2017

A Service Evaluation of Coventry Adult Services Department's Response to Making Safeguarding Personal (MSP)

Christina Palmer, Linda Martin and Gary Spolander

Coventry University

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Executive Summary

This small-scale study was commissioned by Coventry Adult Services Department to evaluate an initiative to develop aspects of practice regarding Making Safeguarding Personal (MSP). The Department prioritised assessing Best Practice and Mental Capacity, implemented a training initiative for all staff involved in these assessments and revised the information leaflet provided for service users in respect of safeguarding assessments.

The research team analysed management data regarding safeguarding adults' assessments for two periods, each of two months' duration. A further questionnaire was distributed to participants and completed before the start of the training event, to ascertain their perceived levels of knowledge and confidence in practice. A follow-up questionnaire was distributed three months after the training event.

On completion of the training, separate focus groups for advocates, case workers and managers were also arranged to provide a more detailed view of their experience. These were attended by four advocates, seven case workers and six managers.

The key findings from the evaluation were:

Questionnaires

Since the training events there has been a significant increase in the distribution of the information leaflet.

According to staff, a greater proportion of service users have reported finding the new leaflet useful compared with the old leaflet.

More case workers also reported that they explain the leaflet to service users since the training took place.

Although the proportion of participants reporting adequate or above levels of knowledge of Mental Capacity did not change, the higher levels of knowledge increased within this range.

Just over half of the participants reported a change in their practice of assessing Mental Capacity post-training.

Knowledge of assessing Best Interests was significantly higher post-training.

However, less than a third of participants reported a change in their practice of assessing Best Interests.

A high level of confidence was reported both pre- and post-training in relation to assessing when to involve an advocate. Just over half though reported a change in practice following the training event.

Advocates' focus group

From the advocates' perspective, their involvement hinges, to a large extent, on individual case workers: their knowledge of the legislation, understanding of the advocates' role, and empathy with the service user.

They considered that a shortage of resources was also likely to impact on the case worker's decision regarding their involvement as their role added a layer of complexity to the assessment that a case worker may prefer to avoid.

The advocates' key concern was the timeliness of referrals. From their experience referrals were sometimes late and tokenistic, with unrealistic expectations of the work they could complete in the timescale set by the case worker.

They were seeing an increase in the number of referrals made to them, although this was slower than desired. While this may have been attributable to the training to some extent, they believed that the promotional and support work that they undertook with case workers had influenced this increase. This was coupled with a concern that this work may not be the best use of their time.

They suggested that practice could be further improved through more use of management data and development of clear protocols for case workers.

Case workers' focus group

Overall, the case workers thought the training initiative had been useful, particularly for less experienced workers. It had provided an opportunity to reflect on their practice and for some this resulted in changes,

A shortage of toolkits and leaflets was a concern. The toolkit was received very positively and more hard copies would be welcomed.

While the leaflet was seen as a significant improvement on the previous leaflet, case workers felt that professional discretion was needed to determine distribution. Sometimes explaining the leaflet was more appropriate and effective.

The case workers were positive about the prospect of the assessment forms being revised and felt it was important that these should support professional practice.

They voiced some of the advocates' concerns about the difficulties of timely assessment, but thought that managers were increasingly emphasising the importance of making referrals.

They also had concerns about the impact of Agile working, as isolation increased and access to support decreased. It was, therefore seen as important for training and supervision to take account of these changes.

While the case workers felt that there was still a good level of training provision, they would recommend more training on complex issues relating to safeguarding practice.

Managers' focus group

Managers involved in the focus group felt that the increased emphasis on putting the service user at the centre of safeguarding interventions and taking an individualised approach was the most predominant learning point from the MSP training. A healthier balance between the service user, timescales and processes appears to have been one of the key changes the training has initiated.

Improved recording was also highlighted as a further impact of the training, particularly in relation to recording discussions and decisions about Mental Capacity and Best Interests. There was a perception that although the training hadn't necessarily improved practice in assessing these, workers appear to have demonstrated improved confidence within this area following the training.

Participants who attended the training appeared to have also welcomed the opportunity to share their practice experience and discuss issues relating to autonomy and risk. Focus group participants noted following the MSP training, workers appeared to be more confident in supporting service users to make choices and supporting them to manage risk (where appropriate) rather than to taking a more paternalistic approach.

The MSP training appears to have increased awareness of the availability and range of advocates that can be involved in safeguarding interventions to provide independent support to service users. There was a view from the managers involved in the focus group that advocates should and would be used more frequently and discussions regarding this would take place more often.

The new leaflet was seen to be useful but there appear to be many challenges in providing service users and their families with leaflets. These include the service user's particular situation, if they are able to read or if they want to read the leaflet etc. No improvements to the current (new) leaflet were identified.

Participants in the MSP training appeared to have welcomed the opportunity to discuss the challenges of safeguarding, assessing Mental Capacity and Best Interests. There was a view that the momentum created by the training should continue with, for example, group action learning sets and MSP being part of individual supervision sessions between workers and their line manager. However, a challenge for group learning appears to be remote working and how this impacts on team members spending time in both formal and informal (i.e. ad hoc discussions taking place in an office) learning activities. There also appear to be some workers who would like greater 'formal' learning opportunities (i.e. courses) to undertake more in-depth safeguarding training.

Management data set

Given the limited data available no significant trends were able to be identified.

Recommendations

Senior Managers

Continue to proactively evaluate management data in respect of MSP, so as to identify trends.

Use the data presented here to inform further training provision in respect of safeguarding practice; recognising the benefits of group learning.

Ensure that the revised assessment forms take account of the concerns expressed by participants of this study.

Continue to monitor the impact of Agile/remote working on awareness, knowledge and confidence of workers in this field.

Ensure ongoing and regular management data systems be developed and utilised to monitor progress and identify any changes.

Service Managers

Assess the benefit/need for group/peer supervision to embed good practice, in particular for inexperienced and remote workers.

Take the lead in ensuring appropriate and timely referrals for advocacy.

Ensure an adequate supply of tool kits and leaflets are available.

Case workers

Take responsibility for ensuring they have up to date knowledge of resources and developing practice.

Review personal learning from the training event and highlight further

development needs in consultation with line managers.

Acknowledgments

The research team would like to give grateful thanks to all of the people employed by Coventry City Council who participated in focus groups and completed questionnaires, and to the advocates who participated in the focus group.

They would also like to thank Maria Pountney for organising the focus groups.

Additional thanks go to the data analysts who contributed to the report, Simon Goodman and Carlo Tramontano

Finally, we would like to thank Jill Ayres and Parbinder Johal for asking us to undertake this evaluation and for the support they have provided to us throughout the project.

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1. Introduction

The intention of this service evaluation was to appraise an initiative by Coventry Adult Services Department to improve their response to adults experiencing safeguarding issues in accordance with MSP (MSP). Initially funded by the Towards Excellence in Adult Social Care (TEASC) Project Board, the Social Care Institute for Excellence (SCIE) and the Local Government Association (LGA) in 2012-13, the MSP initiative was adopted by 53 local authorities in an attempt to improve the support to people making difficult decisions by using person centred and outcome centred approaches. A toolkit devised by the LGA highlighted eighteen aspects of practice that are important in securing positive outcomes in safeguarding practice with adults. To achieve the highest standard, a local authority must evidence its practice in relation to two of the eighteen key areas and provide an independent evaluation of its practice in these areas. Coventry Adult Services Department selected the areas of assessing Mental Capacity and Best Interests.

The purpose of this evaluation was to:

- assess the impact of Coventry Adult Social care MSP project and learning initiatives in response to the MSP Agenda
- Review perceptions of key staff on the impact and challenges to the MSP implementation

Objectives

The agreed objectives for this study were:

- To gather pre- and post-MSP training data and analyse this baseline data regarding current practice in relation to key areas of MSP practice:
    - MSP Workers understanding and perceptions of MSP implementation
    - Impact of MSP learning on professional practice in Coventry City;
    - The perceptions and use of MSP literature/ leaflets in practice, and
    - Through the use of three focus groups (post MSP training) to understand the perception, use and impact of NSP processes by social workers, their managers and paid Coventry City advocates.
- Review existing anonymised Coventry City Council management data.
- Evaluate the impact of the local authority's MSP project and

learning interventions in respect of these areas of MSP practice.

- Inform the city council of implications of the findings and possible future considerations.

2. Background literature

The first policy response in England to the abuse of adults was 'No Secrets' (Department of Health (DoH) and Home Office 2000) which defined abuse and neglect and proposed a multi-agency response to this increasingly evident problem. Since then the statutory response has developed with the establishment of Safeguarding Adults Boards and the embedding of the lead role within Adult Services (Graham et al. 2014). In spite of this rapid development, research indicates that service users are often excluded from the investigation and decision-making processes (Cambridge & Parkes 2004, Fyson and Kitson, 2012 and Graham et al. 2014).

MSP is a sector led initiative responding to concerns that adult care had too heavy a focus on procedure regulation and performance management (LGA 2011) and paid insufficient attention to the experiences of adult service users and carers (LGA 2011, Manthorpe et al. 2014 and Williams 2013). A significant point of departure came in 2010 when Lord Justice Munby delivered his keynote address to the LGA Community Care Conference (Munby 2010) and stated:

'The fundamental point is that public authority decision-making must engage appropriately and meaningfully both with P and with P's partner, relatives and carers. The State's obligations under Article 8 are not merely substantive; they are also procedural. Those affected must be allowed to participate effectively in the decision-making process. It is simply unacceptable – and an actionable breach of Article 8 – for adult social care to decide, without reference to P and her carers, what is to be done and then merely to tell them – to "share" with them – the decision.'

Welcomed by many working in adult social care this stimulated a joint response from professional organisations across the country and resulted in a 4-site project that has since expanded to incorporate many local authorities across the country. Central to the shift in approach is placing the service user at the heart of safeguarding practice, informing and empowering the service user to be involved in sometimes difficult conversations in order to engage in complex decision-making. Given the challenges of frailty and Mental Capacity this requires more than a tokenistic acknowledgement of MSP and local authorities are rising to the challenge as evidenced by the evaluation report of 2014-15 (Pike & Walsh 2015). The importance and the challenges of making service user involvement meaningful are addressed by Redley et al. (2015) and it is

noteworthy that the MSP evaluation (Pike & Walsh 2015) reported that the area of Mental Capacity and Best Interests is one of the most common aspects of MSP that local authorities have chosen to work on.

The evaluation focused on three areas of impact: outcomes for service users, ways of working and partnership working and culture change. At the point of evaluation many local authorities were still in the early stages of implementation but even so some interesting findings were reported: practitioners had been challenged to think differently about how to prepare service users for meaningful involvement and how to involve carers and advocates when appropriate; workers also reported a cultural shift to a more person-centred and empowered approach. They acknowledged that for some, the changes had been more challenging than they had anticipated and engaged them in some difficult conversations, but they also felt it improved practice and raised morale (Pike and Walsh 2015).

A number of organisations have reported on their own experiences of implementing MSP, such as the London Borough of Sutton, whose evaluation reported that service users highlighted the importance of being listened to and being able to communicate regularly with the same person, while practitioners thought the initiative increased their effectiveness, transformed relationships and developed their practice skills (Hopkinson et al. 2015); findings supported by Cooper et al. (2015).

