Section 42

Adult Safeguarding Enquiries in Secure Settings

directors of adass adult social services eastern region

connecting innovating improving

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ADASS East of England Safeguarding Adults Network

Introduction

This guidance is for social workers or any others who will make s42 Adult Safeguarding Enquiries in secure settings.

The creation of this guidance was funded by the ADASS (Association of Directors of Adult Social Services) Eastern Region in 2022 and initiated by the ADASS Eastern Region Safeguarding Network Group in recognition of the complexities of undertaking Section 42 adult safeguarding enquiries in secure settings.

The guidance takes the form of a fact sheet for quick reference to bring key points easily to your attention.

The aim is to:

- Support you when making an enquiry and with the decision making involved in this
- Reduce confusion about who does what, the information that can be obtained and what can be shared
- Empower you in meetings and provide clarity on what should be done and when
- Increase cooperation between social care and health care services in keeping people safe and in making safeguarding enquiries and implementing interventions
- Build positive relationships between social care and health care services.

The guidance should be read alongside your own organisation's policies and procedures. These will take precedence if there is any conflict with the advice in this guidance and will also provide you with local information on timescales, reporting lines and governance arrangements.

Contents

1	What is a secure setting?	4
2	About this guidance	5
3	The role of adult safeguarding in secure settings	6
4	Adult safeguarding and secure settings	7
5	Warning signs	9
6	Safeguarding responses	13
7	Actions and interventions	17
8	Make Safeguarding Personal	21

1 What is a secure setting?

1.1 Secure settings include assessment and treatment units for people with learning disabilities and medium and low secure mental health services. They are characterised by restricted access, a focus on supporting people whose previous placements have broken down from across the region or country and by separation from communities and community-based services.

1.2 Several attempts have been made to replace secure settings with less restrictive alternatives or to reform the way they operate (these include the Five Year Forward View for Mental Health 2016 and the Positive and Proactive Care: reducing the need for restrictive interventions 2014).

1.3 Despite these efforts, secure settings remain a feature of the service landscape and present a number of commissioning, regulation and inspection, strategic and safeguarding challenges. Significant amongst these is that secure settings can often also be "closed" environments. There is no formal definition of a closed environment, but factors include:

1.4 **Physical location:** is the service in an isolated location, difficult to reach by public transport? Is it in the local community but disconnected from it?

1.5 **Physical characteristics:** is the service locked; do all visits have to be made by appointment; are there restrictions on visiting times?

1.6 **Culture:** are managers and supervisors present or are they always in the office or in meetings? Do staff always defer to managers when asked questions?

1.7 Closed environments can include, but are not limited to, medium secure units; assessment and treatment units; specialist education settings and other specialist services.

1.8 The commissioners of services that might be closed environments include NHS England, local authorities, and Clinical Commissioning Groups (CCG). Placements in secure settings are frequently made because of lack of commissioning of local services, either due to insufficient demand, lack of availability of the necessary specialist skills or strategic decisions about the services required.

1.9 Professor Jim Mansell's 1993 request that, *"Commissioners should stop using services which are too large to provide individualised support; service people too far from their homes; and do not provide people with a good quality of life in the home or as part of the community...developing more individualised, local solutions which provide a good quality of life"*, quoted in the Winterbourne View Hospital Serious Case Review in 2012, is still relevant today.

1.10 Whilst this guidance focuses on secure settings, the principles outlined within it can be applied more generally. Closed environments are not confined just to secure services and can be found more widely in many care settings.

2 About this guidance

2.1 Whilst general guidance exists, there is nothing currently published specifically on the role of adult safeguarding in secure settings.

2.2 This guidance draws from safeguarding adults reviews, research, practice experience, other published guidance, including the work of ADASS and the Care Quality Commission (CQC), to fill this gap and to show what adult safeguarding can offer.

2.3 This guidance was written following the unprecedented impact of the global Covid-19 pandemic and the consequent lockdowns and restrictions on access to services. These served to highlight the problems of secure and closed environments and to emphasise the need for greater community integration to reduce isolation. The principles described in this report, however, are not just limited to this specific context and are applicable beyond the effects of any further global pandemics.

