggest that we do not need a joint inspectorate. The newly created CQC will be able to inspect/regulate the majority of the system. However a clear link between CQC and HM Inspectorate of Constabularies must be established with area of responsibilities defined.
- The national guidance should comment on the relationship between personalization and safeguarding setting out clearly organisation's responsibilities, i.e. that all people who use services should be encouraged to take control of their lives and make informed choices. However, on occasions there is also a need to protect the individual and others.
- Some people offered the alternative opinion in that if guidance was local then Bracknell Forest would have more say and a louder voice.
- Safeguarding work is funded via existing resources i.e. through care and support agencies; there is a small budget for publicity materials etc. Currently funding only comes from the Local Authority there is no multi agency budget. We need to look at the type of support needed; it does not always require funding.

#### **4. Managing Risks**

- Ensure people have the right support to manage their money and not get into debt.
- Ensure carers / parents do not decide how a person's money is spent.
- Support to ensure you do not spend the money on something not in your best interests; the person's wishes may have to be overridden for example if there are others at risk or if public money is being used for illegal; or immoral gain.
- A system of accreditation for personal assistants; a programme of training to ensure the impact of a specific disability is understood.
- With self assessment questionnaires the questions in relation to risk need to be clear and simple to follow.

#### **5. Managing Choice**

- The individual must be engaged at all stages of the safeguarding process, it should also

be recognised that their needs and wishes are paramount.

- Professionals place too much importance on process and protection of their professional practice.
- Remind people that they have options. Safeguarding needs to be person centred, follow good practice i.e. empowerment, choice and control. This should be clearly set out in guidance from central government.
- Enable and support people in taking risks. For example when people are being rehabilitated the programme could include how to deal with risk situations and how to take preventative measures.

## **6. Health Services**

- Implementation of 'No Secrets' within the NHS is inconsistent. All Trusts within our area have named leads but this is in addition to their responsibilities therefore the capacity to implement 'No Secrets' is extremely limited.
- There needs to be a clear and unambiguous duty to co-operate in safeguarding work. Furthermore current guidance on patient confidentiality needs to be reviewed to set out a clear duty to share information when it is thought a person is or may be at risk of harm.
- Training is not mandatory in some Trusts therefore knowledge of safeguarding issues is limited as is knowledge of policy and procedures. The only way to achieve change in this area is legislation putting statutory responsibility on all organisations including the NHS.
- There is a need for one set of national guidance that is applicable to all settings however, all organisations will need to have their own internal procedures. The language of safeguarding is key and should be adopted by all organisations.
- At present it is difficult to identify the responsibilities of our local NHS leads. There should be a common set of standards for organisation but it should be for each organisation to decide how to implement/achieve these.
- A regional safeguarding forum could be useful; the blue print for this would be to adopt the same network areas as the ADASS regions.
- Guidance on serious untoward incidents (SUI's) would be welcomed. SUIs are currently dealt with as an internal matter by the NHS and they make no alert/referrals to the LA, therefore the issue is not dealt with in a person centred way. The focus is on learning for the organisation rather than the impact on the individual.
- Training for all staff including doctors, understanding and application of the safeguarding system and learning from past experiences are some of the major challenges for the NHS.
- GP's see a number of vulnerable adults on a daily basis therefore their engagement in this work is vital if change is going to be achieved. It would be useful to have a named GP for adult safeguarding in the same way as we do for child protection.

## **7. Community Empowerment**

- Work needs to be undertaken to raise community awareness of safeguarding more widely, information should be easy to follow and accessible.

- When vulnerable people are housed the location should be considered carefully i.e. will they be isolated? Housing associations need to consider the welfare of their tenants.

### **8. Access to Criminal Justice**

- Specialist teams should be avoided as this will detract from Safeguarding being seen as everybody's responsibility.
- Police should be more accessible and be perceived in a more positive way. Police Community Support Officers (PCSO) should attend more groups and build up relationships.
- All police should be trained and have knowledge of safeguarding vulnerable adults, not just identified specialist officers.