Pike and Walsh (2015) noted that at the moment local authorities are acting in isolation from each other and a clearer leadership was required. Large organisations and those with more referrals are finding the changes more challenging than smaller ones, where specialist teams are often in place; and multi-professional working presents challenges as it does in relation to all aspects of social care practice. However, there is a growing hub of activity and commitment in relation to MSP and it is currently providing the momentum to bring about some positive changes in adult social care practice.

3. Methodology

3.1 Introduction

This study was based on pragmatic ontology, recognising the need for base line data provided through quantitative and qualitative measurement (questionnaire's and the local authority's management data set), followed by qualitative data collection through focus groups, in order to determine the impact of the local authority's intervention. It is an explanatory sequential design, using the quantitative data to inform the interpretation of the quantitative data (Creswell and Plano Clark 2011).

3.2 Data collection

3.2.1 Management data

The research team were given access to the anonymised management data set routinely collected by the local authority in respect of safeguarding referrals and Mental Capacity assessments. This data formed part of a generalised picture of current practice.

3.2.2. Questionnaires

A coded hard copy questionnaire was distributed to all course participants prior to the learning interventions. It asked participants to comment on their current knowledge, understanding, confidence and experience of the two key areas of MSP being evaluated through this project. The questionnaire was completed confidentially, with the City Council not having access to the questionnaire returns of their staff. It was expected that in the region of 100 returns would be completed. A hard copy follow-up questionnaire was sent by post (coded to maintain confidentiality) three months after the training was completed. The timescale allowed staff the opportunity to apply their learning in their professional practice. Blank copies of the pre- and post- training questionnaires, consent form used and information sheet given to participants can be found in the appendices section of this report.

Questionnaires with the appropriate ethical approval from Coventry University were provided to participants pre-and post MSP training. A total of 107 MSP participants received the questionnaire. Out of them:

- 47 (43.9%) provided consent at both pre- and post-training;
- 36 (33.6%) provided consent at pre-training;
- 9 (8.4%) provided consent at post-training;
- 15(14.0%) did not provide consent either pre- or post-

training and as such were excluded from analyses.

Consequently, this resulted in a data set that comprised of 92 participants who, had provided their consent to participate.

Out of the 92 participants, 71 (77.2%) filled the questionnaire both before and after receiving the training, while 21 (22.8%) only filled the questionnaire before the training. Individuals were not tracked pre-and post-training.

Results of the questionnaire analysis are presented in both periods i.e. pre-and post-training.

3.2.3. Focus groups

The involvement of individuals in the research study has been voluntary. All participants of the caseworker and manager focus groups were drawn from those who undertook the training and completed questionnaires. Participants were initially recruited by Coventry Adult Social Care from their groups of staff who had agreed to participate. They were provided with a participant information sheet by Coventry Adult Social Care and there was no contact with the research team unless they indicated a willingness to participate.

Three focus groups of training participants were arranged: two comprising case workers and a one of managers. A focus group of advocates, who had not received the training, was also arranged. The purpose of this group was to provide an understanding of issues relating to MSP from their perspective.

Four people participated in the advocates' focus group, six in the managers' group and a total of seven across the two caseworker groups.

3.3 Data analysis

The quantitative anonymised questionnaire data has been analysed through comparison of Likert scales as well as thematic analysis, in order to provide individual perceptions of the impact of their training and the MSP documentation. This evaluation has provided an indication of individual perceptions prior to training and then three months after training.

The qualitative and quantitative data (both pre-and post-intervention, including data collected through focus groups) was analysed using thematic analysis.

3.4 Ethics

This project aims did not involve vulnerable participants in any of its data collection processes or enable access to any of their confidential data. No

participants in the focus group are considered to be vulnerable and the research team had no access to service users, their carers or their case files. All participants were given participant information sheets and completed consent forms.

Ethical approval was successfully sought from Coventry University (Project P45121)

The project has been conducted in line with the British Psychological Code of Conduct, the HCPC Standards of Proficiency for Social Workers in England: http://www.hpc-uk.org/assets/documents/10003B08Standardsofproficiency-SocialworkersinEngland.pdf and Coventry University Ethics procedures.

Additionally, Coventry Adult Social Care Services will approve the project through their own management processes.

All data have been held securely, coded and in full compliance with all UK and EU Data Protection and Coventry University Ethical Protocols. Data will be held for a maximum of 3 years following the completion of the study.

4 Findings

4.1 Safeguarding adults' management data

Management data from Coventry City Council has been presented in this part of the report. Whilst these data have been presented in a comparative form, caution must be exercised in their interpretation and the conclusions that can be drawn are limited at this stage for two reasons:

- The relatively short time series from which the data is drawn i.e. 2 three consecutive month periods and the relatively small data set
- A revised data capture form for the start of the safeguarding process (SA2) was launched on 1st November 2016. This revised the mandatory fields and added further MSP wishes options 'Adult/representative was asked but did not state any wishes' and 'Adult/representative was not asked for their wishes'

A longer data series will be necessary to understand whether there are other factors that are unaccounted in the data such as seasonal variations.

Between 1 April and 30 June 2016 there were 223 concluded Safeguarding (Section 42) enquiries as against 226 between 1 September & 30 November 2016.

This data is presented in table form below.

4.1.1 Wishes

The number of concluded enquiries, where one or more wishes have been recorded at the start of the safeguarding process:

a. Between 1 April and 30 June 2016

Wish captured	81	36%	161	72%
Wish captured was other (not a pre-determined wish)	80	36%		
No wish recorded	62	28%		
Total	223	100%		

b. Between 1 September – 30 November 2016

Wish captured	89	39%	176	78%
Wish captured was other (not a pre-determined wish)	87	38%		
Person asked but did not express any wishes	12	5%		
Person was not asked	6	3%		
No wish recorded	32	14%		
Total	226			

Of the 161 enquiries where a wish was recorded, those wishes were achieved at a level of 45% (73). Of those enquiries where wishes achieved were recorded, the majority of wish(es) were fully or partially achieved.

a. Between 1 April and 30 June 2016

Fully Achieved	37	51%
Partially Achieved	13	18%
Total	50	69%

b. Between 1 September – 30 November 2016

Fully Achieved	44	58%
Partially achieved	20	26%
Total	64	84%

4.1.2 Capacity

a. Between 1 April and 30 June 2016

Capacity to be assessed	55	25%
Has been assessed as not having capacity	53	24%
Has capacity about the safeguarding incident	106	48%
Capacity not recorded	9	4%
Total	223	

Of the concluded enquiries (223) the capacity of the adult, recorded at the start of the safeguarding process was 97%.

b. Between 1 September – 30 November 2016

Capacity to be assessed	50	22%
Has been assessed as not having capacity	85	38%
Has capacity about the safeguarding incident	91	40%
Capacity not recorded	0	0%
Total	226	

Of the 53 assessed as not having capacity, those enquiries where an advocate was identified at the start of the safeguarding process.

a. Between 1 April and 30 June 2016

Advocate identified	30	57%
Advocate not identified	23	43%
Total	53	

b. Between 1 September – 30 November 2016

Advocate identified	72	85%
Advocate not identified	13	15%
Total	85	

Of the 85 assessed as not having capacity, those enquiries where an advocate was identified at the start of the safeguarding process, was 85%:

a. Between 1 April and 30 June 2016

Advocate identified	26	47%			
Advocate not identified	29	53%			
Total	55				

Of the 55 whose Mental Capacity was assessed, those enquiries where an advocate was identified at the start of the safeguarding process.

b. Between 1 September – 30 November 2016

Advocate identified	26	52%
Advocate not identified	24	48%
Total	50	

Of the 50 capacity to be assessed, those enquiries where an advocate was identified at the start of the safeguarding process.

4.1.3 Summary

The management data provided for this evaluation study must be treated with caution. The time periods compared are in close proximity and by considering only two periods of time it is not possible to establish patterns or trends.

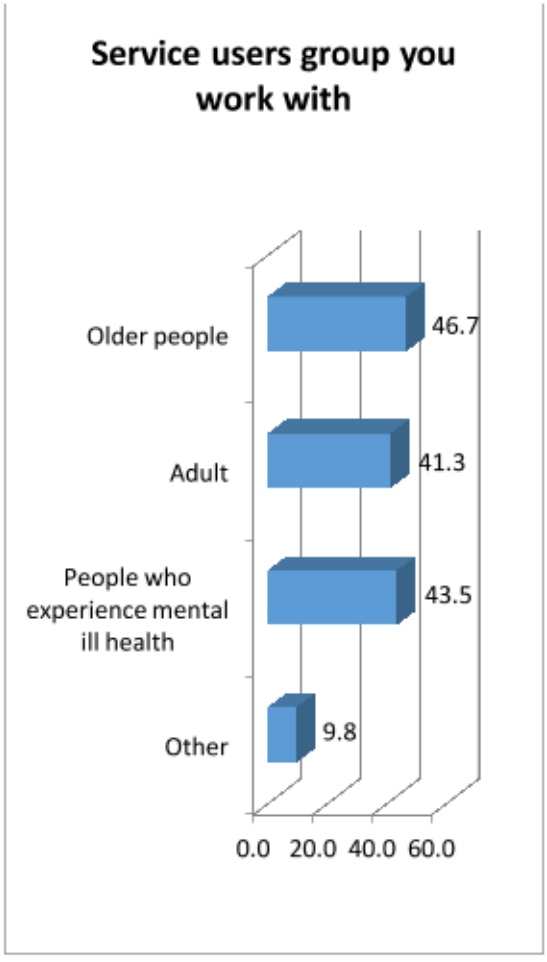
Coventry Adult Services Department may, therefore, choose to use the data here as a starting point and continue analysis over a longer time scale to discern future trends.

4.2 Questionnaire Data

Results of the questionnaire analysis for both periods, i.e. pre-and post-training, are presented here. In total, 92 questionnaires were completed.

Participants were required to indicate what the most prevalent service user group they work with (Q1). Results are summarised in Figure 1. Please note that participants may work with more than one group, as a result the percentage does not add up to 100%.

Figure 1



The 9 participants (9.8%) indicating the option "Other" specify the following:

Figure 2 'Other' service user groups

18-21 / Memory Clinic	1
18-21 IPN	1
All age from 16 onwards	1
Money Service - 18 years (people who have cognitive impairment)	1
Children	1
IPU 18-21	1
Learning Disabilities	2
Memory Services – Adults	1
Total	9

Participants were asked to identify their job role (Q2). Responses were coded as not mutually exclusive to acknowledge the possibility of respondents covering more than one specific role.

