Local Government Association

directors of adass adult social services

Making Safeguarding Personal for commissioners and providers of health and social care

"We can do this well"

Acknowledgements

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Contents

Introduction

This briefing is designed to reinforce and build on earlier work on good practice, when making safeguarding personal for health and social care commissioners and providers[1]. In particular, it aims to build on what is known about good and excellent practice when applying the Care Quality Commission's (CQC) five core components; namely that when making safeguarding personal providers and commissioners are "well-led, caring, effective, safe and responsive".

The intention is to support health and social care commissioners, and providers to make positive differences by engaging with those who use their services. In part this is through understanding and applying good safeguarding practice in its broadest sense[2]. This includes promoting wellbeing and preventing safeguarding issues arising in the first place. Through informed leadership and partnership working the intention is also to identify best practice when supporting staff to assist in making those positive differences. The sub-title for this briefing is deliberate and is drawn from comments repeatedly made at the workshops – "we can do this well".

During the workshop sequence, however, the news about care standards at Whorlton Hall Hospital[3] emerged. This development not only reinforced the importance of identifying and promoting best practice in the commissioning and provision of health and social care, and in its regulation and inspection, but also the responsibility on everyone to identify and take action when standards fall below best practice. It is a further reminder that, whilst many people receive good quality care, the support that people receive remains inconsistent[4].

Running through the workshops were the challenges and responsibilities that all those working in this sector encounter. Namely, "how can I change the moment?" and "how am I making things better today?"[5] These questions require us all to exercise leadership in acknowledging and confronting the barriers obstructing best practice, and to disseminate ways of achieving best practice: that is what this briefing aims to encourage. It focuses on what good might look like across four domains: engaging with people and prevention; engaging across partnerships; workforce development and support, and finally leadership and culture.

1 Lawson, J. (2017) Making Safeguarding Personal: What might 'good' look like for health and social care commissioners and providers? London: Local Government Association and ADASS

2 Care Act 2014 statutory guidance defines safeguarding as: 'People and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.' (DHSC, 2018, 14.7).

3 Panorama broadcast 23 May 2019 featuring this private hospital in County Durham which has closed as a result of an undercover investigation which revealed evidence of abusive treatment.

