Safeguarding in Lancashire: ‘Everybody’s Business’  
- engaging the independent sector

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Introduction
This is an account of an action research project, done with the Lancashire Safeguarding Adults Board and through the Social Care Partnership (SCP), a partnership of the county council and independent sector in Lancashire, conducted between May 2009 and July 2010. The focus of the project was the engagement of the independent sector with Safeguarding as part of the overall Strategic Planning for Lancashire, operating through a newly formed Safeguarding Adults Board and with reference to the CQC’s 2010 Inspection of the County’s approaches to Safeguarding.

The SCP has adopted processes that support commitment and continuity of leadership at senior management level, effective working groups bringing different sectors together (providers, the county council, and, to a lesser extent, health colleagues) with a published programme of work, inter-agency learning events & workshops; strategic ‘awaydays’ (for planning, lateral thinking and trust-building), and evidence-based approaches and research-mindedness. This project is part of that larger process. This approach recognises the challenges faced by organisations, and even more so across organisational boundaries, of learning from experience, translating that learning into new ways of doing and thinking and, hopefully, not forgetting what’s been learned (Flynn and Williams, 2010).

‘Vulnerable adults’ and ‘Safeguarding’
The concept of ‘Safeguarding adults’ entered the critical consciousness of social care only very recently in the history of social policy (Sumner, 2002). A vulnerable adult was first defined, in the context it is presently understood, as someone “who is or may be in need of community care services by reason of mental or other disability, age or illness; who is or may be unable to take care of him or herself or unable to protect him or herself against significant exploitation (Lord Chancellor’s Dept, 1997). There are different definitions across, for example, the Care Standards Act (2000), the Youth
Refinements to and around that core definition have included a challenge to the notion of ‘vulnerability’, on the grounds that it locates the fault within the individual (ADASS, 2005), and extensions to the definitions of those categories of behaviour that might be called ‘abuse’. A UK study of adult abuse prevalence (O’Keefe et al, 2007) outlined four categories of abuse: “psychological, physical, sexual and financial”. Others add neglect and yet other authorities have added ‘discriminatory’ and ‘institutional’ (DH, 2000; OPG, 2007) to the nosology of abuse. The newer additions locate, sociologically speaking, the fault away from the individual and within the social milieu and, as with 'structural racism' (post MacPherson) and gross social inequity (UNICEF, 2007) the abuse it may be structural. This re-location of ‘abuse’ within social structures and away from the individual, away from the 'front-line', also opens an aspect on the commissioning of and funding of care and their link with ‘Safeguarding’.

Policy context
One of the critical features of the current organisational context of ‘safeguarding’ adults, is the fact that service provision is characterised by a mixed economy of care, as envisaged in 1989 by Caring for People (which explicitly required local authorities to stimulate the independent sector) and as shaped over the period since. In the Lancashire area where the current project originates, all domiciliary care (apart from reablement services) for adults and older people and over 90% of care in care homes is provided by the independent sector and the vast majority of that, for older people, is in the private sector. Ownership and management of provider organisations are undergoing substantial change currently, although it is still the case that most care is delivered by small businesses. While ‘personalisation’ is developing ‘customer’ power, the vast majority of care is still bought by local authorities through their local commissioning arrangements from a central allocation.

In this context some see the market as the solution to problems of choice, quality, and scarcity, others see it as the source of the problem. The critique of local authority provision as articulated by IPPR (Leadbeater, 2004; Leadbeater and Cottam, 2006) and
reflected in landmark policy documents such as Modernising Social Services (DH, 1998), and in contemporary policy on ‘personalisation’ (Henwood, 2008), has been that a ‘one-size-fits-all’, top down, ‘Fordist’, model of care is both outmoded and unsustainable.