2.4 For ease of reading, adults at risk of abuse, the preferred and technical term used in the Care Act and its statutory guidance will be referred to as adults.

3 The role of adult safeguarding in secure settings

3.1 The definition given in the statutory guidance to the Care Act is that adult safeguarding means protecting an adult's right to live in safety, free from abuse and neglect.

3.2 To do this requires that people and organisations work together to prevent both the risk of and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted, including their views, wishes, feelings and beliefs in deciding on any action.

4 Adult safeguarding and secure settings

4.1 Secure settings can provide a challenge for adult safeguarding practice due to a number of factors, which include:

4.2 Location

4.3 As a result of commissioning decisions, adults are often placed in secure settings far away from their homes and their placing authority. Local commissioners for the area the secure service is based in are often unaware of placements made there. The BBC File on 4 investigation into specialist mental health services, for example, highlighted how one person, "Emma", was placed 85 miles away from home in a specialist service for adults with eating disorders.

4.4 Assessment and Treatment Centres, for example, are often located away from towns and cities and sometimes are not easily reached by public transport. This can make travelling to and from them difficult, not only for you but also for commissioners and family members. Eldertree Lodge in Staffordshire, for instance, which was closed following removal of its registration by the CQC in 2021, was 11 miles from the nearest intercity railway station yet admitted people with learning disabilities from across the country.

4.5 Lack of integration with communities and services

4.6 Even when secure services are in a town or city, they can still be isolated and disconnected from their local community. Winterbourne View, for example, (South Gloucestershire 2012) was located on an "office park" within the town of Hambrook. Despite its proximity to the town centre there were few public transport links and little relationship with neighbouring businesses or other residents.

4.7 Secure settings can be imposingly institutional to look at, marking them out as different and can implicitly signal "Keep Out" to passers-by and neighbours. They can also be self-contained, bringing services (such as activities and even hairdressing) in rather than accessing them externally. Due to concerns about safety, outside activities for residents may take place away from their local community in isolated settings.

4.8 This isolation even within communities can lead to a lack of regular contact with anyone not directly involved in the operations of the service. This can result in reduced opportunities for observation, intervention and reporting of concerns. It can also restrict opportunities for outside advocacy, on behalf of residents, for improvement in the quality of their care and treatment.

4.9 Secure settings are operated by a diverse range of providers. They are not always linked into development forums and boards such as safeguarding adults boards, health and wellbeing boards or integrated care systems. Consequently, they can sit outside of wider networks and not be part of mainstream developments. As a result, they do not always develop links with other services and operate in isolation. The Organisational Learning Review following the rapid closure of Kingswood (West Sussex, 2021) and the Safeguarding Adults Review of the closure of Highcliffe Nursing Home (Dorset, 2016) identified the need to develop a "System of Care" in which statutory organisations (local authorities, health commissioners, the CQC), public organisations (such as health trusts) and private and voluntary sector providers work in partnership as part of a system and where problems in one organisation become shared concerns for all partners.

4.10 Specialism and uniqueness

4.11 Secure settings can appear intimidating because they might seem so different from the types of services that you are familiar with or might have worked in. They may not always appear easy to understand and you might feel disinclined to challenge the way that they operate. This does not only affect health and social care practitioners but can also affect family members and other visitors too.

4.12 Many secure services also employ health professionals either in clinical or management roles. They are not always part of local clinical and health networks and often lack any other external connections. This can lead to confusion about responsibilities for clinical leadership and difficulties in sharing information and in coordinating interventions.

5 Warning signs

5.1 Despite these factors that make secure settings difficult to visit, monitor, understand and challenge, there are a number of signs that may indicate that a service is operating in a way that may be exposing the people who use it to risk of abuse and neglect. You might need to work with colleagues from the CQC and from your local authority and CCG commissioning and contracting team to identify these. The CQC publishes inspection reports on the internet which may also provide you with important information about the way a secure setting operates. Warning signs include:

5.2 A lack of independent oversight and scrutiny

5.3 A registered manager is registered with the CQC to be in day-to-day management of one or more regulated activities. They have legal responsibilities under the Health and Social Care Act 2008 and associated regulations. The regulations also require that there is a nominated individual with responsibility for supervising the management of regulated activities. They should be an employed director, manager or secretary of the organisation.