4 Care Quality Commission (2018) The State of Health Care and Adult Social Care in England 2017/18. Leeds: CQC.

5 Anna Knight's presentation at the Birmingham workshop, entitled 'Making Safeguarding Personal.'

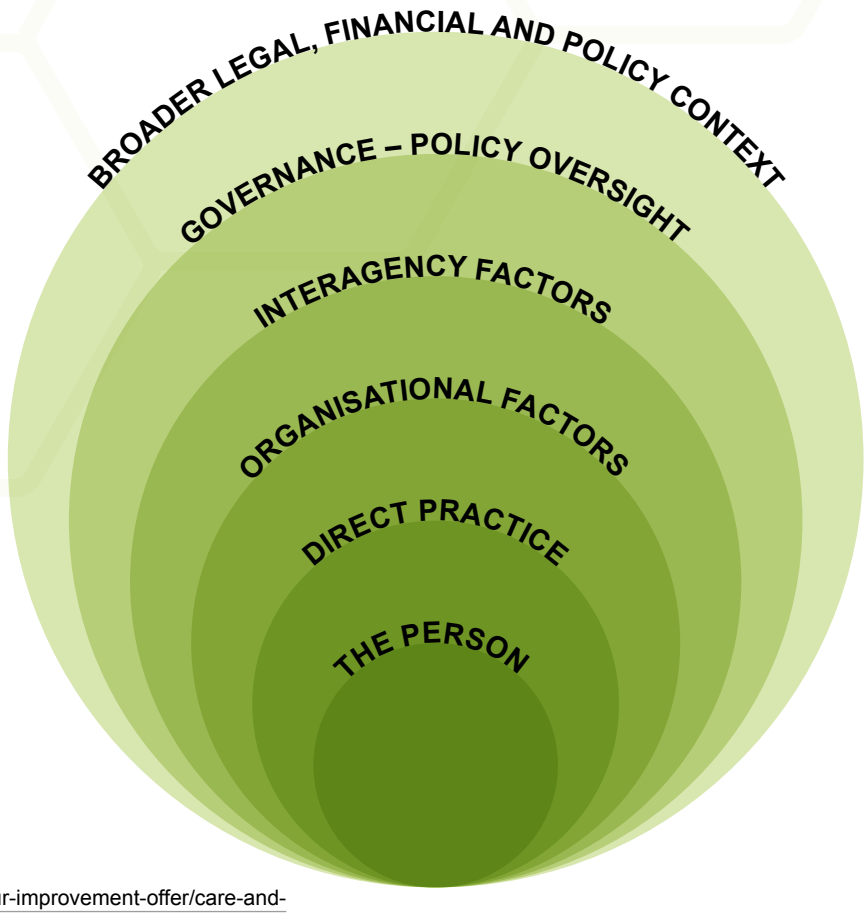
Methodology

This briefing has emerged from three workshops held in London and Birmingham in Spring 2019. Each workshop was well attended by NHS and local authority commissioners, care providers, safeguarding adult board (SAB) independent chairs, contract managers, adult safeguarding and quality assurance staff. Short presentations[6] were designed to present learning about effective practice from: Safeguarding Adult Reviews (SARs); National Institute for Health and Care Excellence (NICE) guidance; learning from CQC inspections; care providers with good and/or outstanding ratings; examples of effective partnership working and commissioning practice. They underlined the importance of legal literacy and effective quality assurance.

Workshop participants were invited to engage in reflective discussions to identify the hallmarks of good practice and how these standards can be achieved. There was a focus on identifying what enables good practice to be developed and sustained, and where the barriers might be. These reflective discussions covered engagement with individual service users and their families, including prevention and early intervention, engagement across the partnership between commissioners and providers, workforce development and support, and leadership and culture. All of these areas of focus emerge as essential where making safeguarding personal is made real in practice.

A whole system approach was emphasised (figure one).

Whole system understanding



6 www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

This recognises that best practice will only flourish and be sustained when there is alignment across the whole system. Put another way, making safeguarding personal for service users and their families will be more effective when the team around the person is enabled to practise in this way. How commissioning and care provision is delivered therefore becomes crucial. How multi-agency partnerships support individual organisations to embed best practice when making safeguarding personal, will also be fundamental. Moreover, there must be effective governance oversight by SABs. This briefing presents the outcomes of the workshop deliberations across these domains[7] of practice and leadership of practice.

7 Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

Engaging with the person, prevention and early intervention to enhance wellbeing

This is the first domain. One golden thread for best practice is that the focus should be on "what matters to you, not what is the matter with you." Ways forward should be co-produced.

A second golden thread recognises that relationship-building is everyone's responsibility. Establishing trust and modelling transparency are key.

A third golden thread is that leadership must be demonstrated by everyone involved to make this happen.

The hallmarks of best practice, then, begin and end with person-centred engagement and involvement, whether the focus is on contracting/commissioning; assessment, care plan reviews, contract management reviews and/or service development. This means actively involving the person with care and support needs in all decisions affecting them[8]. Professional curiosity is central, listening to understand the person's life journey, what matters to them, what is valuable to and valued by them, and their future hopes. This will ensure that any care package is tailored to their wishes, interests and skills, as well as their needs. It involves communication that promotes exchange, not just of information but, of desired outcomes and, where future needs are foreseeable, advanced care planning. It asks: "what are your lives like?" and "how are you feeling?" It focuses on what people can do, not just on what they cannot do, to inform personalised care and support plans that enable people to have the best life they can where they are. Knowing the person well, including their preferred means of communication, will enable staff to tell when things are wrong and to intervene as soon as this is noticed. The involvement and support of family members, and advocates where appropriate, should be sought.

Questions for supported decision-making[9] remain very relevant to prevention and early intervention, to finding and responding to the person.

Some lines of inquiry focus on the here and now. What is important to you now? What is working well? What is not working well? What things are difficult for you? What could make things better?

Some lines of inquiry focus on the future, a new there and then. What could be done in a different way to support you? What would you like to happen?

Finally, some questions focus on moving towards that future. Who might be able to help? What could we do to support you?

8 A key message from NICE guidance, highlighted in Jane Silvester's presentation at the workshops.

9 Department of Health (2007) Independence, Choice and Risk. A Guide to Best Practice in Supported Decision Making. London: The Stationery Office.

Case study from an Isle of Wight care provider[10]

This example illustrates why a person's story is so important and what can be achieved through a lens of person-centred prevention and early intervention.