In relation to the IPPR critique (Leadbeater & Cottam, 2006), specifically, the argument was put that monolithic public sector social care might learn from other sectors in the economy who have different models for the core relationship between providers and system-managers, on the one hand, and ‘users’/customers, on the other. The exemplar given was the process of software development and the relationship between ‘users’ and software developers. This new relationship meant moving the ‘user’ from passive recipient of welfare to active system engineer, partner (‘co-producer’), and engaged stakeholder.

While the focus of the policy discourse has been on ‘customers’ or 'citizens' having choice and power to help shape the care and support system, it is a matter of prima facie logic that a having a provider sector which is not engaged, or is a secondary victim is counter-productive. The Human Rights Act (HMSO, 1998) recognises, at the very least, the right to a “fair hearing” under Article 6.

The transformation of social care, to a ‘personalised’ service, where users have the option of their own budget to spend as they want means that the position held by local authorities is set to change. Customer power, a mixed economy of care provision, and a, cash-strapped, monopsony purchaser, present opportunities and challenges for those trying to manage Safeguarding in the context of these broader systemic pressures.

**Safeguarding, employers, and abuse.**

Under the Health and Social Care Act (HSC Act, 2008 (Regulated Activities), Regulation 2010) providers are obliged, under Part 4, “to comply with the requirements specified in regulations 9 to 24 in relation to any regulated activity in respect of which they are registered” and under 27 (1) a failure to comply with any of the provisions of regulations 9 to 24 shall be an offence”.

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The sections cover a range of activities relevant to safety and the quality of care received, including care and welfare of service users, assessing and monitoring the quality of service provision, safeguarding service users from abuse, cleanliness and infection control, management of medicines, nutritional needs, safety and suitability of premises and of equipment, respecting and involving users, consent, complaints, records, staffing (recruitment, fit person, staffing numbers and support for workers) and cooperating with other providers.

It is not always clear where ‘abuse’ ends and ‘poor practice’ practice begins. It is more than a semantic issue as, unless there is an unambiguous threshold for abuse (clearly distinguishing ‘abuse’ from quality issues, in day-to-day care), the concept of ‘safeguarding’ becomes indistinguishable from broader aspects of care that would usually be seen as issues of quality. If it is indistinguishable, it becomes impossible to separate processes around quality management from a quasi-legal process, such as Safeguarding. A blurred boundary will also mean the consumption of resources better directed towards quality matters.

The regulator (CSCI, 2008) called for greater clarity around the “boundary between abuse and poor practice”. The structural concern behind this philosophical debate about terminology is that unless the term ‘safeguarding’ has some discrete meaning, readily intelligible to those in the ‘system’, the resources available to local authorities, as the lead agency for overseeing ‘safeguarding’ are likely to be exhausted by dealing with the number of alerts into the safeguarding system. CSCI (ibid) para 31 p 8, has affirmed their concern to distinguish ‘abuse’ and ‘safeguarding’ from “other types of complaints about providers.”

Opportunities and threats
The research arose from a combination of factors: a CQC inspection of Safeguarding in Lancashire, a new Safeguarding Board and Chair developing new structures, procedures and protocols, and a forward workplan drawn up between the independent sector and the council through the Social Care Partnership (SCP). The broad aim was the engagement of the provider sector, particularly the independent sector, in Safeguarding as a shared process. Specific aims were to explore provider views of the nascent Safeguarding procedures and Safeguarding culture.
Method
The project was overseen by an interagency Reference Group and applied an action research approach for its method (Hart and Bond, 1995) involving multiple methods and ‘reflective practice’ loop: brief literature review, followed by a telephone survey (1/5) of all providers and focus groups (with a subset of independent sector providers who'd had experience of investigations and with council assessment staff). This fed back into the reference group and a review of local practice and procedures through the Safeguarding Board and ‘Learning Together’ workshops leading to a public joint statement and joint protocols around investigation (Simic et al, 2010; Wareing, 2010).

A questionnaire was devised by the project team with covering a range of issues across four domains: information, advice and support, training and experience of investigations. The full questionnaire is available as an appendix to the report.

The focus groups were conducted with providers who'd had experience of investigations in the previous year.