Figure 3

The 38 participants indicating the option 'Other' further specified their response as follow:

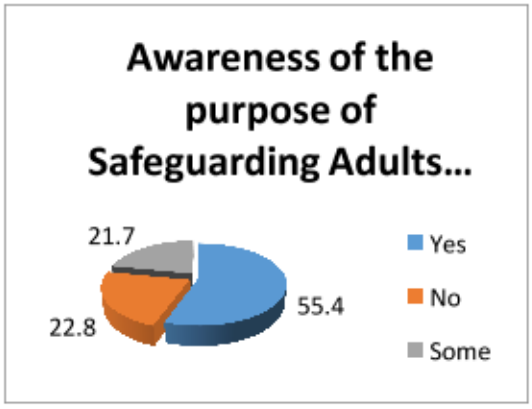
Figure 4 'Other' job roles

Assistant Psychologist	1
Clinical psychologist	1
CM + IN	1
Community Care Worker	3
Community Case co-worker	1
Community Case worker	4
Community Mental Health Nurse	2
Community Nurse	1
Community Support Worker	1
CPN	11
Nurse	4
Occupational Therapist	5
OT/Care Coordinator	1
Psychologist	1
Registered Nurse	1
Total	38

4.2.1 Information leaflet

Participants were then asked to report whether they were aware of the purpose of Safeguarding Adults Leaflets (Q3).

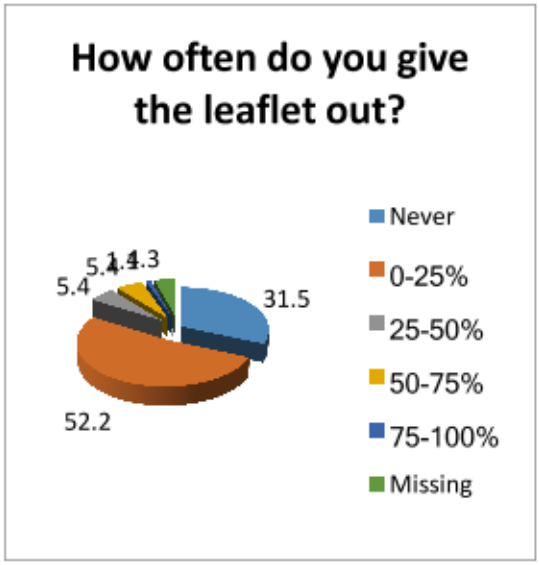
Figure 5



Participants were asked to report how frequently they give the leaflet out.

Pre-training (Q4)

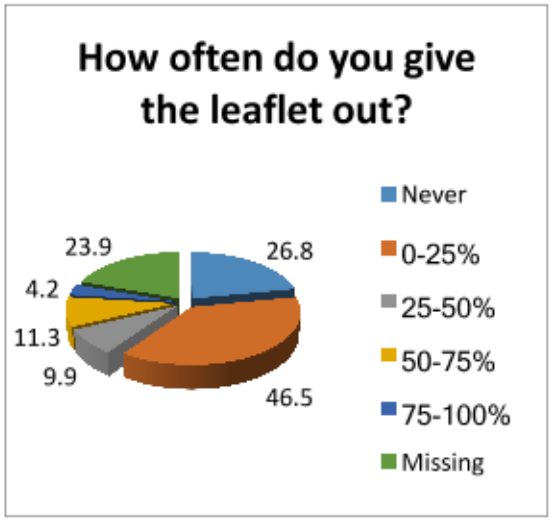
Figure 6



Post-training (Q3)

Overall when comparing respondents for whom questionnaires are available both pre- and post-training it is possible to identify a significant increase in the reported frequency of giving the leaflet out (t (65) =2.199, p =.031)

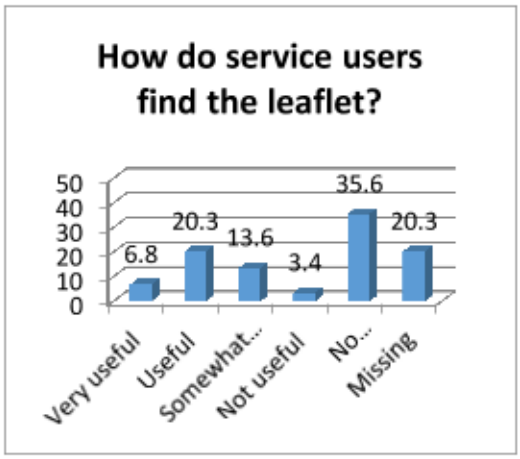
Figure 7



Participants were asked to report their experience about whether and to what extent service users find it useful (Q6) and whether they provide explanations when handling the leaflet (Q7). In response to Q4 reported 29, (31.5%) that they never give the leaflet out or did not provide an answer. 4 (4.3%) were excluded.

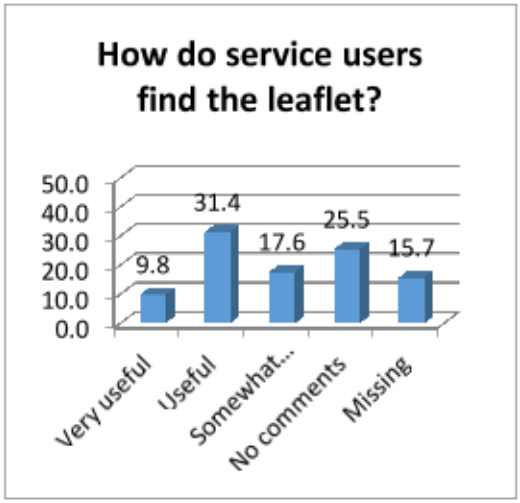
Pre-Training (Q6)

Figure 8



Post-training

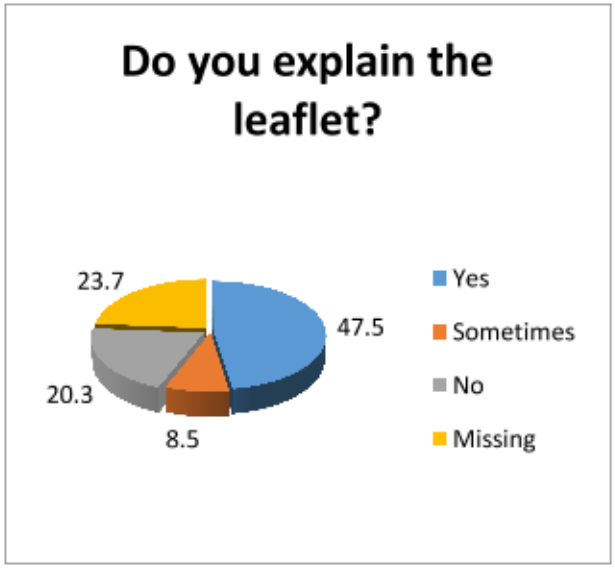
Figure 9



A significant variation was highlighted in relation to whether or not participants provide an explanation to the service users (Q6). This change in practice may have impacted on the increased usefulness of service users' perception of the leaflet.

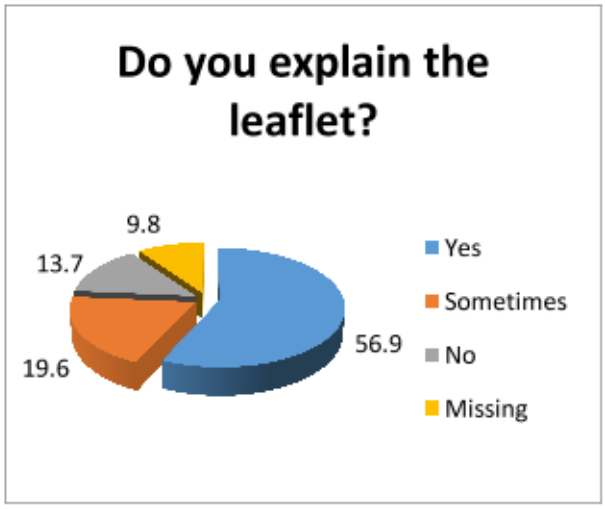
Pre-training

Figure 10



Post-training

Figure 11

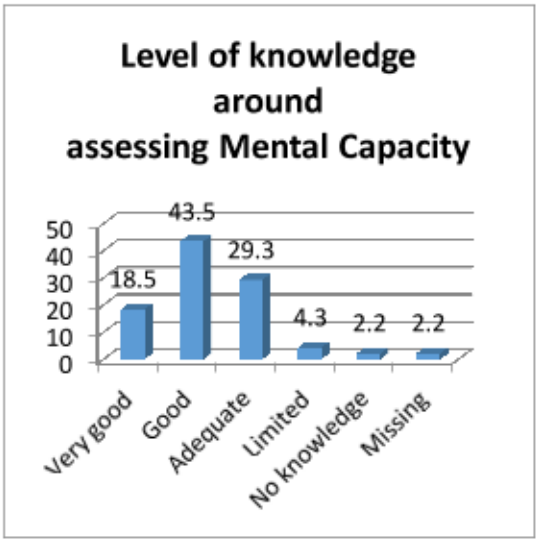


4.2.2 Mental Capacity

Participants were asked to rate their level of knowledge around assessing Mental Capacity.

Pre-training (Q9)

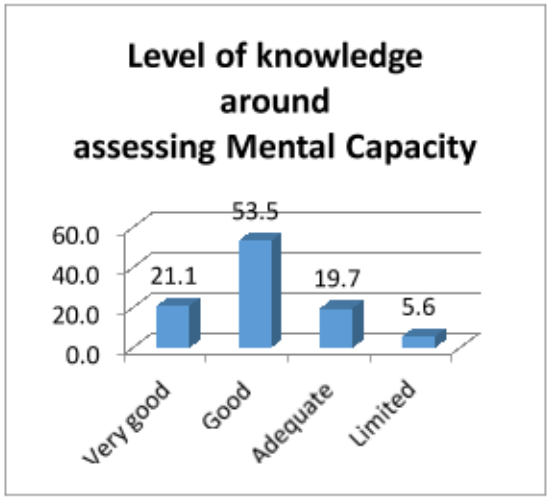
Figure 12



Post-training (Q8)

When considering the reported level of knowledge around assessing Mental Capacity, no significant differences were identified between pre- and post-training responses. There was, however, a perceived increase along the spectrum of adequate to very good.

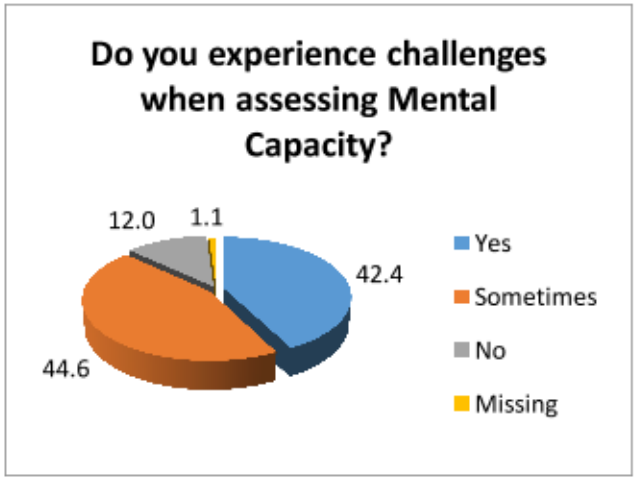
Figure 13



Further, participants were asked to report whether they experienced challenges when assessing Mental Capacity.