5.4 Reviews have identified that sometimes this separation does not exist (for example Kingswood (West Sussex 2021) where the registered manager and the nominated individual were the same) or that there is a lack of oversight and control despite there being individuals in place to perform this role.

5.5 For example, in the Matthew Bates and Gary Lewis safeguarding adults review (West Sussex 2018) the area manager for the provider delegated some of their work to the registered home manager for undertaking enquiries into safeguarding concerns. This meant that the person managing the service might be enquiring into their own decisions and management practices, with a consequent conflict of interest and possible accusations of having a vested interest in not finding problems.

5.6 Themes or patterns of safeguarding concerns

5.7 Services where there have been several safeguarding concerns can be a warning sign, but numbers do not tell the whole story. Repeating patterns and themes of safeguarding concerns are just as important since they can give you an insight into the extent to which the service is responding to the need to improve. Concerns raised by several independent sources, such as the ambulance service, trades people, whistle-blowers and relatives can also be a sign of problems.

5.8 Safeguarding concerns may not only alert you to failings by individual members of staff, they may indicate unsafe groupings of clients and broader problems, including the excessive use of restraint and seclusion by unqualified staff; overmedication of clients; high tolerance of inactivity or the presence of hazardous environmental factors (such as regular falls or swallowing inedible and harmful items).

5.9 Lack of safeguarding and / or other incident reporting

5.10 An absence of safeguarding concerns raised by a provider is not necessarily a sign that the service is a safe and effective one. It might indicate that the service is worried about its reputation and fearful of the negative impact of safeguarding reports despite this being a registration requirement. It might be that the service culture is closed and desires to avoid the scrutiny that may follow the report of a concern. It might be that the staff and managers in the service do not understand what should lead to a safeguarding concern or to an incident report being required. The CQC requires that safeguarding concerns are reported to it by registered providers but as found during the Kingswood review, had not at the time specified what might indicate that safeguarding concerns were not being reported to it.

5.11 Individual, relatively low-level concerns about quality, may be handled by practitioners or managers in the hope that improvements will be made. It can be difficult to recognise when insufficient improvement is being made and when concerns should be escalated further. This also results in a lack of shared information about quality problems and, as in the Kingswood review, to a disconnect between the number of safeguarding concerns and practitioners' own knowledge of problems in the service. The result was that Kingswood Care Home was closed at short notice because of quality and safeguarding failings despite an absence of safeguarding concerns about the service provided.

5.12 This can also be a problem during safeguarding enquiries and interventions. The review following the closure of Grantley Court, Merok Park and Faygate, London Borough of Sutton 2013, found that the safeguarding manager who led the enquiry had tried to work with the owner of two nursing homes and one care home to improve both environmental and service quality. The challenge was in recognising when the lack of improvement was sufficient to require moving clients from the service, when there was risk that doing this would make the service economically unviable.

5.13 Physical health needs not being met

5.14 The extent to which physical health needs are met can also be a warning sign. The safeguarding adults review of Joanna, Jon and Ben at Cawston Park Hospital (Norfolk, 2021), for example, found that physical health needs had been neglected and there had been rapid weight gain as a result of reduced physical activity.

5.15 Physical illnesses not being identified can also be an indicator. This can be a result of lack of access to outside medical services such as General Practitioners or from a focus on mental health and behavioural explanations for physical signs and symptoms. Sometimes a secure service does not have the competence that it claims. For example, a BBC investigation found that Emma was placed in a service which, despite claiming to be a specialist in working with people who have eating disorders, did not have a dietician.

5.16 Even when pre-existing conditions are known, this does not mean that they will be responded to. The Serious Case Review of James (Suffolk, 2015), for instance, found that despite having suffered from chronic constipation for much of his life, signs and symptoms went unnoticed by care staff until James died from constipation induced aspiration pneumonia.