SURVEY

Characteristics of the sample
There was a 97% response rate to the telephone survey. The sampling frame was a 1/5 stratified random sample taken from the CQC Lancashire provider list for the LCC area (by 'care homes only', 'care homes with nursing', and 'domiciliary care'), for adults and older people.

The sample (domiciliary care n=26, care homes only n=69, care homes with nursing n=22) reflected, broadly, the split of the care sector, with 81% of the domiciliary care (73% private, 8% voluntary) and 90% of the care homes sample (80% private, 10% voluntary) being from the independent sector. Local authority domiciliary care represented 8% and care homes 3% of the sample. Some 6% of the care homes sample was from other than elderly (‘LD’, ‘MH’, ‘YPD’). The information collected on domiciliary care showed a more mixed pattern with 21 out of the 26 providers covering more than one category (‘OP >65’, ‘PD’, ‘SI’, ‘MH’, ‘LD’, ‘Dem’, ‘AD’, ‘TI’). Again, this showed the sample being representative of the provider population.
Summary of findings

*Safeguarding incidents:* 9% of care homes reported a Safeguarding Incident in the previous 12 months; 42% of care homes with nursing did, as did 55% of domiciliary care respondents.

*CQC ratings:* 92% dom care and 78% of care homes in the sample were 'good' or 'excellent' according to CQC.

*Provider types:* 77% of dom care were “large” by CQC definitions; 20% of the sample of care homes were smaller homes, with 10 or fewer beds (37% had 10-29, 21% 30-39); 90% of the care homes sector were preferred providers as were 62% of the dom care respondents.

*Quality mark:* 70% of dom care and 89% of care homes said they had a quality mark (IIP, ISO, or RDB), the main one, by far, being IIP (there was no distinction made in the survey between the two levels of IIP).

*Awareness training:* 58% of respondents from the care homes sector and 65% from the dom care sector said they had been on awareness training in the last year.

*Guidance:* Almost 9 out of ten (overall) reported they had a copy of the LCC Safeguarding Adults guidance, the majority (more than 7 out of ten) finding it helpful.

*Suspension policies:* 80% of domiciliary care and 90% of care homes had their own suspension policies that they reviewed (usually, annually).

*Recognition of abuse:* All of the domiciliary care respondents and more than 8 out of 10 care home respondents said they felt it relatively easy to recognise abuse and distinguish it from issues of good and bad practice.

*Domain satisfaction ratings*

The questionnaire covered four domains eliciting views on information, training, advice and support, and experience of the management of safeguarding incidents. The sample showed high levels of satisfaction with information and with advice and
support, more than 7 out of 10 saying they were very satisfied, less so with training, satisfaction levels falling just over 50%, and falling further when considering satisfaction for the subsample with recent experience of a safeguarding investigation.

### Table 1. Domain satisfaction, Care Homes, All

<table>
<thead>
<tr>
<th>Ratings %</th>
<th>Info/ Pols</th>
<th>Training</th>
<th>Supp / Adv</th>
<th>Exp'ce of Inv</th>
</tr>
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<td>Not satisfied</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>32</td>
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<td>Mixed/ some satis</td>
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<td>32</td>
<td>13</td>
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<tr>
<td>V satisfied</td>
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<td>2</td>
<td>5</td>
<td>0</td>
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</table>

| Sample n.         | 91         | 91       | 91         | 22            |

### Table 2. Domain satisfaction, Domiciliary Care

<table>
<thead>
<tr>
<th>Ratings %</th>
<th>Info/ Pols</th>
<th>Training</th>
<th>Supp / Adv</th>
<th>Exp'ce of Inv</th>
</tr>
</thead>
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<tr>
<td>Not satisfied</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>Mixed/ some satis</td>
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<td>0</td>
<td>7</td>
</tr>
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</table>

| Sample n.         | 26         | 26       | 26         | 15            |

The profile was similar across the whole sample with those who’d had experience of investigations having lowered satisfaction levels. This directed the Reference Group to explore the issues through Focus Groups (see below).