Pre-training (Q11)

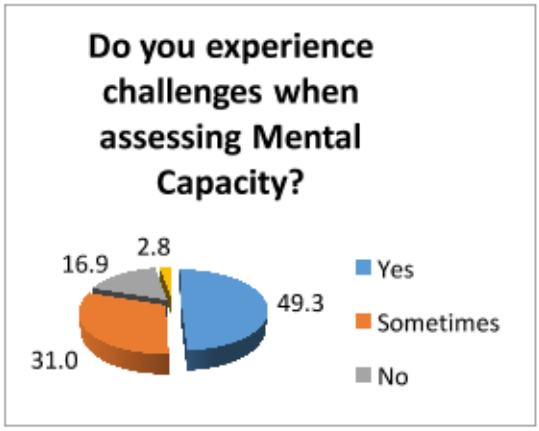
Figure 14



Post-training (Q11)

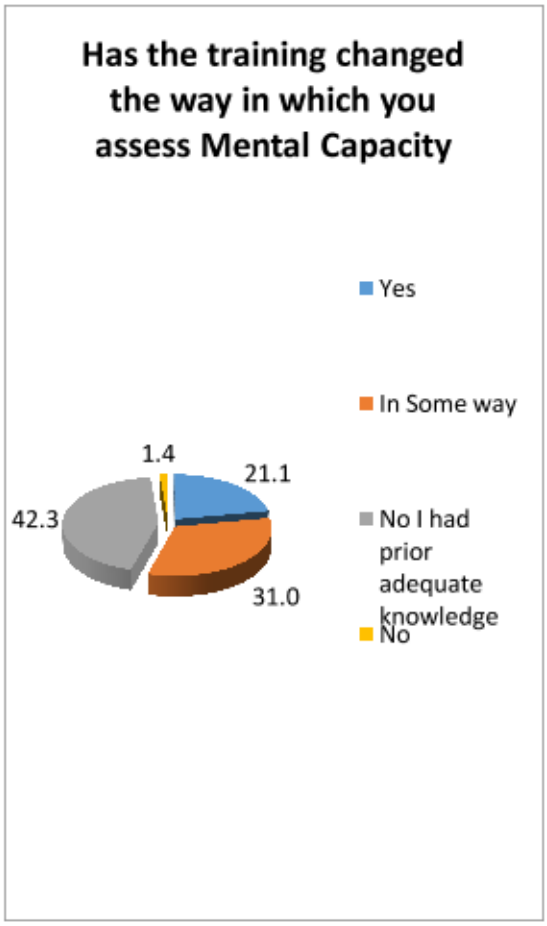
No significant associations were identified when considering pre- and post-training responses about experiencing challenges when assessing Mental Capacity.

Figure 15



Notwithstanding this, 52.1% of respondents reported that the training changed at least to some extent the way in which they assess Mental Capacity (Q9).

Figure 16

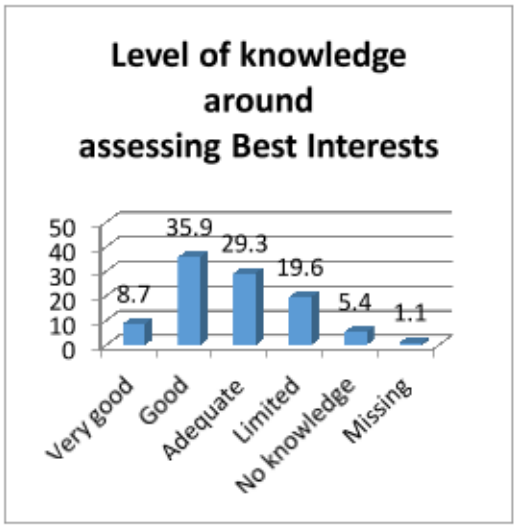


4.2.3 Best Interests

Participants were asked to rate their level of knowledge around assessing Best Interests and to report whether they experience challenges when assessing Best Interests.

Pre-training (Q14)

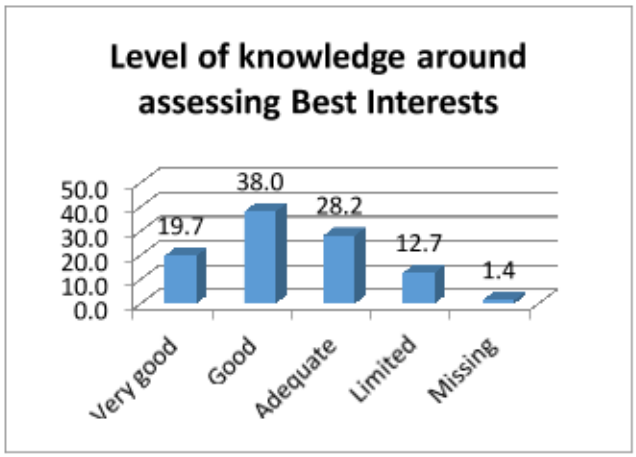
Figure 17



Post-training (Q14)

In relation to the reported knowledge around assessing Best Interests (Q14) a significant improvement in the post-training evaluation was found ($t(68)=4.346$; $p<.001$).

Figure 18



Pre-training (Q16)

Figure 19

Post-training (Q17)

Figure 20

57.8% of participants still report that they experience challenges when assessing Best Interests (Q17). However, no significant association with the pre-training question was identified.

Figure 21

Notwithstanding this result, 31.0% of participants stated that the training changed the way in which they assess Best Interests at least to some extent (Q15).

4.2.4 Advocacy

Participants reported their confidence in assessing when to involve an advocate with around 92.4% expressing confidence.

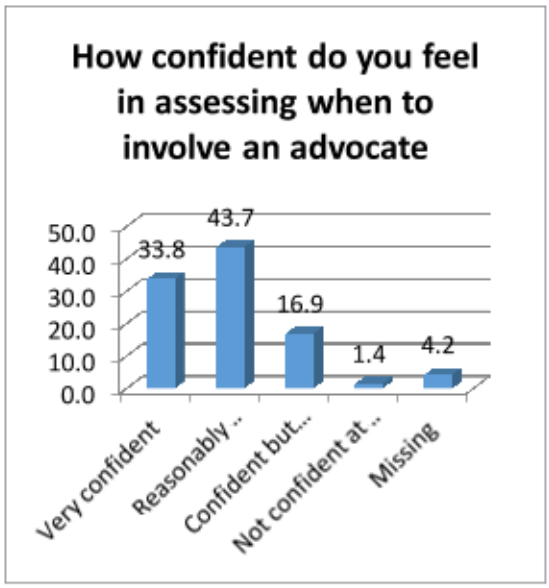
Pre-training (Q19)

Figure 22

Post-training (Q20)

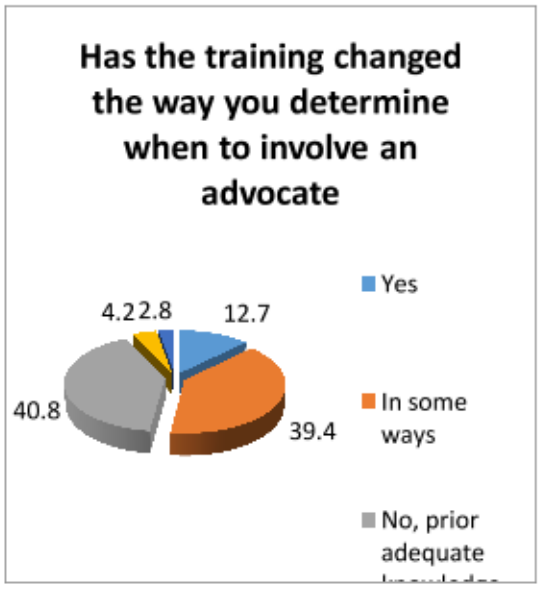
Although the overall percentage of those expressing confidence (94.4%) remained similar to before training (92.4%), a significant improvement in the perceived level confidence about assessing when to involve an advocate was highlighted (t(68)=4.346, p<.001).

Figure 23



Indeed 52.1% of participants reported that the training changed, at least to some extent, the way they determine when to involve and advocate (Q21).

Figure 24



4.2.6 Summary

Since the training events there has been a significant increase in the distribution of the information leaflet.

A greater proportion of service users have reported finding the new leaflet useful compared with the old leaflet.

More case workers also reported that they explain the leaflet to service users since the training took place.

Although the proportion of participants reporting adequate or above levels of knowledge of Mental Capacity did not change, the higher levels of knowledge increased within this range.

Just over half of the participants reported a change in their practice of assessing Mental Capacity post-training.

Knowledge of assessing Best Interests was significantly higher post-training.

However, less than a third of participants reported a change in their practice of assessing Best Interests.

A high level of confidence was reported both pre- and post-training in relation to assessing when to involve an advocate. Just over half though reported a change in practice following the training event.

4.3 Focus Groups

4.3.1 Advocates' group

Four advocates from different organisations attended the focus group. They each supported service users with different levels of need and from different age groups. However, there was a consistency in their experiences that was commented on at the end of the discussion:

"I think it's quite nice to know that it's across all services that we're identifying the same..."

"...all showing the same frustrations".

During the discussion, an interesting range of issues were raised and are presented here under the headings of challenges/concerns; factors contributing to good practice; and improving practice.

4.3.1.1 Challenges and concerns regarding current use of advocates

Understanding and valuing the role of the advocate

Irrespective of legislative requirements, advocates shared a view that case workers used discretion in determining whether or not to request the involvement of an advocate. Factors that influenced this decision included the case worker's understanding of the role of the advocate and her or his view of the importance of this role:

"I think there's not that understanding sometimes from social workers about what the role of an advocate is and I think sometimes it is still a box tick exercise; or, we've got an advocate, that's great, but we'll pick and choose when we want you to be involved and the information we tell you and the bits that we invite you to".

"I think it really comes down to the professionals who understand how useful advocacy is and professionals who see it as something awkward, or it's going to be causing problems for them".

"...it really worries me that senior managers are saying it's okay, completely against the Care Act but it's still okay to do that".

"I think, as an advocate, you then become viewed as somebody who wants to place people at risk almost and you say, well no, I don't want to place them at risk, but listen to what they're saying and listen to their understanding of the situation".

Timeliness of referrals

Linked to the concerns above, views were expressed about the timeliness of referrals. Clearly, a lack of understanding of the advocate's role or an ambivalence about involving an advocate may impact on this.

"…we're finding that it's ... we're getting involved but we could have got involved a lot earlier and done a lot more work earlier".

"…we're not being referred to as soon as a referral comes through. I'd rather have a referral come through to us, go and meet the person and realise, actually, they've got an appropriate person who can help them participate in a really impartial way, or that they're able to advocate for themselves. And I'd rather pull away and leave rather than miss somebody who might need advocacy".

"…what really annoys me about that, is it feels like that allows the professionals to tick the box to say advocacy was enforced and it's just tokenistic, it's meaningless because it's just far too late".

"I think it was last week it was on the Tuesday we received the referral and they wanted an advocate at the meeting on the Thursday".

"It just gives no time to support the person, find out ... it is tokenistic".

Knowledge of safeguarding processes

There was a substantial discussion of social work practice relating to safeguarding referrals and procedure. Concerns were expressed that some case workers did not fully understand the difference between different types of referrals. Additionally, there were concerns about a very limited interpretation of what could be considered as a safeguarding issue being adopted. Rather than fully investigate and learn lessons from safeguarding incidents, some advocate's experience was that provided the service user had been made safe, adult services' view was that there was no need to investigate further.