5.17 Behavioural management

5.18 Safeguarding adults reviews, such as that of Joanna, Jon and Ben at Cawston Park Hospital (Norfolk, 2021), have highlighted the importance of gathering background information about clients. This is important in two ways:

5.19 Firstly, clients often arrive at assessment and treatment units, for example, following previous placement breakdowns (whether in services or at home) and frequently background history that might help to understand the reasons for behaviours that challenge, and the approaches that have been tried, is missing. The consequences / implications of this are that the behavioural management programmes used in an assessment and treatment centre may not be effective since they are not based on a detailed understanding of needs.

5.20 For example, responses to Joanna's behaviour included physical intervention or restraint, seclusion and medication. There were over 10 occasions when Joanna was subjected to seclusion and at least one of these was overnight. There were over 40 references to physical intervention and over 30 references to the administration of PRN (to be given as required) medication.

5.21 Secondly, it is a mistake to consider each safeguarding concern in isolation. It is vital to read the records of previous concerns and to consider: What were the concerns about? What was done about them? Was there sufficient exploration of what happened or were conclusions jumped to? How effective were the interventions?

5.22 The CQC report, "Out of Sight – who cares" (2020), reviewed the use of restraint, seclusion and segregation for people with autism, learning disabilities and / or mental health needs.

5.23 The CQC found that the majority of Positive Behaviour Support Plans were of poor quality. None of the plans considered how the person's diagnosis affected them; sensory assessments for people with autism were unsatisfactory or poor and people in long-term segregation received care that was unlikely to do much to change their situation.

5.24 Reviews such as that of Winterbourne View Hospital and Suffolk have identified that the provision of "on the job" training led by support staff can be a warning sign. Lack of external challenge and oversight can lead to the development of poor and abusive practices. Sometimes where external training providers are delivering training, there can still be a lack of challenge. For example, at Winterbourne View, the externally provided training programme focused on the use of restraint rather than positive behavioural support. This served to cement the prevailing work culture and approaches rather than change them. This inward focus can be part of how a secure service develops a closed culture.

5.25 A further warning sign is where local community health teams are concerned that their expertise is called upon by providers that have taken clients whom they cannot support effectively. This is of particular concern when the service claims expertise with difficult to support client groups.

5.26 Staff skills and composition

5.27 Services that rely on agency staff often lack consistency, training and the ability to develop skills to improve. A high proportion of agency staff is therefore a warning sign to be alert to. It might indicate that the service has management and recruitment problems or is not able to retain staff. It might mean that level of skill and commitment are low.

6 Safeguarding responses

6.1 Recognising closed cultures and environments

6.2 Not all secure environments have closed cultures and and not all closed cultures and environments exist in secure environments. Closed cultures and environments, however, have been found in secure settings (for example, Winterbourne View, Whorlton Hall) and are defined by the CQC as "a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm". The CQC has published guidance on identifying and responding to closed cultures and environments, which highlights that closed cultures can be recognised by:

Characteristics of Closed Cultures and Environments

- Incidents of abuse and restrictive practice
- Issues with staff competence and training
- A culture of "cover-up"
- Lack of leadership and management oversight
- Poor-quality care generally
- Poor-quality reporting

6.3 ADASS has also published a useful checklist on recognising and responding to closed cultures and environments (available on many safeguarding adults board websites, including here) and is included as an appendix to this practice guidance.

6.4 Challenges for safeguarding in secure settings

6.5 There may be a number of repeating but often unrecognised and sometimes unconscious biases in the assessment and analysis of information and evidence gathered during safeguarding enquiries. Remember that even if you are particularly aware of and resilient to these biases, previous reviewers and visitors may not have been and may not have been sufficiently professionally curious to dig deeper.

6.6 The Norfolk Safeguarding Adults Board Professional Curiosity Guidance 2020 has been used by many other safeguarding adults boards and provides a practical guide to the most important biases and challenges and how to overcome them. These include:

6.7 The 'rule of optimism'

6.8 The 'rule of optimism' is a well-known process in which practitioners and managers can rationalise away new or escalating risks despite clear evidence to the contrary. They believe that if they just keep trying then things will work out and that, fundamentally, everyone has the best interest of clients at heart. The review of the closure of Grantley Court, Merok Park and Faygate, found that even the assumption that the owner of the homes had their own business interests are heart was overly optimistic.