Figure 1 Comparing Domains (Care Homes, All)
Care homes and domiciliary care surveys – Free text analysis, selected questions.

There were some free text responses which asked providers what would help with managing Safeguarding and what would address their main concerns as a provider. There were no substantial differences between the domiciliary and residential samples, and the findings are summaries together. Answers fell into 9 categories shown in rank order based on frequency (Table 3).

**Table 3. Free text: what would help?**

- **Staffing issues:** to be able to have higher staffing levels; better pay and conditions for staff; more time for more face to face contact staff-resident; to be able to use temp staff less; better qualifications for staff
- **Guidelines:** clearer guidelines / screening tools.
- **Training/learning:** more time to organise training; staff with higher competency levels; timeliness and updating; more joint learning opportunities;
- **Communication / information:** better communications; one central point for genuinely independent, balanced, informed, advice; ‘phone a friend’ ("rather than an enemy!") for advice on alert;
- **Planning:** more joint; more shared; more forward planning; ("too much comes at you too late/too quickly");
- **Culture:** to build a culture of trust (provider/commissioner); less of a punitive approach, more
appreciative of the pressures on providers (esp SME); more appreciation and understanding of challenges faced by providers; natural justice issues (workers and employers have rights, too); the 'accused' has rights;

*Interface*/ work-*ing with others*: better cooperation from hospitals; better understanding on their part of the role of the registered manager;

*Policy*/ implementation: Overlapping: DOLS, more clarity re DOLS and Safeguarding; greater appreciation from authorities of initiative overload and initiative synergy/ dissonance;

*Funding*: better funding for the sector.

There were also more general concerns around fee levels and funding and the impact of personalisation/ direct payments on the domiciliary care market, a call for greater clarity in commissioning; and at a personal level, recognition and respect for providers.

As with the care home sample, most domiciliary care respondents (see table 2 above) were largely satisfied with three of the four key domains rated for satisfaction: ‘information’, ‘advice and support’, and (although less so) ‘training’, but domain satisfaction ratings also dropped substantially for that subgroup who had ‘experience’ of Safeguarding incidents.

This directed the team to the need to explore the area of provider experience in more detail. We set up two focus groups one with care homes and one with domiciliary care providers. Note: the aim is to follow up a year on, resources allowing.

**FOCUS GROUPS (group n. = 8-10)**

The two focus groups (care homes group, domiciliary care group) were notable for their similarities on the substantive concerns are so are reported on together here. Each group was facilitated by two researchers with an observer and note-taker). The session was conducted in line with the 'Introduction and Background' information on the 'topic guide' drawn up with the Reference Group earlier.

All attendees had had recent experience of Safeguarding investigations. All attendees
were Registered Managers or equivalent. The groups were aware of local policies and *No Secrets* guidance.

There were 7 Topic Areas on the facilitator’s Topic List: (1) experience of Safeguarding meetings; (2) defining Safeguarding; (3) the ‘culture’ of Safeguarding; (4) communication; (5) working with others; (6) good practice pointers, and (7) ‘magic wand’ valedictory question.

**Summary of Topic Areas:**

**(1) Safeguarding meetings: “...no one expects the Spanish Inquisition.”**

The role of the Chair: “The Chair is very important. The meetings can be very different according to who is chairing and how they do it.” Chairs, it was said, can help maintain fair ‘due process’ under pressure which can get lost if managed poorly - “It all went pair shaped.... It was like the Spanish Inquisition.”

The secret ‘professional’ pre-meetings were a source of concern. Opaque and inscrutable, their role and legitimacy were subject to question. One example was given of when the formal Safeguarding meeting was starting, immediately following a private (“secret”) pre-meeting (excluding the provider), “You could have cut the atmosphere with a knife.”