"…when you get into safeguarding with a vulnerable person, it's almost like the professionals want all risks to be eliminated and for him to be completely safe, because that's about their worth, their professionalism, and not allowing the person to have some risks to make it personal for them".

"I sometimes find …they go into safeguarding with a preconceived plan of what they want to achieve. So, the social worker has an idea very clearly already, this is what we're going to set out to do and it sometimes throws them a little bit when you say, well actually, that's not what they want at all, this is what they said they'd like".

"I'm having to take time out to go to the XXX team to actually sit with social workers and/or case workers to actually support them, to encourage them, to help them make referrals, safeguarding referrals which for me is a real concern".

"…when we're getting IMCA referrals that are for safeguarding, we're now saying okay, tell us who the Care Act advocate is. Because the reaction then is, oh we haven't done that. And we're saying, well why are you making an IMCA referral, which is a discretionary but you're not making a Care Act which is mandatory?"

"It's just, their safeguarded now, closed…the process doesn't seem to allow an investigation to look at what lessons can be learnt, how can that make sure ... what went wrong? Is there a system failure, how can we make sure it doesn't happen again? The focus seems to be, the person's safe now because we've moved them, we close it down."

Resources

Advocates were aware of the increasing pressures on case workers resulting from financial cuts and staff turnover. Although the impact of these pressures is not clearly evidenced, they speculated on how this might relate to their experiences.

"…within teams you've got workers that you know will refer and other workers that you've never even heard of. And I don't know whether that's a turnover issue, an agency issue, I don't know".

"It's different when you have an advocate in. You're going to be challenged and I just wonder that what's the incentive, other than supporting the person, when they're so overstretched as well?"

"You can kind of see professionals thinking if we get an advocate in it will take twice as long, there will be lots of challenges or I could just overlook that and my caseload is getting bigger and bigger and next one".

4.3.1.2 Factors contributing to good practice

Although a wide range of concerns was expressed, there were also positive comments about improvements, good practice and factors that contribute to good practice.

Referrals were not increasing at the rate they might have hoped, but there was an acknowledgement that there was some increase.

"…we are getting many more safeguarding referrals come through now…"

However, there was concern that this was due to the time they spent encouraging and supporting case workers and that this may not be the best use of their time.

"…I think it is generating more safeguarding referrals. But I'm not sure that's what we should be doing as advocates, we should be doing direct work".

The ability of the case worker to empathise with the service user was thought to be a positive influence on prioritising advocacy.

"I think sometimes it can resonate on a personal level as well".

There was also a view that situations that were viewed as high priority within adult services also resulted in better practice.

"The actual issue which would be violence towards women or extremism, I would say those are two issues that I've dealt with recently that were dealt with really, really well in terms of the process, applying the process and involving the person…It's what's at the top of the agenda of making sure you do something properly".

Although two advocates had not noticed any differences in practice since the adult services training, one did think that some aspects of practice were showing a gradual change.

"I'm noticing more service users and families being invited to safeguardings, so I think that's positive. But I don't know that it's necessarily had an impact on the timeliness of referrals and information we receive. I think in the process, things are improving but at the actual point of referral not a lot has changed".

It was also thought that management practice within some teams of encouraging new workers to meet with advocates as part of their induction, was achieving positive change.

"…one of the things that we've been quite lucky with is that new starters to the team at XXX, they've been asking them to come

and spend some time with us at XXX to learn about advocacy and what it is. Which has been really, really positive".

4.3.1.3 Improving practice

There were reservations expressed about whether further training would be effective. Generally, the advocates' view was that this was an issue of compliance, as legislation supported and promoted their involvement. So, very clear procedures stating who should be involved and when may have more impact.

"I think having a protocol in place which says this is what you need to do in terms of who you need to involve. I think having a protocol that they must follow is almost like you must involve an advocate rather than it just being left to training and then how much awareness and a decision on a professional by professional basis".

There was also discussion about the advantages of a specialist safeguarding team. A neighbouring local authority had structured their services in this way and this was felt to have been successful.

"I think the safeguarding worked brilliantly in XXX because they had that dedicated team and you could rely on those social workers to communicate with you, refer…But, yeah, when it went back to being everybody doing everything, yeah, the quality definitely declined".

The final idea expressed by the advocates involved more proactive use of management data already collected.

"Okay how many people have we had through, how many people were eligible to have it, how many of them got referred, so there's a gap so let's go back and identify what ... that figure should be higher. And that they're assessed on that as well".

Through sharing their experiences, the advocates highlighted a number of issues that warrant further consideration. These relate to attitudes, knowledge and understanding, processes, structure and management and are discussed later in the report.

4.3.1.4 Summary

From the advocates' perspective, their involvement hinges, to a large extent, on individual case workers: their knowledge of the legislation, understanding of the advocates' role, and empathy with the service user.

They considered that a shortage of resources was also likely to impact on the case worker's decision regarding their involvement as their role added a layer of

complexity to the assessment that a case worker may prefer to avoid.

The advocates' key concern was the timeliness of referrals. From their experience referrals were sometimes late and tokenistic, with unrealistic expectations of the work they could complete in the timescale set by the case worker.

They were seeing an increase in the number of referrals made to them, although this was slower than desired. While this may have been attributable to the training to some extent, they believed that the promotional and support work that they undertook with case workers had influenced this increase. This was coupled with a concern that this work may not be the best use of their time.

They suggested that practice could be further improved through more use of management data and development clear protocols for case workers.

4.3.2 Case worker Groups

Two focus groups (CW1 and CW2) were held and were attended by seven social workers. They all had extensive experience of adult social work assessments including Mental Capacity and Safeguarding assessments. They had all attended the MSP training. The main purpose of the focus groups was to discuss how useful the training had been and what impact it might have had on practice. In the course of this process, a number of other issues were raised and discussed and these are also presented here.

4.3.2.1 MSP training event

There was a very positive response to the one-day training event.

"I found it useful at the time…" (CW1)

"I found it quite positive…" (CW1)

"It's good format, covers what it needs to". (CW1)

Although, as this was a very experienced group of workers there were mixed views about its relevance to them.

"…it's building on quite a lot of stuff that I know that we've had to get really up to speed with, like personalisation, working with people…" (CW1)

"The problem I think with a lot of training, it starts at such a basic [level] and you just get into it and it's time to finish." (CW1)

"I think the training, the getting together… because we did have a lot of discussions, group discussions about different cases and situations in safeguarding, and that was useful as well". (CW2)

"I think it has been helpful for us to have done the training, because it has become something that we have referred to subsequently as a team and in supervision, and as we're talking about things, just between ourselves in the team". (CW2)

"…keep the person at the centre, and their wishes and feelings about the whole process are to be taken account of and taken on board, and use advocates. That's what I came away with from the training". (CW2)

However, they recognised the value of it for less experienced workers.

"Community case workers...I know they've found training helpful". (CW1)

The training course introduced a toolkit which this group thought was particularly useful, but these were not provided as part of the course, which they would have welcomed. There was a view that this was now more widely available, but to what extent, was unclear.

"The tool kit wasn't given out immediately at the training. I think only team leaders got it..., I think they're available now because I've seen them being given out more routinely" (CW1)

"I understood from the training that you have to download it..." (CW1)

"I have printed it but you know when you print it, it's black and white. As you look at this, it's a lot more easy to understand and it's more colourful and the booklet is a lot better than just reading it in black and white". (CW1)

"There's a copy in my top drawer...there is a copy of that which all my team are referring to. They're constantly going into my drawer to have a look". (CW1)

"*It was positive training and that tool kit would be really useful..."* (CW1)

The revised leaflet was also welcomed by those who had used it but had not been used by all.

"...it's useful. It's a leaflet and everybody's views about reading a leaflet, people that we're working with, it's going to be different, but it's something to leave with somebody and it clearly outlines the process". (CW1)

"I suppose I try to explain things at the time to the people involved. And, generally speaking, with people with dementia, they may not be able to take on board written information. But I haven't thought about it". (CW2)

The previous comment reflected a view that service users and families can struggle to relate to the term 'safeguarding'.

"...I might not use the word "safeguarding". Because, you know, it's a kind of professionals' word. What does it mean to a relative who's concerned that some stranger's nicking their mum's money or something?" (CW2)

It was also seen as an improvement on the previous leaflet.

"...because the other one was all about vulnerable adults". (CW1)

"There was a lot of writing. Quite a nasty picture on the front that proved a point, quite a strong message on it". (CW1)

"It was easy reading. It was less bureaucratic. It didn't look like a typical council leaflet. You could read it. It wasn't too long, it was factual". (CW2)

There was a shortage of leaflets initially though and some people still did not have a copy.

"…that was a huge bit of our training. We didn't have it in the building. We've got it now, yes". (CW1)

"I think Xxx was concerned that we hadn't received them and I know senior managers are concerned because they're not receiving them because we hadn't got them to give out". (CW1)

"I haven't even got one". (CW1)

4.3.2.2 Impact on practice

A range of views were expressed about how the training might have affected practice. Although some of the workers thought it had limited effect, this was either because of the time delay between attending the training and being able to use it, or because the level of experience of the worker meant they were already integrating the key messages into their practice. Of particular interest, the process of reflecting on the training, initiated a discussion regarding some of the challenges involved in practice.

"…now it's at the back of my head. I don't use it every day neither." (CW1)

"Me personally, I don't think it's going to have a massive impact on how I practice. It's not something that's stayed with me where I think right, I'm going to change my practice now because of that training. It's not had that impact". (CW1)

"Nobody's perfect, least of all me, and I have changed my practice. It's made me a bit more wary of why I'm not doing an MCA [Mental Capacity Assessment]…" (CW1)

"I think it was helpful for me to be sort of refocused on the individual and what they're going through when they go into the process". (CW2)

"…it emphasised the role of IMCAs and advocates. And we need to be using the advocates more and that was a really helpful thing, I think, that came out of that". (CW2)

"…from the training, it was more focused on the person themselves and …when I was in case management, that did get lost more often than not, really, and it was just about sorting out the problem or the

safeguarding issue, rather than always involving the person". (CW2)

Four practice issues that sparked discussion were the timing of the Mental Capacity Assessment, the difficulty of timely assessments when initial assessments may not involve a home visit, the prevalence of excluding the service user from discussions and the forms used during the assessment process.