A business man who loved his wife (they were childhood sweethearts), cycling and sport, gardening and animals, his family and 80s music. He was diagnosed with early onset Alzheimer's disease aged just 49. He soon developed distress at being helped with his daily needs and frustration at being unable to do things he always did. His son was visiting to help his father shower/bath. His wife became very afraid of this very strong, fit man on some occasions when he was fearful, frustrated and angry. The package of home care broke down. He was sectioned to a mental health unit and subjected to restraint every day in supporting him with personal care and subsequent high level of inappropriate medication. He could no longer return home so a care home was sought with an appropriate resource package agreed.

What is making safeguarding personal here?

It is well documented care planning that places a premium on establishing individual and family trust. Through dialogue and observation planning seeks really, empathically, to understand what it is that makes a person feel safe and "what it is like for me." This enables meaningful activities to be put in place and to promote wellbeing, rather than restrictive practices, supported by well-trained staff who can work one-to-one.

This case study highlights the importance of the care contract being triangular – between the individual, the commissioner and the provider. It highlights too that prevention and (early) intervention is a crucial component of promoting wellbeing.

10 Maggie Bennett's presentation.

The focus on engaging with the person, on wellbeing and on prevention is not just good practice, but is lawful practice[11]. Section 1, Care Act 2014, highlights the various components of wellbeing, including dignity, physical and mental health, emotional well-being, protection from abuse and neglect, suitability of accommodation and contribution to society. Section 2, draws attention to prevention of needs for care and support, whilst section 4 focuses on the importance of providing information and advice. Section 9 is the duty to assess for care and support needs. Statutory guidance[12] provides crucial detail on how these sections should be implemented, which should be followed.

For these hallmarks to flourish a clear, shared vision of standards of best commissioning and care provision practice, and promoting awareness of how to share concerns when standards fall is required. Feedback, including complaints, should be taken seriously as learning; poor practice should be addressed immediately. Disseminating information about what good commissioning and care and support look like, using NICE guidance[13] for example, raises everyone's awareness, including those funding provision themselves. Once arranged, the person's experience should be central to contract as well as care plan reviews, and staff training and appraisals. People should know where to take feedback and what to expect when they do.

For these hallmarks to flourish also requires ongoing work on the barriers that can undermine best practice. Time pressures; gaps in the care market limiting choice; commissioners, providers and health and social care staff not working together; risk-averse practice and lack of staff capacity and/or confidence to respond appropriately in the moment can all result in forgetfulness about people's fundamental humanity.

11 See Nicole Ridgwell's presentation to the three workshops.

12 Department of Health and Social Care (2018) Care and Support Statutory Guidance: Issued under the Care Act 2014. London: The Stationery Office.

13 Jane Silvester's and Charlotte Goulding's (NICE) presentation provides relevant references.

What needs to happen?

- Listen to the person, engage with the person as a person – and with their family who will continue to care even after the person begins to live in a care setting.
- Keep the person in view and make every contact count from the start. Be mindful of this even before an individual begins their stay in a care setting. Information-sharing and planning the best way of enhancing their wellbeing, involving them in quality assurance monitoring and service enhancement thereafter are all ways of doing this. Finally, keep track rather than considering cases closed.
- Explore deeper rather than accept what you first hear[14].
- Consider the need for advocacy – an essential component of prevention.
- Share information so that service users and their families know what standards to expect and who to contact should difficulties arise.

14 Vanessa Keen's presentation.

The team around the person

This is the second domain. The golden threads of building and sustaining relationships, and of everyone accepting that demonstrating leadership is inherent in their roles and responsibilities, feature strongly again. Whether or not formally designated as such, those involved need to be visible champions for best practice. For this to happen, another golden thread emerges as essential, namely staff having the requisite confidence, knowledge and skills.

Best practice in this domain involves good communication and genuine partnership working between providers and commissioners. This needs to be founded on a shared understanding of the systems within which they are working, of the vision that underpins their work, and of their roles and responsibilities. It demands a willingness to learn – which is a core component of prevention – and to embrace evidence about best practice drawn from research, service user and carer feedback, feedback from staff and SARs. This openness to learning also recognises the importance of care reviews – of the quality of care and outcomes for the person, and of challenges presented by the person, such as reluctance to engage.

Genuine partnership working is also inclusive, bringing in others to the team around the person because of the particular/specialist contribution they can make towards identifying and meeting people's needs; for example at key transition points in their lives such as hospital discharge.