### **9. Guidance & Legislation**

- Generally people seem to agree that updated and refreshed guidance is necessary and should be a combined document for all agencies i.e. the criminal justice system, the health sector and the local authority to include social care, housing and community safety.
- We need a specific duty to share information and assessments.
- National guidance should ensure statutory training for all agencies.
- We need standardisation, if people have the same duties they cannot pass their responsibilities on. This would increase people's confidence.
- There needs to be a general duty set out. At present there is overlap between agencies for example with CSCI. Legal responsibilities should be set out we should not be operating on 'goodwill'. Leadership should be centralised.
- If safeguarding adult boards were statutory they should be co-terminus with local authorities (not PCTs). To place the boards on a statutory footing may require additional funding.
- Safeguarding boards should have a statutory basis as they would then be answerable. They should have powers and responsibilities including the need to work in partnership, contribute resources and where appropriate commission serious case reviews.
- There should be a clear and unambiguous duty to co-operate in safeguarding work; this should apply to Local Authorities (not just adult social care) Probation, Police, the NHS, providers of regulated services and regulators. The relevant regulators should be empowered to take steps to enforce compliance with this. It may be also be appropriate for the Secretary of State (Health) to force Safeguarding Boards to take action if partners are not able to demonstrate that they are co-operating.
- Powers of entry should be included as per Section 136 of the Mental Health Act. There needs to be judicial oversight – for example via application for a warrant. The powers should be similar to those in the Children Act.
- There should be a power to enter domestic premises (including residential and nursing care settings). The power should be similar to that of Section 135(2) of the Mental Health Act i.e. that a police officer may enter premises (having obtained a warrant from the magistrate) with a social worker and a doctor to assess a person's safety.

- If the person has capacity and they are not being coerced into making decisions then the state has no right to intervene in a person's life unless it considers using its powers under section 47 of the National Assistance Act 1948
- If we are saying that the person has the capacity to consent to an abusive relationship then the state has no right to intervene. Unless however the person whom we are concerned about is by someone acting in a professional capacity in which case this would be a dereliction of their duty of care. It may be appropriate to consider the need for a new criminal offence regarding this issue.
- Further guidance is needed regarding capacity and coercion
- If the person has capacity they are at liberty to make unwise decisions. The only grounds where this may be appropriate is when someone is living in shared regulated care and the service is being closed due to safeguarding concerns in these circumstances it may be appropriate to remove someone.
- People are still entitled to protection but may need support to report the abuse.
- The use of force to remove someone who is self neglecting or self harming is already covered by the Mental Health Act or Section 47 of the 1948 National Assistance Act. The 1948 Act is old fashioned and should be modernised, it should come out of the health arena and into the social care field. There should be a mandate/order for people like paramedics to protect people, at present they will not take a person to hospital if they refuse to go.
- We need to be careful about overlapping laws and confusion over which law to use.
- There should be a power to remove a person if it is believed that they **do not** have capacity or where it has not be possible to establish their capacity (despite reasonable efforts) to consent/object to the perceived abusing acts. The person should be removed to a place of safety designated by a magistrate, this could be the home of a relative or a more formal setting like a care home and for no longer that 14 days and this for a period of assessment. The applicant should make a suggestion to the Court if the placement needs to be a secure one.
- CSCI are the guardians of regulations as opposed to the guardians of standards. CSCI are to slow to respond to safeguarding issues and are not willing to attend meetings unless there is a breach of regulation. This is in a conflict with safeguarding being seen as everyone's responsibility. It seems difficult to believe that the regulator is not responsible for improving the standards of the services it regulates. The changing role of CSCI has pushed the responsibility for improving services to the Local Authority hence why we have invested in our Care Governance Board.

## 10. Definitions

- The revised 'No secrets' whether guidance or legislation needs to give a clear definition as to who the guidance/legislation is supposed to protect; clarification about adults whose circumstances make them vulnerable as opposed to vulnerable adults. The vulnerability of the adult could be due to physical incapacity, how does this fit in with the Human Rights Act? Some people with poor mental health or a learning disability may need different levels of support and or protection and the key is to focus on their support as opposed to say that everyone with MH issues or a LD is a vulnerable adult.
- We need clarity on thresholds i.e. what is significant harm? We need clearer definitions about when poor care in a hospital or care home amounts to abuse or neglect. If the neglect is unintentional what are the consequences?

- It is more beneficial to talk about 'harm and crime' rather than abuse. The term perpetrator is not always an appropriate one as it is rare that we can say without doubt that there is a perpetrator. More useful to talk about the perpetrator in terms of 'the person who we have concerns about'.
- Safeguarding legislation needs to state the principles of safeguarding as in the Mental Capacity Act. This gives a clear message to all about what is expected of them and what they must do. We need more than guidance on these issues, guidance has only taken us so far and there is no evidence that further guidance will move us forward.