"…one of the key things from the training that came through to me, that I should be doing more routinely Mental Capacity Assessments if there's somebody who has got permanent diagnosis and there is some sort of question mark. Whereas before I was thinking really principled, I'm working with this person and until such time that it really is obvious to me that they do lack capacity…" (CW1)

"I can't do the carer's assessment and this assessment, I can't do 3 assessments, even 2 assessments at the same time. I prefer to get one right and do it properly and then yes, I will consider the Mental Capacity but I wouldn't be doing it on my first visit". (CW1)

"…xxx's advice was that at the very beginning of a safeguarding process, you should be at least determining the person's capacity and I was thinking we do that already but we don't offer it up in a piece of paper". (CW1)

"To work properly with somebody and really focus on making it personal, ideally it would be for them to go out and meet that person on every referral, but that's just not possible". (CW1)

"I know when I put cases forward for allocation in safeguarding, it's because… some of the time, it's because I just couldn't get to speak to that person and it wasn't practical over the telephone and we needed to do a face-to-face visit". (CW2)

"…I still see so much practice where it's been so far down the line before actually anybody's even spoken to the person. It's spoken with daughter, son, husband, wife, where's the person in it?" (CW1)

"I think a lot of is just ageist practice where 70, 80, 90 year old person and then you've got a daughter or a son at 30, 40, their voice seems to be the stronger of the two". (CW1)

"…because we've had these blinking forms, you feel that you've got to fit the system and you've got to shoehorn your situation and your person into the process. And that inevitably means that the person themselves gets squeezed out of the process… So, if this process results in a more flexible system for

acknowledging and working with safeguarding situations, then that would be really, really helpful…". (CW2)

For the social workers in this group though, personalisation was critical to good practice.

"…you need to be person centred, because I've had a safeguarding case from duty and the person wasn't approached". (CW1)

"…I always feel I involve the person and I've got into many, many scraps, debates, discussions, challenges, from family because I will go straight to the person and then, in fact this morning, typical example. Phone call from a daughter, 'why did you go to see my dad without getting consent from me?' So, that's part of my daily practice, that I'm being challenged by family because I will always go to the person first. So, it happens from point of referral right the way through, from duty to social workers and NHS…" (CW1)

"You've got a balance of priorities there and it's about trying to keep the person at the centre of what they want, but within the context of the whole picture. It's difficult". (CW2)

Other factors that were impacting on practice included advocates, resources and structural changes.

"…advocacy and the need for advocates are constantly part of the discussion…" (CW1)

"We're more aware of it (advocacy) based on my little team, managers definitely prompt". (CW1)

"The only issue I have is the timescale of getting an advocate". (CW1)

"I've never had a problem. I've always had a really quick response from them…" (CW1)

"Obviously if you want to go out and do assessments, you're having to wait, but that's a separate issue to this". (CW1)

"…it feels to me like a clumsy process, and adding an advocate in there as well, you know, just makes it even more clumsy". (CW2)

"…I'll go and knock on my manager's door and, obviously, if a safeguarding concern comes up, I need to discuss that straight away. And her question there is, "Right – and what about an advocate?" So, the question is around much more than it ever was, I think – which is good". (CW2)

Staffing shortages within the duty system were seen as potentially impacting on their ability to make home visits, and the reality of financial restraints was noted.

"The duty team is short staffed". (CW1)

"…we haven't got the time to go and do what we would have years ago, do 2, 3, 4 visits and that is down to time and we're performance managed on everything we do. Automatic allocation. I know we're veering off the subject, but it all has an impact on our practice, safeguarding or not". (CW1)

A further change that may be influenced by restricted resources, that was perceived to be relevant to the impact of training and quality of practice was the move towards Agile working.

"…you are isolated and there's lots of things that are going on that I'm probably not aware of". (CW1)

"…I only work 3 days a week, which is great, but in terms of keeping myself up to speed, is a real hard slog and if I worked from home on those 3 days, I'd be lost. I just wouldn't get there". (CW1)

"You just don't know where people are. So, you feel much more reserved about making contact with people. And I think that has an impact on how you develop your practice – and with safeguarding, I think that will have a knock-on effect, because you're just not around in the office to say, "Oh, anybody faced this situation?" So, yes, it's definitely a downside of the Agile working". (CW2)

4.3.2.3 Future training and support

The challenges presented in keeping abreast of developments and promoting best practice in respect of MSP led to a discussion of future training and support needs. There was a recognition that a valuable aspect of training was learning with and from others and that although there are still many collective training opportunities provided, there has been an increase of e-learning.

"The way I see training is on your own. You are responsible for your own training". (CW1)

"We're encouraged now to do e-learning" (CW1)

"I still think we do have the round the table training as well, which I feel is invaluable…" (CW1)

"I think training is important to get together with your colleagues, peer group support". (CW1)

For some, group supervision was a regular forum for support and development.

"What I've found is we've got good supervision and that's been nice. I've had other group supervisions which were invaluable and that's when we discuss Mental Capacity or we look at a case. They're good". (CW1)

This was variable though as it was organised by some supervisors but not all.

Thinking about further training and support needs, more detailed training regarding complex issues relating to Mental Capacity were considered priority, particularly self-neglect.

"Self-neglect, that's a huge area, now that that is being an abuse category, and that the person's declamations of care and service provider's responses to that and duty of care, all of that, that to me is really making my head spin at the moment". (CW1)

Of equal importance to the topic though, was how training and support are delivered.

"…it would be useful to have more, rather than a one off, because things change all the time". (CW1)

"…our MCA lead worker to have more regular surgeries. She's ever so good…" (CW1)

4.3.2.4 Summary

Overall, the case workers thought the training initiative had been useful, particularly for less experienced workers. It had provided an opportunity to reflect on their practice and for some this resulted in changes,

A shortage of toolkits and leaflets was a concern. The toolkit was received very positively and more hard copies would be welcomed.

While the leaflet was seen as a significant improvement on the previous leaflet, case workers felt that professional discretion was needed to determine distribution. Sometimes explaining the leaflet was more appropriate and effective.

The case workers were positive about the prospect of the assessment forms being revised and felt it was important that these should support professional practice.

They voiced some of the advocates' concerns about the difficulties of timely assessment, but thought that managers were increasingly emphasising the importance of making referrals.

They also had concerns about the impact of Agile working, as isolation increased and access to support decreased. It was, therefore seen as important for training and supervision to take account of these changes.

While the case workers felt that there was still a good level of training provision, they would recommend more training on complex issues relating to safeguarding practice.

4.3.3 Managers' Group

Six managers attended the sessions from a range of adult service user group services who led team supporting older people, people with a learning disability, people who experience mental ill health and the hospital Social Work team.

The themes identified from an analysis of transcript of the focus group can be found below.

4.3.3.1 Processes and a personalised approach

The predominant benefit of the MSP training was in relation to how it encouraged and has resulted in a more personalised approach towards safeguarding. Participants felt the training enabled practitioners to *'…focus…on the person'*, *'Put the person in the centre'* and *'[consider] the person not process'*.

However, the timescales within which workers are expected to complete safeguarding cases was identified as a challenge to this as one participant noted

"it's a timescale to work towards a set amount of forms, very bureaucratic in its nature, whereas the emphasis on training was around trying to break through that and actually look at the person as being the centre part of the safeguarding, looking at what their views are, what their needs are, what they want and consulting them".

This was a view shared between participants with another suggesting that

"One of the things that people previously got hooked up about was the fact that there's just this timescale. Well I think that should be secondary because we should be doing it properly".

One participant, in relation to a particular worker commented

"he was penalised for not meeting the timescale, whereas now we're saying there is a time limit but it's not the most fundamental part. It's based around what it is they want to happen as opposed to what we need to happen".

Other participants agreed with this with one stating

"Yes, they'd have pressure, should I really go and do a visit and then do another

visit, just so the person gets to know me a bit better. Should I go with a visit and a capacity assessment in one go because I'm not going to hit the 5 days and 28 days…but they don't have to explain it now. They can just go and do what they wanted to do in the first place without having to justify the social work reason".

An interesting point raised by participants was that previously there may have been a tendency to investigate whether abuse or neglect had actually taken place, with one participant noting

"I think the other change in emphasis from the previous process was before it seemed that you were very much aiming towards [whether the abuse or neglect] *was substantiated, not substantiated and so it almost becomes this quasi almost police process…you're trying to be a detective…which took the emphasis away from the person and what they wanted to happen".*

Working with people who have dementia or a learning disability was seen as potentially extending the length of the process with one participant noting

"things do move very slowly…We're never making any of those timescales at all. They're just completely out of the window but you feel like you're doing it wrong…When they all started to disappear and it's about at the pace of the person, that's when the worker felt this links in better…it allows a social worker to be a social worker".

4.3.3.2 Improved recording

Participants felt that recording of the work undertaken during safeguarding cases had improved since the MSP training had taken place although most participants felt that some of the person-centred activities related to safeguarding had been taking place prior to the training but had not been adequately recorded. Participants shared comments such as

"…it was more about documenting what people have done, because a lot of our workers thought they worked that way already, so what I was saying to them, it isn't evident in your documentation, so you need to record certain elements of that so we can measure it…"

and

"I think that workers have worked in that way but it's not been obvious and it's not been documented, so now it actually puts it on the map".

One participant was particularly complimentary about the MSP training noting that

"…I've noticed the quality of recording has improved significantly since the training.

It's far more thorough and to me it shows their confidence…because of the way it was written so methodical".

Completing Safeguarding forms were previously viewed by some participants as a barrier to working in a person-centred way with one noting that

"We were writing to the language of the form. Because the form was very process [driven] *and language is quite corporate, you write in that style and therefore it lacks the personal detail…* [The training has] *encouraged good practice".*

Another participant commented

"I think we do have problems with forms because it's…probably what we want to collect…rather than what does this form mean and how's it going to make sense to that person. So, we have forms and then almost have to interpret them when we're with the people".

4.3.3.3 Making Decisions regarding Safeguarding

In relation to deciding whether a situation that a service user is experiencing should be classified as 'Safeguarding', the group stated that they had noticed differences in their colleague's perceptions of this with one participant noting

"we do get a lot of referrals and it's like everything's safeguarding and you look at it and think this isn't safeguarding…Some people are quite shocked…"

"it's not going to safeguarding?"

"…and you say 'no'".

Participants expressed that this could be due to people feeling that once they had passed on their concerns,

"[they] *shift the risk* [for example] *'I told them it was safeguarding…'".*

Another commented

"They think you prioritise the case over other cases if they use the word safeguarding".

The need to take an individual approach to identifying what should be deemed as a safeguarding issue was also discussed. One participant expressed this as

"…it's putting the person at the centre…are they concerned about whatever it is, do they not feel safe, obviously depending on capacity… [sometimes the person] *actually wants to carry on being associated with* [the potential perpetrator] *and then you can also explore things around the risks and how they can help themselves be safe, more than it being very paternalistic…".*

This was a view shared by other participants

"…this person's got capacity, they know what they're doing…to outsiders [it might seem like] *they are being exploited but they understand that and the pay-off to that is more".*

An example offered by a participant was

"Somebody who had disclosed that the son in law who she was living with was the main carer because her daughter was out at work, he had been physically abusive towards her at times but she did not want it taken further on a formal level…didn't want her daughter to know at all and we did have to respect that because she had capacity, but we were still able to work with her and him around why were these tensions happening…".
Another participant concurred with this view noting that

"The purpose of safeguarding itself is really quite key… It's what it going to achieve, what's the outcome we're looking to achieve and how viable is that?"

Preserving the autonomy and accepting the choices of people who are referred as potential victims of abuse or *neglect was expressed* as one of the most important aspects of safeguarding and social work. One participant noted

"I think that is one of the issues, because as soon as the referral's been made to us, then it's almost, we've got to go and solve it or rescue them or whatever, but what people don't understand is people have the right to live how they choose, they have the right to make decisions".