6.9 Disguised compliance

6.10 A more accurate name for this might be feigned compliance. A carer, manager or the owner of a service gives the appearance of co-operating with you to avoid raising suspicions, to allay concerns and ultimately to reduce your involvement. The review of Kingswood found that social workers and district nurses were regularly shown only what carers and the homeowner wanted them to see and, if they asked questions about when, for example, activities were going to take place, they were routinely told that they had just missed them or that they had been delayed until the next day.

6.11 Maintain concerned curiosity about whether compliance with your requests might be feigned rather than genuine and challenge respectfully. Ask to see a client in their room, for example, if you only see them in a communal space and ask for evidence that activities have taken place or that a repair to a boiler, for instance, has been booked. Check afterwards that activities, repairs and other requests that you have made have been fulfilled. If they have not, then think about how long and how many more chances you are prepared to give. What is the life of your client or the person you are concerned about going to be like in the meantime?

6.12 If there have been concerns about a person swallowing inedible objects, when you visit, check whether there are loose bits of litter, stones, loose screws, remote controls lying about in areas the person has access to. Raise this with a manager and check back again to make sure that risk assessments have been updated and environmental hazards have been removed.

6.13 Not seeing the whole picture and not identifying accumulating risk

6.14 Always look for patterns and for signs of escalation of harm and of risks. Do not respond to each situation or new risk as if it is a discrete event. Single incidents are often easy to explain away as accidents or exceptional events which will not happen again.

6.15 Consider how many safeguarding concerns have been raised and over what period of time? What did they involve and who was involved? Have the same people (either as the adult at risk of harm or the adult alleged to have caused harm) been involved?

6.16 What actions were set to improve quality, protection and the empowerment of clients and to prevent abuse and neglect in the future? What monitoring has there been of the progress of these actions? Is there an improvement plan or are actions just reactive to single incidents? Are there repeating patterns of concerns, which might suggest that the service is not responding effectively to safeguard the people it serves?

6.17 The patterns and themes may include incidents and accidents as well as concerns about abuse and neglect. For example, reports of residents swallowing inedible objects such as batteries may indicate the need for an environmental risk assessment and for physical interventions to increase safety such as fitting secure battery compartments to remote controls to prevent access to batteries.

6.18 Repeated safeguarding concerns, particularly if they form a pattern either for the same person or for different people, may be an indication that there are deeper problems in the way that a service operates or is managed. They may also show that interventions are not working and new approaches may be required.

6.19 Normalisation

6.20 People who have been placed in assessment and treatment units, for example, are likely to be there because their previous placements or living arrangements have broken down. This is often due to problems managing their behaviour. Consequently, it is tempting to believe that their behaviours which challenge services are routine, explicable and predictable: if they did not behave like this, then they would not be placed there. Family members may be concerned about how these behaviours are responded to, but they were not able to manage them and so it is inevitable that the person is now in a secure environment where their behaviour can be controlled. Similarly, if the person regularly complains about how they are treated then this too can become regarded as part of their 'normal', irrational behaviour.

6.21 Beware of normalisation in which abuse, neglect and failures to provide support effectively can come to be seen as 'normal' or 'natural'; or as only to be expected. Situations like this cease to be questioned and therefore present the potential risk that indicators of abuse or neglect may not be recognised.

6.22 Confirmation bias

6.23 It is sometimes tempting to only look for evidence that confirms our pre-held views and ignores contrary information. Confirmation bias occurs when we filter out potentially useful facts and opinions that don't coincide with our preconceived ideas and ignore anything that might refute our conclusions. The review of Matthew Bates and Gary Lewis (West Sussex, 2018) for example, found that an early conclusion had been reached that Mr Bates' and Mr Lewis' injuries were accidental. This prevented further enquiry into whether or not injuries were actually non-accidental, despite the presence of evidence to support this alternative conclusion. The result was that there was insufficient consideration of potential abuse and institutional failings which might constitute criminal offences.

6.24 Focus your enquiries on what you do not know. Contested accounts, vague or retracted disclosures, deception and inconclusive medical evidence are common in safeguarding practice. Practitioners are often presented with concerns which are impossible to substantiate. In such situations there is a temptation to discount concerns that cannot be proved.