These hallmarks will flourish when time to engage with other members of the team, develop trust, and find a shared vocabulary about making safeguarding personal is allowed. When focusing on the work with the person themselves, sharing information, agreeing roles and responsibilities to meet valued outcomes, and commitment to regular meetings and reviews to track progress will be important. Knowledge of legislation and skills in applying it, such as the Mental Capacity Act 2005 or the Data Protection Act 2018, may prove useful; early reporting of concerns is essential.

Barriers that need to be resolved may include; different vocabularies and understanding about safeguarding and wellbeing, divergent understanding of what constitutes a safeguarding concern and disagreements about roles and responsibilities. Staff turnover may disrupt teamwork as may an absence of leadership. SARs have observed[15] that omitting to share information about the person and their life journey, wishes or needs may negatively impact on decision-making; providers also need to feel enabled to raise concerns about care packages so that joint working identifies concerns early.

Observations from the workshops (Spring 2019) underline this need for a joined up understanding of safeguarding and for working to resolve issues together. Safeguarding should be a safe place to go with concerns; fear should not be allowed to drive it underground[16]. Safeguarding should also not be about imposing something on providers, but engaging with them. It should be an "intelligence-sharing and care monitoring community." Safeguarding should model working together to prevent abuse and to intervene early, it is about much more than statutory enquiries. It is about engaging in partnership across sectors and organisations, and engaging with people, with prevention as well as problem-solving, at the centre of the drive for quality care.

Safeguarding is not only concerned, therefore, with the 'is it safe?' question. It also has to be concerned with the four other CQC questions[17], namely is provision caring, is it effective, is it responsive and is it well-led? Such a broad focus will support making safeguarding personal.

15 Michael Preston-Shoot's presentation for the three workshops.
16 Nick Sherlock's presentation at all three workshops informs the observations reproduced here.
17 Care Quality Commission (2016) Our Next Phase of Regulation: A More Targeted, Responsive and Collaborative Approach. Leeds: CQC.

What needs to happen?

- Build positive relationships with other members of the team around the person, including their family (where helpful).
- Encourage early sharing of concerns.
- Develop a common understanding of the language being used and the standards for what good care and support looks like.
- Be open to learning and encourage the same in others, having the courage to challenge and to escalate concerns where practice falls short.
- Leadership involves having the courage to suggest changes to practice and procedures that are evidence-informed, and monitoring the outcomes being achieved.

Organisations across the partnership: leadership and culture

The same golden threads feature strongly here – the central importance of relationships and communication, reflective of a genuine partnership that aims to be transformative. Once again, leadership is everyone's responsibility, a commitment to making things work and getting it right (first time). Much of the focus will be on building consensus on what good partnership working and excellent service delivery looks like, and a common language when talking about it. Some of the focus will also fall on building arrangements to ensure this consensus is reflected in practice. This will include information-sharing agreements within the partnership and between authorities.[18] Regular meetings might be a feature of this,[19] where information from contract monitoring, CQC inspections and reviews can be triangulated about the quality of provision, knowledge shared, concerns openly discussed and support offered.

The focus here is on transparency and open dialogue as essential features in building and maintaining a partnership culture. Good leadership, effective partnership working and strong organisational cultures are essential building blocks for the provision of high quality care[20]. Here especially leadership is concerned with creating a vision and delivering a strategy to achieve it. This requires leaders to demonstrate personal qualities and to work with others in setting, maintaining and reviewing direction[21]. Leadership here is inclusive and engaging, building and maintaining trust, openness and partnership. Moreover, safeguarding is at the heart of this quality vision[22].

There will be a commitment to the best service possible, learning from case discussions, inspection, audits and reviews. Senior managers will take the lead in setting the tone of openness and transparency, in which there is parity of esteem between health and social care, between commissioners and providers, and between staff and service users. There is an equality amongst voices. There is a willingness to listen and an atmosphere where honest conversations can take place about the challenges of practice, such as the level of resources available, gaps in the care provision market and the challenges involved in responding to risk in a person-centred way.

The emphasis on parity of voices and on inclusivity provides a link back to co-production. Here, co-production means the involvement of service users and families in how quality is assured. It is one means of ensuring community presence in the governance of the care sector[23]. Co-production can also mean staff and service users working together to set out the vision and mission for provision – their lives, their home[24] – or engaging jointly on prevention projects, for example to increase feelings of safety and security[25]. These examples provide positive demonstration of how diversity and quality of provision can be promoted (section 5, Care Act 2014).