Being based in multi-agency teams or where there is a lot of joint work with other professionals highlighted how different professional values might impact on how safeguarding cases are managed as one participant noted

"… at the hospital…with health colleagues, a lot of them being risk averse and we took somebody all the way through the safeguarding process and still she wanted to go back to the situation she came in from. We had no legal framework to allow anything any different and we then had a phone call from the ward manager to say if you allow this lady to go home to the same situation, we're putting a safeguarding in against social care. Had anybody spoken to the lady? It's what she wants?"

4.3.3.4 Use of advocates

When asked what criteria were used to instigate a referral to an advocate in relation to a safeguarding concern, participants commented

"It's usually the person hasn't got capacity or doesn't understand the process and if

they haven't got anybody to act appropriately for them, on their behalf".

There was a general consensus that advocates could be utilised more in some safeguarding cases. One participant noted

"…we should use them more. They're massively under used… it can be quite daunting [for service users]*…Someone independent is better than someone who's linked to the system".*

Participants commented positively on the improved availability of advocates and how the MSP training had improved their knowledge of this noting that

"there's more access now than there was to advocacy as well, which makes a difference"

and

"That was something that came out of the training for me… that in my area I use XXX advocates…there's [also] *sexual violence advocates and domestic violence advocates and we've never really thought about that before....*

Participants expressed that they were not aware on any 'official' assessment to decide whether involvement of an advocate would be useful in a safeguarding case with one noting

"…we don't do an assessment for that. It's more about the discussions you have and documenting that in that sense. I'd have to go back and look at how we do document that because I don't know how it's done".

Other comments in relation to this included

"It's the case discussion"

"…we'll have a chat and then we'll decide".

Participants also said that there were tick boxes on the Safeguarding Adults forms but the boxes didn't allow workers to record the thinking process around it. One participant noted that new forms being developed would encourage more consideration and discussion regarding if an advocate is required and what type of advocate would be most beneficial.

4.3.3.5 Reflections of new leaflet/forms

Participants commented positively on the recent changes that had been made to the safeguarding leaflet

"It's more user friendly than it was before…it's not written in jargon that no one understands, which is how the old stuff was written".

However, participants identified challenges with being able to give the leaflet to service users and their families' including

"*A member of staff said to me yesterday I've got the leaflet but I can't take it out because* [the person is] *in a domestic abuse situation and so she actually can't take that and she meets her at a wound clinic".*

"… Sometimes you can actually use that to explain this is the process and you might not be able to leave it with them or you explain it and then they can read about it and digest it afterwards. You can't just rely on one thing…some people can read, some people can't, some people learn or understand in different ways".

"If people want to be involved they'll read the leaflet. If they don't care, then they won't. That's quite hard to benchmark. You can't force people".

"It's our agenda, not theirs".

"They were pushing our team a little while ago. You can hand them out but you can't make people hand them in".

Participants did not identify any specific improvements that could be made to the leaflet.

4.3.3.6 Assessing Mental Capacity and Best Interests

Participants identified a number of challenges with assessing Mental Capacity and Best Interests. One participant noted the complexities of working with people who have fluctuating capacity and in relation to timescales, another reflected that

"at the hospital, we sometimes have to wait a long time before we can [assess] *because a person comes into hospital poorly. Sometimes they might even be on a life support machine or they come with delirium".*

Ensuring the person's safety whilst enabling people to make choices was also identified as a potential challenge by some of the participants with one noting

"Safety is paramount…the conditions they're suffering from…with treatment they'll have capacity. You have to try and work out what decision you're making, can it wait, is it needed now and if it is, how short can you make that solution or

approach you take and try and do it with the lightest touch possible…".

Another participant commented that

"It's also around being specific, decision specific and looking at nuances…they are capable of making [some decisions] *whereas other things they don't have capacity and actually that can be difficult for families or others involved to accept".*

Participants expressed differences of opinion in relation to how effective their teams were in relation to assessing Mental Capacity and Best Interests. For example,

"Mental Health [practitioners] *are probably more au fait with dealing with capacity. I guess in social care…the assumption is people have capacity…until proven otherwise, whereas coming from mental health, because there's dementia, psychosis, we tend to assess it anyway as part of the routine".*

In relation to one of the activities in the MSP training, one participant noted that

"I can replay the tape from some that sat in my group…and they come at you like a train, it's safeguarding and we need to go to Best Interests. So, I went hang on a moment, we've missed out the Mental Capacity part first, but I don't mind that because it means they are thinking along the right lines and this is what they need to embed…".

Participants commented that the way in which Mental Capacity and Best Interests are assessed had improved over recent years, partly due to the introduction of the Mental Capacity Act (2005)

"…years ago…if they didn't have [capacity]*, they didn't have* [capacity] *for anything. In some senses that was a lot easier…but not for the person…now you are breaking things down".*

Participants felt that the MSP training hadn't necessarily improved the way in which practitioners assessed Mental Capacity and Best Interests but rather experience gained since the implementation of the Mental Capacity Act (2005) has slowly improved practice over time

"I think we've started getting better on capacity before MSP. It's not MSP; I think it's been an ongoing culture".

Some participants felt that the MSP training had positively impacted on the level of confidence that workers appeared to have when assessing Mental Capacity and Best Interests and also, the way in which assessments were recorded. One participant commented

"…that's the part that people felt was most beneficial, when we were talking about having the Mental Capacity assessments".

A further comment from a participant in relation to this was

"workers were saying I'm not sure I'm confident in that area, can you get me on some training?"

However, another participant commented

"the Mental Capacity bit? We didn't cover that bit".

4.3.3.7 Group learning and future development needs

Participants in the focus group noted that participants in the MSP training had greatly valued the opportunity to reflect on their safeguarding practices. One commented that

"the way it was structured for us in mental health, it was a collaborative process…the professionals and team managers, senior practitioners and very much it built in lots of interaction, lots of time to discuss issues and the staff fed back that they found that really valuable. We could have done with longer".

Another suggested that it

"was really valuable in terms of people talking about the cases they've been involved in".

Participants felt that the training had highlighted and/or reinforced the need to continue conversations within teams about safeguarding and perhaps focusing on real life cases to extract and share learning from these. One participant noted

"I think there was some talk about having some sort of action learning sets or reflective practice to follow up from the training'.

Another participant noted

"For me, it's keeping the momentum going. We have a lot of training, we have days, it's really good and we go away and for 6 months we don't hear anything about it. It's got to have some validity. If you're going to do the training, at least follow it up with some review, something which is tangible".

However, the time taken to participate in action learning sets or similar groups was identified as a challenge with participants noting

"The only problem I think is that because of the demand of the work… [it] *is probably seen as more important than the talking about things…and I think it's about*

getting that balance, because you don't want people…There's probably something about peer supervision and the professional as well".

The positive impact of participating in training with people from different team or different professional backgrounds was also seen as useful as commented on but one participant

"I think the fact that it just ended up being mixed groups for our training…That worked really well because people were bringing slightly different perspectives to it".

Another activity which the group felt would reinforce the safeguarding training was reflection and supervision. In this respect one participant noted

"they could do some structured reflective supervision, to talk through the case or whatever".

However, participants always commented on the value of structured training and how they would benefit from more of this with one participant noting that

"there isn't really any sort of basic training on safeguarding. There's the real basic safeguarding awareness type stuff but not on the processes. When it first came out, I think there was 4 days of training. They don't offer that anymore, so anybody coming in, there's virtually nothing..."

There was also a view that not all workers involved in safeguarding had access to, or participated in this training with one participant noting

"I think it's a shame that people aren't actually even given, some of these health practitioners coming in do safeguarding work when it's not been part of their role before".

However, there were differences of opinion relating to this as one participant noted that health colleagues do get access to safeguarding training however, there was a view that the courses they undertake do not

"follow… our processes. It is much more general. They do it with some fairly basic awareness type training…".

Many participants felt that to keep the momentum going following the training, a range of activities was necessary with one participant noting

"It should be a combination of things, of training and supervision, one to one, group supervision, sharing...".

However, the issue of remote working was seen as a factor which could impact on the opportunities to undertake some

of these activities. This was raised as an issue by most participants as commented on by one participant

"I think the value of being together in an office, sharing an office, is that richness you get from that discussion and that learning from discussions".

One participant stated that the team she worked in was office based and therefore this didn't present an issue. The need to find ways to share learning and experience, even if team members are home based, was commented on with one participant suggesting

"We do need to be creative or think of other ways of when people are out of the office, how do you bring them back in".

4.3.3.8 Summary

Managers involved in the focus group felt that the increased emphasis on putting the service user at the centre of safeguarding interventions and taking an individualised approach was the most predominant learning point from the MSP training. A healthier balance between the serviced user, timescales and processes appears to have been one of the key changes the training has initiated.

Improved recording has been a further impact of the training, particularly in relation to recording discussions and decisions about Mental Capacity and Best Interests. There was a perception that although the training hadn't necessarily improved practice in assessing these, workers appear to have demonstrated improved confidence within this area following the training.

Participants who attended the training appeared to have also welcomed the opportunity to share their practice.

The training appears to have increased awareness of the availability and range of advocates that can be involved in safeguarding interventions to provide independent support to service users.

The new leaflet was seen to be useful but there appear to be many challenges in providing service users and their families with leaflets. These include the service user's particular situation, if they are able to read or if they want to read the leaflet etc. No improvements to the current (new) leaflet were identified.

Participants in the MSP training appeared to have welcomed the opportunity to discuss the challenges of safeguarding, assessing Mental Capacity and Best Interests. There was a view that the momentum created by the training should continue with, for example, group action learning sets and MSP being part of

individual supervisions sessions between workers and their line manager. However, a challenge for group learning appears to be remote working. Some workers would like greater 'formal' learning opportunities (i.e. courses) to undertake more in-depth safeguarding training.

5. Conclusions

This was a small-scale study and caution is, therefore, urged when interpreting the findings. However, the data provide indications regarding the training event and changes to practice.

5.1 The training event was welcomed, appreciated and perceived to be beneficial. This appeared to have impacted on practice relating to Mental Capacity Assessment and use of advocates most significantly.

5.2 The information leaflet was well-received and considered to be a significant improvement on the previous leaflet. Increased use of the leaflet may be linked to this perception. However, other factors that may have impacted on this were increased awareness and confidence.

5.3 While the degree of confidence appeared to increase amongst practitioners, the proportion who lack knowledge and confidence has remained the same.

5.4 The toolkit was considered to be very useful but the availability of copies was limited.

5.5 Confidence in involving advocates may have increased but there are structural and professional barriers that need to be addressed to improve practice further.

5.6 Previous assessment forms have not been perceived to be sympathetic towards person-centred practice. The momentum provided by the training provides an opportunity to improve these.

5.7 Agile/remote working was perceived to increase isolation and potentially mitigate against developing good practice.

5.8 Further training was highlighted as a need in respect of complex aspects of safeguarding practice.

6. Recommendations

6.1 Senior Managers

Continue to proactively evaluate management data in respect of MSP, so as to identify trends.