6.25 Always look for evidence that contradicts your assumptions and conclusions. Ask yourself "What if…?" and ask a colleague to challenge you with alternative explanations and to test whether your conclusions are fully supported by evidence.

6.26 Consider your client's needs more widely and think about their wellbeing (section 1 of the Care Act). How do they seem? Have they put on weight? Are they pale and do they look unwell? These may be signs that their needs are not being met and that there is an over attention to their behaviour at the expense of their wellbeing. When did they last see a doctor for a physical health check?

6.27 Spend time in the service observing what is going on around you. How do staff and clients interact? How do staff interact with each other and how do clients interact with each other? Are managers present and do they show leadership and model how to behave?

6.28 Is there a connection and flow of information through from care plans to nursing plans to diet plans to activity plans etc, or are they all separate and unrelated?

6.29 Do not just focus only on your client's experiences and needs. Consider how the service operates more widely for all the people placed there.

6.30 Professional deference

6.31 There can be a tendency to defer to the opinion of a 'higher status' professional who has limited contact with the person you are concerned about but who argues that risks are less significant or that you do not understand the situation.

6.32 Be confident in your own judgement and always outline your observations and concerns to other professionals, be courageous and challenge their opinion of risk if it varies from your own. Escalate ongoing concerns through your manager or draw on the support of the CCG's safeguarding lead.

7 Actions and interventions

7.1 Commissioning

7.2 The most effective solution to the problems presented by secure services is to commission local alternatives that are better integrated with generic and specialist health services, are accessible, visible and open. There is a policy foundation for this set out for people with learning disabilities in "Homes not Hospitals" and in ongoing work on Transforming Care.

7.3 There are tools that commissioners and practitioners can use to reduce the need for secure settings. Care and Treatment Reviews, for example, for people whose behaviour challenges services and/or have a mental health condition are part of NHS England's commitment to transform services for people with learning disabilities and autism. They can be used by commissioners for people living in the community and in learning disability and mental health hospitals, and are reported to have helped reduce the number of people who are admitted to and retained in hospitals.

7.4 A secure service where there has been no Care and Treatment Reviews should be prioritised for client reviews and for checking for the presence of the warning signs outlined in Section 5 of this guidance.

7.5 Similarly, The National Safe and Well Review Programme was introduced by NHS England in 2021, partly in response to the Joanna, Jon and Ben at Cawston Park Hospital (Norfolk, 2021) safeguarding adults review. (National Safe and Wellbeing Review Programme December 2021 | Local Government Association).

7.6 Safe and Well reviews of all people with learning disabilities in assessment and treatment centres are expected to have been completed by 31 January 2022, and are an opportunity to uncover safeguarding concerns. Despite this process very few concerns have been identified. As outlined in section 5, there is a need to exercise professional curiosity and to dig deeper through records and incident reports. Safe and Well reviews focus on moving on from secure services, so consider if there are any barriers to this and who is benefiting from a continued placement there. If this is not the people who live there, then it is time to find an alternative service for them.

7.7 One of the requirements for a Safe and Well review, which can be applied more generally, is to sit down and observe what is going on around you. Get a feel for the flow of the service and consider what is going on and what is it like to live there. Do not focus just on your client but watch and think about the interactions between staff and people who use the service and any visitors. Find out what is understood about safeguarding and empowerment.

7.8 It is important to find out if any problems with the service have been identified and if there is an improvement plan in place. Read the last CQC inspection report. Did it identify the need for improvement in any areas? Are the CQC and commissioners working with the service?

7.9 Discuss the secure service with the quality team at the Clinical Commissioning Group. Have they identified any concerns and what actions are they taking? Has the CQC been notified of safeguarding concerns by the service and what actions are being taken.

7.10 The Quality Network for Forensic Mental Health Service report, "Standards for Forensic Mental Health Services: Low and Medium Secure Care – Third Edition 2019", sets out essential, expected and desirable standards for areas including admission and assessment; physical health care; treatment and recovery; patient experience; family friends and visitors; security; safeguarding; staff skills and governance in forensic mental health services including in secure settings.

7.11 This guidance can be used to audit the quality of services and can also help you to determine "what good looks like".