The process can become quasi-judicial with no clarity of process. “I felt like I was on trial and had already been judged.” “The blame heaped on the company was dreadful.”

The impact on staff and on the home atmosphere can be substantial and may not be clearly appreciated. “We had a problem between two residents (both with dementia) which became a safeguarding issue...The police turned up and said 'are you having a laugh?' Social services were very nasty about it” (said to a 'hear, hear' chorus around the group).

It was felt that there was some significant structural bias against providers in the process. “You knew their thinking was “We'll denigrate this company whatever.” (nb
again, 'hear, hear'). There was no appreciation of the impact on innocent staff e.g., one was arrested and spent 9 hours in a cell .. “and the police took from Feb to Dec to find that there was no case to answer.”

There was some significant lack of clarity around who was responsible for organising Safeguarding meetings. “We were expected to organise it all. We were doing all the running. They kept cancelling.”

Examples of bad chairing included notes purporting to be minutes of the meeting, and put into circulation across the agencies involved as such, which were solely the chair's own views with no 'confirmation' process, laxity over distribution and no appreciation of potentially libellous statements.

User involvement – often service users may know little or nothing about the safeguarding investigation being conducted in relation to them. There were issues of user consent (and related capacity questions). “This doesn't happen.” “The machine takes over.” “A lot of people receiving our support couldn't give consent.”

The type of abuse attracts a differential response. It was strongly felt that local authority staff were not motivated to deal with service-user-to-service-user 'abuse' because this does not fit the preset 'institutional abuse' template of perpetrator (provider) and victim ('user’) but something rather more complicated and layered in its interpretation. It was equally certainly held in the group that local authority staff were not motivated to deal with financial abuse. This reflects the rather firm prejudices held across sectoral boundaries between the public sector and private sector.

But there were examples of good practice. “The one I was at yesterday went very well. There was no blame. Minutes of the meeting were taken and circulated promptly.” The Focus Group worked through, in the session, what a model chaired meeting involved. A model meeting...

...is non-judgemental
...is open, encouraging all to speak
...involves risk assessment, of action and inaction
...involves users appropriately
...works to foster a culture of care and partnership rather than a culture of fear
...follows a standard procedure.

(2) Defining and contextualising Safeguarding

Demarcation: It was felt strongly that the lines between genuine alerts and other 'problems in living' were very blurred

Advice: It was also felt that there was no way of getting balanced independent advice about a borderline issue as the mere asking of the question to local authority staff would result in it becoming a safeguarding case.

Inconsistency: Providers had experience of the same sort of incident being handled very differently according to who deals with it within the local authority.

Escalation: “Stuff that would have been more to do with complaints are now safeguarding.”

Hospital sector: Hospitals, it was felt, have little knowledge of when something is or isn't appropriately a safeguarding issue and it was felt that somehow there is a perception that safeguarding cases can only happen in a care homes or the private sector. There does not seem to be any acceptance that some behaviours in relation to older people was abusive.

System skew: There is also the danger of skewing resources towards formal services and away from familial abuse, towards care homes and away from other services. Also, commissioners, who may have clear responsibility for the quality of a service by how they commission seem to be completely outside any scrutiny (reinforcing, perhaps, the latent aspects of the processes - “You can't refer piss-poor commissioning into Safeguarding.”)

Personalisation: The issue of how safeguarding will be addressed in the context of the personalisation agenda (with personal budgets becoming more mainstream as a means to buy care) and the differential impact on the preferred provider market is a great worry. The worry is that only one part of the market carries the regulatory burden, with more leeway given to those with their own budgets to do as they will unrestricted in
any comparable way.

Worker rights: Dealing with challenging behaviours and mental capacity issues. There are safeguarding issues for staff, too, especially when working with the most challenging clients.