For these hallmarks to flourish, strong leadership is necessary. This doesn't simply rely on individual relationships, but seeks to embed in structures and processes a positive, non-hierarchical culture and strong, clear and visible values. Co-production will be the approach taken to organisational arrangements surrounding making commissioning and care provision personal. Barriers that reside in defensiveness, anxiety about having difficult conversations, inflexible decision-making on where safeguarding support is appropriate and necessary, and rigid procedures need to be addressed.

18 NHS England (2012) National Protocol for Notification of NHS Out of Area Placements for Individual Packages of Care (including Continuing Healthcare). ADASS (2016) Out-of-Area Safeguarding Adults Arrangements: Guidance for Inter-Authority Safeguarding Adults Enquiry and Protection Arrangements.

19 Nick Sherlock's presentation to all three workshops outlines the approach taken in one local authority area.

20 Care Quality Commission (2018) The State of Health Care and Adult Social Care 2017/18. Leeds: CQC.

21 The National Skills Academy for Social Care (2013) Leadership Starts With Me. London: Department of Health.

22 Haidar Ramadan's presentation.

23 Vanessa Keen's presentation.

24 Anna Knight's presentation.

25 Vanessa Keen's presentation.

Undoubtedly, there are challenges surrounding commissioning and care provision – gaps in types of services available, financial pressures on commissioners and providers, staff shortage and separately held recording systems – but excellence is possible, both in terms of the care and support that is commissioned[26] and how patterns of performance and concerns are identified and addressed[27].

What needs to happen?

- Strategic and operational leaders and managers should focus on building and disseminating a clear vision, an ambition, for making commissioning and care provision personal.
- This sets out a clear and non-negotiable set of values.
- In building and sustaining this culture, every voice should count and it should be easy to have and learn from conversations.
- The emphasis is on learning from experience by empowering staff, service users and families to raise issues and to make suggestions for quality improvement. Where there are shortfalls or gaps in provision, these are addressed openly and flexibly.

26 Presentations from Anna Knight and Maggie Bennett are examples.
27 Presentation by Abigail Simmons explores one such case.

Organisations across the partnership: workforce and workplace development and support

Golden threads feature strongly here – leadership being everyone's responsibility and staff having the confidence and competence to work effectively. However, workforce development has to be accompanied by workplace development[28] if the values, knowledge and skills acquired are to make a transformational difference to the quality of people's lives. A key question to ask will be "what enables best practice to flourish in this workplace and where are the barriers that need to be confronted?"

Securing a skilled and empowered workforce begins with values-based recruitment. Recruitment interviews and subsequent reflective supervision should, once again, be asking questions such as "how can you change the moment?", "how can you make things better today?" and "can you give me an example of how you do that?"[29] It is further developed through individual and team commitments to continuing professional development – training, supervision, case discussions, briefings on research and best practice (NICE) guidance, feedback from individuals and their families, and learning from SARs. The most effective learning combines human stories, real life scenarios – with research findings – and provides staff with practical tools to use[30]. It will address commonly encountered dilemmas and challenges, such as managing tensions between self-determination and a duty of care, assessing fluctuating capacity, and promoting autonomy whilst managing risks.

When drawing on feedback from service users and their families, and from research, guidance and SARs, the questions to be asked are: "how do we compare?", "where can we improve?" and "how can we achieve this?" Learning directly from people with experience of the care system and of adult safeguarding can be especially powerful and informative for practice and service development. Learning from providers rated as good or outstanding can also contribute to this focus on staff and service quality, especially if an ongoing improvement plan exists.

For these hallmarks to flourish recognition from senior managers of the value of a skilled and knowledgeable workforce is essential. Leadership from senior managers includes making sure that staff are listened to and that their messages inform improvement. There will be a strong emphasis on recruitment and retention of staff, building with them, and the people they are working with, a community of practice that places the lived experience of work and the lived experience of receiving care and support at the centre of an emphasis on delivering and tracking quality. Thus, it is not just about continuing professional development, the quality of supervision and the frequency of training and surveys of staff and service user experience. Furthermore, it is not just about the availability of adult safeguarding champions or staff with specialist expertise, on whom to draw for advice. It is also about the transfer of learning into workplace culture and practices that support staff to manage complex and challenging situations well.