7.12 Out of area placements

7.13 A further commissioning and practice challenge is working with out of area placements. Many assessment and treatment units and medium secure units do not have a single commissioner since they take people from across the country. Others are not commissioned locally but regionally by NHS England.

7.14 The Nuffield Trust reported that in September 2021, 90% of out of area placements for people with mental health needs were deemed "inappropriate", which means that they were made because a local service was not available and more than half of the placements were between 60 and 180 miles away. In 2019, the CQC found that inpatient mental health facilities run by independent providers had an average length of stay of 359 days compared with 197 days for NHS services.

7.15 The challenges include keeping contact with people placed out of area, working with commissioners in other areas to piece together information about patterns of concern, and for the commissioners in the area where the secure setting is based, actively engaging with a service that they are not commissioning.

7.16 **Approaches to overcome these include:**

7.17 Prioritise reviews at least annually in person: not by telephone. When there, review support and care plans to ensure that the care provided enables the person's autonomy and development, rather than creates dependency and institutionalisation. Does the Positive Behaviour Support plan tell you anything about the person or their needs? Does it describe their behaviours in a respectful way, or does it blame them for how they respond to other people or their situation? Senior clinicians and managers should support the reviewer to challenge institutional practices and care plans which do not promote independence and development.

7.18 Use multidisciplinary assessments of the current needs of the person in an out of area placement. Question whether a local service is available to meet their needs or might be adapted to be suitable. Just because no service was available when they were placed does not mean that their needs have not changed or that local services have not changed or cannot change.

7.19 Ensure that the out of area service has access to all the relevant information about the person's history, needs and risks. This will assist the service to understand why the person is behaving in certain ways. Check that the information provided has been understood and has been incorporated into behaviour support plans and care plans.

7.20 Require progress reports from the placement and from the professional(s) reviewing the placement. If there has been no progress, then is the secure placement working? If there has been progress, then is the placement still required? No secure service should be permanent. The ongoing suitability of the placement should be reviewed regularly, with the intention of a move to a more independent placement when feasible.

7.21 Speak to family members not only to understand their views of the service but also their expectations of it and experience of health and social care services more widely. Discuss their expectations of the service. Sometimes, family members do not know "what good looks like" and might be concerned about the consequences of raising concerns. They might be worried about where the person will go to if they leave the secure service.

7.22 Contact the local authority and CCG for the area in which the secure service is placed. Notify them that you have a placement there. Discuss concerns with them, find out if they have concerns too and whether any improvement plans are in place. Find out what market shaping work the local commissioners are doing.

7.23 There are a variety of resources that might be useful to help them to understand what to expect, for example Mencap's "Your rights if you are in an Assessment and Treatment unit" and NHS England's "Getting it right for people with learning disabilities".

7.24 The Institute for Mental Health guide, "Secure Hospital Care: information for carers" is a useful resource for increasing the knowledge of family carers about what to expect from secure mental health services. It explains jargon terms and includes suggested questions for family members to ask about the care and treatment of people placed in secure hospitals.

7.25 Also check if local information for family and friends has been created, such as the "Forensic Mental Health Service Information for Family, Friends and Carers" published by Oxford Health NHS Foundation Trust.

7.26 Some areas have also created guidance aimed specifically at supporting children to visit their parents or other relatives in secure settings (for example The Greater Manchester Safeguarding Children's Board's "Children Visiting Psychiatric Wards and Secure Psychiatric Hospitals".

7.27 Gaining access to secure settings

7.28 Secure settings, by their nature, are often locked or offer limited access for visitors, often by appointment only. This can prove a barrier to unannounced visits outside of prescribed visiting hours. If you are refused entry at these times, or outside of them, ask for the reasons why and explain the reasons for your visit.

7.29 There are few legal powers to enter a premises, even if you are commissioning it. Section 42 of the Care Act 2014 places a duty on local authorities to make enquiries, but this does not include legal powers of entry or access to the adults at risk of abuse of neglect. Instead, there are a range of existing legal powers that are available to gain access should this be necessary. SCIE (Social Care Institute for Excellence) suggests that powers of entry may be derived from a variety of legislation including the Mental Capacity Act 2005 (MCA), the Mental Health Act 1983 (MHA) and the Police and Criminal Evidence Act 1984 (PACE), along with common law including the inherent jurisdiction of the High Court, and common law powers of the police to prevent or deal with a breach of the peace.