Impact: There is little appreciation, it was evidently felt, of the impact on a business (financial, morale, time) when a member of staff is suspended and no appreciation of the impact on the worker (psychological, emotional) who, natural justice would dictate, is innocent until proven guilty; there is little concern in the system for the length of time investigations take, compounding those effects. There also needs to be consideration of the broader effect on the motivation of the workforce and the effect on recruitment and retention from a culture where safeguarding is not about protection of the vulnerable but a power game between stakeholders or sectors. Businesses operating on narrow margins will be more likely to fail or have limited resources unnecessarily exhausted. There needs to be a cost analysis of the impact of safeguarding on business.

Employers: “There's also insufficient awareness of the legal framework of employment law..” that providers operate within. “I was told ‘You must suspend your member of staff’. I tried to explain employment law and the possibility of a tribunal but it was not possible to discuss options” (e.g., removal/ managed risk).

(3) Culture: ...of fear?

Providers are pre-judged, they feel. Often they do not know what information informs judgements and are anxious of a whispering culture that is structurally biased against providers and the private sector, in particular. To what extent this paranoid set is founded in reality is a moot point but that it is believed firmly and shared is tangible. The relationship between independent sector provider and the local authority commissioning and assessment staff involves dealing with stereotypes about 'self' and 'other' but the 'whip-hand' is the local authority's. The danger was expressed as a punitive culture which shows little characteristic of the 'co-production' implicit in the notion of “Everybody's Business”.
The whispering influence is feared by providers who are reliant on Social Services staff for referrals – no matter what is said about customer choice in reality, it was said, social workers do influence who relatives go to in residential services, and in domiciliary it can be more significant. This means there is fear, threat and prejudice at this key interface, it was felt.

“Establishing the right culture is crucial.” This requires the right sort of leadership and process audit. “It's not easy. If it were easy we wouldn't be where we are. It's just a matter of how you deal with that difficult situation.”

(4) Communication: ‘It’s good to talk.’
Communication was originally a separate topic for the topic list but became more of a continuous thread running through the other topics. Providers feeling excluded at key points through the Safeguarding process being the predominant view of the group. Not seeing draft minutes and being able to comment/correct inaccuracies were seen as breaches of natural justice. Provider 'exclusion' from the whole process became the issue.

(5) Working with others: Is it really ‘Everybody's Business?’
“This should be a partnership”. “We don't want it [abuse] to happen either.”
“You can't say stuff to social workers.” There is, the perception, that an informal 'blacklist' can be applied if you 'get on the wrong side' of a care manager/social worker. “Bad news travels fast” and your reputation can be damaged without you even knowing about it because of clandestine channels of informal information that is not subject to scrutiny or balance.

'No Secrets' is almost, it was viewed, an ironic phrase when looking at provider experience of a process which is perceived to be very much about secrets and the abuse of power associated with mishandling information and processes and thus skewing the system away from a shared challenge towards an unjust quasi-judicial procedure. Stereotypes it was felt that should be challenged were that Safeguarding is just about care homes or just about the independent sector rather than any other players.
Managing a complex system can be more effective working as partners. There is the threat of chaos in the system (lack of clarity over what is a 'safeguarding' case, different practices in different areas, fear/prejudice driving processes) and there is too much mystery/secrecy in the whole process (e.g., secret pre-meetings, blame-shifting culture, manifest and latent power processes, information vacuum).

There are perverse drivers in the system in relation to reporting incidents e.g., CQC’s interpretation of incident reporting as a negative outcome (a measure of bad care) rather than a positive one (a measure of commitment to tackle bad practice). “For CQC, the number of alerts is taken as measure of problem within a service.” One service reported they had had a letter from CQC raising questions about the number of safeguarding alerts involving their agency. “This is the wrong way round. A good service deals openly with safeguarding. Good services are more open, deal with bad practice properly and are likely to report more. Poor services will hide them.” However, the punitive response from CQC will cause providers to become defensive.

(6) Good practice pointers

Chairing: Chairs of Safeguarding meetings need to be competent and be motivated to ensure that processes are open, inclusive, fair, and sensitive and follow a standard process.

