social care
institute for excellence

SCIE's briefing on the Safe Care at Home review

Published: November 2023

Introduction

The government identified evidence of abuse against people receiving care in their own homes during the passage of the Domestic Abuse Act 2021. As a response they commissioned a review of the existing protections and support for adults with care and support needs who are at risk of, or experiencing, abuse in their own homes by people providing their care. The Safe Care at Home Review (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1162498/Safe_Care_at_Home_Review_.pdf) was jointly led by the Home Office and Department of Health and Social Care (DHSC). The review took place from February 2022 with the final report published in June 2023.

The review set out eight findings under three themes:

- Leadership and accountability
- Effectiveness of the local response to abuse in the home
- Research, evidence and learning.

For the purposes of the review, care at home was defined as:

"settings where people are permanently residing in their own home (whether rented, provided by the local authority, or owned). It includes settings where an adult is supported to live independently in supported living accommodation or accommodation with care arrangements, paying either in part or full, towards the tenancy". (Para 43)

This briefing sets out the findings along with SCIE views about its strengths and areas that require further development/consideration.

Theme 1: leadership and accountability

a) Oversight of safeguarding in England is fragmented and there is limited accountability.

One of the key findings is that 'leadership and accountability' for adult safeguarding is fractured at both the local and national level. The review identified that although there are a number of agencies at national and local level e.g., CQC, safeguarding adult boards, local authority, it was unclear "who holds strategic oversight of the safeguarding of adults with care and support needs, at both local and national levels". (Para 72)

This is an important finding, one which reflects SCIE's learning from our work in the sector about the gaps in accountability and oversight. This is clearly highlighted in our Safeguarding Adult Review (SAR) of the Whorlton Hall assessment unit. This set out the "need for closer working between CQC and local authorities to improve from organisation safeguarding enquiries in specialist hospitals". The review also set out the importance for those that draw on care and support of being supported by "a sustained relationship of trust with a professional to enable effective safeguarding responses in specialist hospital settings". (SCIE's webinar on the findings from Whorlton Hall (https://www.scie.org.uk/safeguarding/adults/reviews/whorlton-hall-webinar) is available to be viewed.)

b) Competing pressures and insufficient resources have a negative impact on the safety of the people with care and support needs and exacerbate pressures on those delivering care.

The review recognised the range of pressures with stakeholders noting the fragility of the system and the need for increased funding and resources.

c) There is limited sharing of information and learning from best practice and failures where exists there is limited accountability for monitor progress to address failures.

The review noted the inconsistencies in the application of Care Act 2014 safeguarding duties (more is said about this under theme 2). The plan to review Care Act guidance is timely and helpful. It will be important to ensure that the review and the revisions of best practice are shaped by the learning which have emerged from the various national fora and the findings of the LGA analysis (https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf) of SARS. A key element is ensuring that the guidance is clear in recognising and promoting the role of third sector organisations in supporting and safeguarding adults.

One of the positive developments has been the establishment of the Safeguarding Adult Review National Escalation Protocol. This sets out a clear

process for a local board to raise an issue with DHSC and starts to address the gap of local learning in many cases needing a national response. However, it does not address the question of how well SAR recommendations/findings are implemented. Whilst safeguarding Boards should report on the implementation of recommendations in their annual report, SCIE believes there should be independent reporting/scrutiny on how well the recommendations are implemented.

SCIE would be happy to take this on as a research project that could be taken forward building on our relationships with local authority safeguarding leads and Safeguarding Adults Board Managers.

Theme 2: effectiveness of the local response to abuse in the home

There were three findings:

a) There is varying implementation of the Care Act 2014 provisions between different local areas.

b) This type of harm and relevant legislation is highly complex, making it challenging for frontline professionals to address.

c) Frontline professionals often lack the necessary tools and resources to allow them to best protect and support people with care and support needs who are, or are at risk of being, abused in their own home by the person providing their care.

The evidence "reflected that victims in different localities experience different sorts of barriers which make it more difficult to report abuse or contact their local authority safeguarding team" (Para 101). There is an equal variation in relation to carers assessments.

The report sets out some of the increased funding to adult social care and this is welcomed but stakeholders commented on the "need for sustainable, multi- year investment to improved adult safeguarding responses and victim support".

Adult safeguarding requires good multi-agency working and as our Safeguarding Adults Reviews in Rapid Time (SARiRT) and audits show, alongside the national analysis of SARs (2019), there is still a way to go on having a consistent response across the country. There is a significant difference in the understanding of issues such as the Mental Capacity Act, learning disabilities and older people across services and this is reflected in the reporting of concerns. Our review of Whorlton Hall found that the lack of national standards of good practice to guide staff carrying

out enquiries could contribute to poor outcomes. It also highlighted variable quality assurance of investigations carried out by staff with limited skills and expertise in conducting them, particularly in third sector provider organisations, where the abuse or neglect might have occurred.