28 Braye, S., Orr, D. and Preston-Shoot, M. (2013) A Scoping Study of Workforce Development for Self-Neglect Work. Leeds: Skills for Care.

29 Anna Knight's presentation.

30 See the presentation given by Vanessa Keen for one example.

What needs to happen?

- Invest in staff development – training, supervision, mentoring and appraisal.
- Draw on existing resources and develop new ones, such as seven minute briefings.
- Create safe spaces for reflection on learning from working with individuals and their families.
- Share and discuss feedback.
- Review what might need to change in the workplace to enable best practice to flourish, and knowledge and skills acquired from staff development to be used effectively.
- Involve service users in staff recruitment.
- Create ways of identifying through recruitment those staff who can offer kindness and "caring with" as well as "caring for and about."[31]

31 Adapted from Anna Knight's presentation at the Birmingham workshop.

The role of safeguarding adults boards

This is the final domain, where governance brings the golden threads of relationship-building, communication, leadership and system-wide working together, as well as working alongside and hearing the voice of people who may be in need of care and support. Strong and effective governance is one hallmark of developing and maintaining high quality care[32].

When adults who have care and support needs, are experiencing or at risk of abuse and neglect, and because of their needs are unable to protect themselves. SABs are responsible for coordinating and seeking assurance on and supporting the effectiveness of what partner agencies do[33].

The mandate includes supporting development of policies and guidance, and promotion of multi-agency learning. SABs are also responsible for overseeing and holding partners to account for the quality, responsiveness and effectiveness of adult safeguarding services. The mandate also extends to raising community awareness about types of abuse and neglect, standards of practice, and pathways through which concerns can be raised.

SABs can enquire into the quality of commissioning, of care provision decisions and of practice through audits, surveys and reviews, and through reporting by partner agencies, including the CQC. Where appropriate action plans can be developed and implementation outcomes monitored. SABs can engage directly with commissioners and providers through meetings of the board and its sub-groups. SABs can also engage directly with service users and their families, or through organisations of service users and carers, again through board and/or sub-group meetings. The golden threads of "every voice counting" and whole system focus should permeate the SAB's approach.

Importantly, the SAB also has a leadership role, modelling of the kind of leadership culture and values (including transparency, listening, honesty, openness) that support effective safeguarding.

For these hallmarks to flourish, the importance of developing and sustaining the values and culture of partnership and openness to learning emerge strongly. For these hallmarks to flourish a focus on learning for service development derived from picking up on patterns of performance through the use of audit and SARs is required. Governance is not another level of hierarchical management but a means of ensuring that services provide excellent standards[34].

32 Care Quality Commission (2018) The State of Health Care and Adult Social Care 2017/18. Leeds: CQC.
33 Section 43 and S42 (1), Care Act 2014.
34 The National Skills Academy for Social Care (2013) Leadership Starts With Me. London: Department of Health.

Conclusion – "We can do this well"

Good practice by and between commissioners and care providers is happening.

Good practice is built on relationships, trust, transparency and values at strategic and operational levels.

Good practice takes time and commitment to development.

Individuals and their wellbeing must always be at the forefront of practice and service development.

Everyone involved must be vigilant and demonstrate professional curiosity, as well as being ready to escalate concerns if needed.

Learning in practice requires a safe, non-punitive culture.

Leadership is indeed everyone's responsibility.

The hallmarks of making commissioning and care provision personal begin with leadership and culture based on core values of respect and care for people. They flourish when there is parity of esteem, when every voice is heard and every contact counts towards maximising the quality of people's lived experience. Furthermore, they flourish when settings are focused on sharing learning and taking coordinated action to improve.

What needs to happen?

Leadership on three levels, namely:

- Practice and professional leadership to ensure the quality of personalised care and support.Active consideration and review of how to demonstrate "responsibility to care[35]", here an internalised commitment to making safeguarding personal by attending to threats to wellbeing.
- Collaborative leadership, which finds and develops shared purpose and ways of working across organisations.
- Community leadership that encompasses co-production and builds service user and staff capacity – their strengths, skills and talents[36].

35 Engster, D. (2019) 'Care ethics, dependency and vulnerability.' Ethics and Social Welfare, 13 (2), 100-114.

36 Drawn from The National Skills Academy for Social Care (2013) Leadership Starts With Me. London: Department of Health.

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REF 25.142