7.30 The CQC, however, is empowered by law (Health and Social Care Act 2008, s62) to enter premises for unannounced inspections as is CareWatch (local Government and Public Involvement in Health Act 2007).

8 Make Safeguarding Personal

8.1 Making Safeguarding Personal involves actively seeking the views, wishes and perspectives of the person you are trying to safeguard (or those of their family or other representative). It means engaging the person you are trying to safeguard in the safeguarding process and asking them what outcomes they want, what interventions they think will work, whether they think that positive change has happened and to what extent their desired outcomes have been achieved. Sometimes a provider may represent a person's view to you (for example by advising you that they do not want to take a complaint further) but you should be curious about the extent to which the person really has understood the decision they have made and its consequences. Speak to them directly whenever possible.

8.2 Remember that by making safeguarding personal you are also working in a way to help to redress what has happened to them. You empower the person when previously they had been disempowered; you give them control when before they were controlled; and you give them a voice by listening and acting on what they say instead of ignoring or silencing them.

8.3 The CQC also expects services that it regulates to make safeguarding personal. From this perspective, making safeguarding personal means that there is a safeguarding culture that focuses on the personalised outcomes desired by people with care and support needs and that the safeguarding is everyone's responsibility in the service. During an inspection, the CQC should expect the following questions to be answered:

8.4 **Does the registered service know what abuse is, how to spot it, or how to spot when people may be at risk of it?**

8.5 Talk to the staff and managers about their knowledge of adult safeguarding and specifically, for the person you are visiting, about what the risks are for them, reviewing the risks and checking up on progress.

8.6 **Does the registered service know how to act when it spots abuse or the risk of abuse?**

8.7 Does the service report safeguarding concerns to the CQC? What protective and preventative actions did it take in response to these (and not just for your client)? Did these lead to increased restrictions or did they empower people who use the service?

8.8 **Does the registered service learn from safeguarding incidents or safeguarding risks?**

8.9 Look for evidence that the service is learning from each incident. Is there openness to learning and development in the service and have any interventions made or actions taken made a difference? If not, question why the change has not made a difference or has not been embedded.

8.10 Give reasonable time frames for changes to be implemented and embedded. If change does not occur, escalate in a timely way. This could be an example of "feigned compliance" or indicate a systemic problem.

8.11 Given that being able to answer these questions at least adequately is part of the requirement for a service to continue to operate, you should expect satisfactory answers to them, even if you are not a CQC inspector.

8.12 Apply the six principles of adult safeguarding

8.13 In order to make safeguarding personal, remember to apply the six principles of adult safeguarding and consider:

8.14 **Empowerment:** What are you doing to involve the person who you suspect has been abused or neglected in the safeguarding process? Are you explaining what is happening? Are you giving them a say in how the safeguarding enquiry is progressing? Are you focusing on the outcomes they want? Remember to get the view of person rather than that of someone who may have an interest in minimising concerns.

8.15 **Prevention:** What are you doing to reduce the risk that harm or neglect will reoccur? Is it enough?

8.16 **Proportionality:** What safeguarding response and actions are most appropriate or responsive to the risks? Is enough being done? In your zeal to safeguard, have you placed unnecessary or overly controlling restrictions on the person at risk of abuse or neglect? In your zeal to protect their autonomy have you done enough to make sure that they are safe?

8.17 **Protection:** What actions need to be taken to increase the person's safety now? Remember, the purpose of a s42 enquiry is to enable you to, "…decide whether any action should be taken in the adult's case and, if so, what and by whom". If you know what actions to take, then take them as soon as possible to protect against abuse and neglect.

8.18 **Partnership:** Who should you work with in the safeguarding enquiry or intervention? What additional skills do you need to help you and to help the adult at risk of abuse and neglect? How confident are you about medication or positive behavioural support, or restraint? Who might know more about these than you do and how can you involve them?

8.19 **Accountability:** Are you able to justify your actions and decisions to the adult at risk of abuse or neglect? Are you able to explain to them that you put their interests and wishes first and that you did all you could for them?

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