The issues around variation of risk assessments, the interpretations of the Care Act safeguarding duties and the quality assurance of safeguarding enquiries are ones SCIE believes need to be addressed.

To support learning and improvement SCIE would want to see:

a) DHSC develop an enhanced focus on the effectiveness of Section 42 safeguarding enquiries undertaken. There is variation across the country as identified by the Safeguarding Adults collection (SAC) data.

b) Allied to that is the need to develop a consistent and shared understanding of what constitutes a safeguarding concern. The LGA led the development of a framework (https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/safeguarding-resources/understanding-what-constitutes-safeguarding-concern) to support consistent and confident decision making (2020). This was helpful but the COVID-19 pandemic meant a loss of impetus and further multi-agency promotion of this would be helpful. Further work is needed with non-statutory partners (see below).

c) Given the concerns about frontline practitioners' understanding and application of existing legislation, there needs to be a programme of support to improve legal literacy amongst practitioners in all organisations.

Think Local Act Personal (TLAP) has been funded by DHSC to produce a series of podcasts (https://www.thinklocalactpersonal.org.uk/Latest/Two-Co-production-Journeys-ADASS-West-Midlands-and-ADASS-East-of-England/) about the Care Act 2014 to help bring key sections to life through the eyes of people with lived experience. SCIE are running a series of webinars (https://www.scie.org.uk/transforming-care/webinars) for the sector, with one specifically addressing the issues of third sector organisations in raising and managing safeguarding concerns.

The review identified the need to improve awareness of safeguarding. SCIE welcomes the DHSC/Home Office communications plan for raising public and professional awareness of adult safeguarding issues. From our previous experience SCIE would recommend that:

a) The national fora is involved in the planning in order to ensure the campaigns can maximise impact.
b) A range of messaging and channels is considered in order to ensure it is understood across the diverse audiences that should be targeted. There is a danger in developing one set of messages which are distributed using

standard media (mainstream TV, papers). Quite often whilst these miss a number of communities For example some of the best and most effective messaging on COVID-19 for minority communities was the sharing of short videos via WhatsApp, whilst one LSAB on another occasion by ensuring its material was available in a range of languages was able to generate interest from a number of people, rather than just those whose first language was English.

The review also considered the issue around the lack of entry as a key barrier in being able to communicate with and assess the safeguarding risks for an adult. This is a critical area for development and one we welcome. SCIE produced a paper on this important area of practice (updated in 2018) gaining access to an adult suspected to be at risk of neglect or abuse (https://www.scie.org.uk/files/safeguarding/adults/practice/gaining-access/gaining-access-to-an-adult-at-risk.pdf) which has received positive feedback from practitioners. We are conscious however of the need to ensure the safety of those that draw on care and support and frontline practitioners when entering a property in unpredictable circumstances.

Whilst the review has placed some focus on the police, we believe it is important that equal weight is given to all statutory partners. SCIE would also emphasise the role that NHS primary care staff and the third sector have in being able to access the home and potentially speak to the person in a safe space. In that context there is an opportunity if those staff are confident in their understanding, identification and reporting of safeguarding concerns.

It is therefore important to ensure that staff/volunteers in those roles can access good quality training and support.

Theme 3: research, evidence, and learning

a) There is a lack of available data on the prevalence of abuse in care relationships and the data that is available is poorly utilised.

b) There is a lack of understanding of the nature and causes of abuse in care relationships, and the behaviours of perpetrators in this context.

The review identified that there was limited understanding about the causes and nature of abuse within caring relationships and even less on care-related abuse within the home.

Whilst the terms of reference noted a plan to focus on intersectionality, there is little in the way of consideration in the review partly because of the paucity of data. It is worth noting in the LGA SAR analysis, in 70% of cases ethnicity data was not provided. There has been a wealth of evidence in relation to health inequalities and ethnicity especially as a result of COVID-19. In that context it would be reasonable

and important to consider how issues of ethnicity/gender would also impact safe care at home.

Conversations with practitioners have identified some issues about the use of the DASH (Domestic Abuse, Stalking and Honour Based Violence) assessment (used by police and others to initial assess domestic abuse) in relation to older people. We would therefore recommend some research/evaluation should be undertaken on its effectiveness in relation to domestic abuse of older people.

The national analysis of SARs provided good evidence and SCIE welcomes the plan to commission another national analysis of SARs. Consolidation and dissemination of learning from serious incidents was also identified as an area for improvement. SCIE will continue to support the sector with this by delivering training and support on conducting reviews, and promoting the SAR Quality Markers (https://www.scie.org.uk/safeguarding/adults/reviews).

Conclusion

The review is an important step in drawing together both evidence and the views of the sector in terms of the issues that currently impinge on the quality and effectiveness of the safeguarding response.

There are some important actions that government have committed to, and we look forward to seeing how these commitments are implemented in a timely manner to reduce the risk of abuse as everyone should be safe, especially in their own home.