Protocols: Meetings must have common, agreed, explicit processes (e.g., on who’s invited, management of open/closed sessions, minute-taking and drafts circulated before finalised.

Training: More joint learning events and joint training urgently required and on a rolling basis.

(7) Magic Wand question – If there was just one thing you could change what would it be? (roundtable, one response each)

Group 1

• “consistency”
• “advice on whether something is safeguarding or not” ('phone a friend' option)
• “audit what's going on.. badly needed..”
• “formal meetings with common, explicit, format”
• “no blame culture”
• “protocols for shared practice / review”
• “joint training”.
Group 2

- “..engagement as a partner”
- “..timeliness in the whole process”
- “..fair and objective due process”
- “The focus should not be on blame (which it is); it should be on safeguarding”
- “CQC and Commissioners need to look carefully at how they treat bald statistics on safeguarding”
- “..'them' listening to ‘us’”
- “..respect.”

**Action Research process: research > reflection > 're-action'**

As a result of the information back from the research, the project reference group (Chaired by the Head of Safeguarding) made recommendations to the Social Care Partnership and the Safeguarding Board around principles and practice issues:

- A shared framework of explicit principles guiding Safeguarding in Lancashire
- A clear, joint, statement to affirm the shared intent to deliver safe care and support.
- An urgent review of the protocols and principles around secret pre-meetings
- Protocols and guidelines to be developed and disseminated to ensure good practice in decision-making panels
- Timely and useful management information
- Ongoing training for staff and Registered Managers
- Clearer synergy with other policy (e.g., DOLS/ MCA)
- Ongoing, effective, joint management through the Safeguarding Board and evidence-based approaches (such as the Safeguarding research project) to aim for effective Safeguarding service users and making best use of resources.

The most visible recommendations were around a Joint Statement and Joint Protocols around investigation which were launched at a ‘Learning Together’ event held on World Elder Abuse Awareness Day.

At the time of writing the Head of Safeguarding post was disestablished as part of
service reviews in place arising from the economic crisis and its impact on local government funding.

**Discussion**

This has been an account of the setting up of a inter-sectoral Reference Group in the context of the Lancashire Safeguarding Board and the Social Care Partnership, an established forum for the independent sector to work with the local authority on strategic approaches to planning social care. The aim was to explore the new Safeguarding procedures and processes from the point of view of the independent providers so that a partnership approach would help deliver what a partial approach might not. The aim is to include the very disparate provider sector as an effective and constructive stakeholder.

The multiple methods action research project produced recommendations for the management of investigations, sharing core principles, contributing to the ‘Learning Together’ approach, but with recognition that the majority provider, the independent sector, needs to be engaged and that there are specific strategic and inductive approaches that can help this work rather than the traditional top-down authority to authority strategic plan.

It is recognised by the parties to the project that Safeguarding is not something separate or peripheral. It is at the core of everyday care. The Safeguarding procedures need to be inclusive to be effective. The process needs to be robust but also just. The ‘Safeguarding - Everybody’s Business’ research project, in its immediate local joint working context, resulted in a set of recommendations for action, including jointly shared public statements and auditable protocols around investigation (involving the officer side of the council as well as the political side through the relevant Cabinet Member and the independent sector) and represents an concerted attempt, arising from some years of effective partnership working between the council and the independent sector, to create a genuine learning environment and an evidence-based approach to local systems management.

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Appendix

Safeguarding in Lancashire – Everybody’s Business Reference Group (Reporting to Social Care Partnership and to Safeguarding Board, Chair: Dr. Margaret Flynn)

Dave Wareing, Head of Safeguarding, LCC, Chair
Barbara Campbell, NLPCT
Marie Hill, Cornmill NH (& Director, LWDP)
Liz Leung, Business Support Unit, LCC
Dilys MacDonald, LCC
Brian Monk, LCC
Ann Mylie, LCC
Steve Newton, Director, LCA
Paul Simic, CEO, LCA
Mike Walker, Business Support Unit, LCC

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