Use the data presented here to inform further training provision in respect of safeguarding practice; recognising the benefits of group learning.

Ensure that the revised assessment forms take account of the concerns expressed by participants of this study.

Continue to monitor the impact of Agile/remote working on awareness, knowledge and confidence of workers in this field.

6.2 Service Managers

Assess the benefit/need for group/peer supervision to embed good practice, in particular for inexperienced and remote workers.

Take the lead in ensuring appropriate and timely referrals for advocacy.

Ensure an adequate supply of tool kits and leaflets are available.

6.3 Case workers

Take responsibility for ensuring they have up to date knowledge of resources and developing practice.

Review personal learning from the training event and highlight further needs in consultation with line managers.

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Images

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8 Appendices

8.1 Participant information sheet

Information sheet for Coventry City Council - MSP research participants

What is the research about?

This research will evaluate an initiative by Coventry Adult Services Department to improve their response to adults experiencing safeguarding issues in accordance with MSP (MSP). The MSP initiative was adopted by 53 local authorities in an attempt to improve the support to people making difficult decisions by using person centred and outcome centred approaches. A toolkit devised by the LGA highlights eighteen aspects of practice that are important in securing positive outcomes in safeguarding practice with adults. To achieve the highest standard a local authority must evidence its practice in relation to two of the eighteen key areas and provide an independent evaluation of its practice in these areas.

The proposed study will evaluate Coventry Adult Services practice in relation to

1) Providing personalised information and advice. Coventry Adult Services interventions to improve practice in these areas are the development and distribution of an information leaflet and new feedback leaflet for service users regarding safeguarding practice and a training intervention for all staff.

2) Consideration of mental capacity and the person's best interests in its decision making process.

The evaluation of these changes will take place between July 2016 and January 2017

Who is undertaking the research?

Linda Martin, Christina Palmer and Gary Spolander who are Senior and Principal Lecturers at Coventry University will be undertaking the research. Members of Coventry City Council's Adult Safeguarding team are providing support for the researchers but will not have access to the data collected during the research project.

Aims and objectives of the research

Aim:

The purpose of this evaluation is to assess the impact of Coventry Adult Services information distribution and training initiatives in response to the MSP Agenda.

Objectives:

To gather and analyse baseline data regarding current practice in relation to two key areas of MSP practice: Personalised information and advice; and Mental Capacity Best Interests.

- To gather and analyse post-intervention data regarding the same two areas of MSP practice.
- To evaluate the impact of the local authority's interventions in respect of these two areas of MSP practice and inform the local authority of further aspects of practice
- they might address.

What research methods will be used?

Pre-training practice:

The research team will have access to the management data set routinely collected by the local authority in respect of safeguarding referrals and mental capacity assessments. This data will form part of a generalised picture of current practice.

A questionnaire will be distributed to all course participants at the start of the training session. It will ask about participants' current knowledge, understanding, confidence and experience of the two key areas of MSP being evaluated through this project. Additionally, it will provide demographic data. The questionnaire will be completed anonymously and participants will be provided with an envelope to put the questionnaire into which they can seal. The analysis of the data gathered will inform the agenda of the post-intervention focus groups and interviews.

A focus group of service users (with their carer and advocate as appropriate) who have experienced safeguarding assessment in 2016 prior to the social workers' training will gather data on the strengths and weaknesses of current practice and procedures. The analysis of the data gathered will inform the agenda of the post-intervention focus groups and interviews.

Post-training practice:

Following the introduction of the revised information given to service users and/or their advocate and the training intervention for staff, a series of focus groups will be arranged:

- Service users (with their carer and advocate as appropriate) who have experienced safeguarding assessment after the social workers' training will gather data on the strengths and weaknesses of current practice and procedures;
- Two groups of social workers who have been involved in a safeguarding referral since attending training; the focus will be to find out how practice has changed, how the authority's interventions have impacted on their knowledge, understanding, confidence and approach to safeguarding practice, and what further changes might improve practice.

Additionally, up to eight managers will be interviewed individually. There are seven different teams/units who can be involved in safeguarding referrals. The aim is to interview at least one manager from each unit that has a post-intervention safeguarding referral.
The project will be conducted in line with the British Psychological Code of Conduct, the HCPC Standards of Proficiency for Social Workers in England: http://www.hpc-uk.org/assets/documents/10003B08Standardsofproficiency-SocialworkersinEngland.pdf and Coventry University Ethics procedures. Additionally, Coventry Adult Social Care Services will approve the project through their own processes.

Participant recruitment

The involvement of individuals in the research will be voluntary. All participants for the focus groups and interviews will initially be contacted by Coventry Adult Services. Participants will be provided with the participant information sheet by Coventry Adult Services so there will be no contact with the research team unless they indicate a willingness to participate.

Where there are questions or uncertainties regarding mental capacity, the participant information sheet will be explained in the presence of the person's advocate and a consent form will only be signed if the advocate is satisfied that the individual has sufficient understanding and wishes to participate in the research.

How will the information I provide be used within the research project and be stored?

Any information provided by you will be anonymised and you will not be named. Your individual contributions will not be shared with your employer. Data collected will be analysed and presented collectively as the views of a group e.g. service users, carers, workers and therefore will not be personally attributed to you. This data will be written up into a final report which will be submitted in January 2017. Transcripts, recordings and any data collected will be kept safely locked away and electronic files will be password protected. Once the final report has been submitted any data collected (e.g. transcripts / notes of interviews, recordings etc) will be destroyed.

To request further information please contact:

Christina Palmer and Linda Martin, Senior Lecturers, School of Psychological, Social and Behavioural Sciences, Coventry University, Tel 02476 887042 / 024 7688 8196

email: christina.palmer@coventry.ac.uk linda.martin@coventry.ac.uk

If you are unhappy about the research and wish to discuss this with someone other than the researcher you can contact Prof I. M. Marshall, Pro-Vice Chancellor (Research), Coventry University, Priory Street, Coventry CV1 5FB.

Further advice and support available

CRASAC http://www.crasac.org.uk - Emotional support for people who have experienced recent or past abuse. Access services via email: helpline@crasac.org.uk or text: 07936 836 130. Helpline : 02476277777. Helpline open Monday to Friday 10am to 2pm and also, Monday and Thursday from 6pm to 8pm. Offers free and confidential initial support and information to anyone from the age of 5 years old who have been affected by sexual violence, no matter when or how it happened. Also provides support to parents, partners, supporters and professionals

Mental Health Matters - Coventry and Warwickshire Helpline - Freephone 0800 616171. Open 24 hours, no charge for a mobile or landline. SMS Text: 07786 202242

Samaritans - Freephone 116 123, (24 hours) or can make contact via email jo@samaritans.org

Carers UK - 0808 808 7777, Free from any landline or from the following mobile phone networks:- 3, T-Mobile, Vodafone, Orange, O2, EE, Virgin Mobile. Open Mondays and Tuesdays, from 9am to 7pm, Wednesday, Thursday and Friday 10am-4pm

8.2 Consent form

MSP Evaluation Consent Form

I agree to be involved in the Coventry City Council's MSP evaluation research project conducted by Coventry University.
I am aware that my responses within the questionnaire will remain confidential and if I participate in a focus group, discussions will be recorded. No comments or opinions will be personally attributed to me. Data collected during the research project will be anonymised.
I have had, for the purposes of the research project, the following points explained to me and been given the opportunity to ask questions;

- I have been informed that I may refuse to participate at any point by simply saying so
- I have been assured that my confidentiality will be protected as specified in the information sheet that I have been given
- I may withdraw from the research by contacting the research team (details below)
- I agree that the information that I provide can be used for educational or research purposes, including publication

SIGNATURE	
NAME	
DATE	

Further information about the research can be obtained from the researchers:
Christina Palmer and Linda Martin, Senior Lecturers, School of Psychological, Social and Behavioural Sciences, Coventry University, Tel 02476 887042 / 024 7688 8196
Email: christina.palmer@coventry.ac.uk linda.martin@coventry.ac.uk

If you are unhappy about the research and wish to discuss this with someone other than the researcher you can contact Prof I. M. Marshall, Pro-Vice Chancellor (Research), Coventry University, Priory Street, Coventry CV1 5FB.

8.3 Pre-training questionnaire

MSP Evaluation – Pre-training questionnaire

This questionnaire is designed to gain information regarding your pre-training knowledge of assessing Mental Capacity, Best Interests, when to involve advocates and your understanding of the use of the Safeguarding adult leaflets which are given to people you are receiving social work intervention due to safeguarding issues. We would be grateful if you could complete the questions below. Thank you in advance.

Research Code:

1. Please state you the service user group you work with (please tick):

Older people ☐

Adult ☐

People who experience mental ill health ☐

Other (please specify below) ☐

---

2. Are you:

a), A Social Worker? ☐

b). A Manager? ☐

c). Other (please state you job role below) ☐

---

3. Are you aware of the purpose of Safeguarding Adults leaflet?

a). Yes ☐

b). No ☐

c). Some knowledge, but don't know much about it ☐

4. How often do you give the leaflet to people you are working with who you are supporting?

a). Approximately 0-25% of the time? ☐

b). Approximately 25-50% of the time? ☐

c) Approximately 50--75% of the time?

d). Approximately 75-100% of the time?

e). Never

5. If you give the leaflet out less than 100%, please tell us why this is?

---

6. If you give the leaflet to service users, in your experience do they find it:

a). Very useful

b). Useful

c). Somewhat useful

d). Not useful

e). No comments given

7. Do you explain the leaflet to service users/their advocates/carers?

a). Yes

b). Sometimes

c). No

If you don't always explain the leaflet, please tell us why below:

---If there are any changes to the leaflet that you feel would improve it,

please tell us what these are below:

---

8. How would you describe your level of knowledge around assessing mental capacity?

a). Very good

b). Good

c). Adequate

d). Limited

e). No knowledge of this

9. Please tell briefly below how you assess mental capacity

---------Do you experience challenges when assessing mental capacity?

a). Yes

b). No

c). Sometimes

10. If you have indicated that you experience challenges when assessing mental capacity, please tell us what these are below

---

---

11. Please tell us below what would make assessing mental capacity easier for you

---

How would you describe your level of knowledge around assessing Best

Interests?

a). Very good

b). Good

c). Adequate

d). Limited

e). No knowledge of this

12. Please tell briefly below how you determine Best Interests

_____

Do you experience challenges when assessing Best Interest?

a). Yes

b). No

c) Sometimes

13. If you have indicated that you experience challenges when assessing Best Interests please tell us what these are below

---

---

14. Please tell us below what would make assessing Best Interests easier for you

---

---

15. How confident do you feel in assessing when to involve an advocate?

a). Very confident

b). Reasonably confident

c). Confident but often need to ask for guidance

d). Not very confident

e). Not confident at all

Please explain your response to the above question – what makes you feel more confident or less confident?

---

16. What would help to increase your confidence further?

_____

_____

Please add any further comments you would like to make below:

Thank you for completing this questionnaire

8.4 Post-training questionnaire

MSP Evaluation – Post-training questionnaire

This questionnaire is designed to gain information regarding your post-training knowledge of assessing mental capacity, Best Interests, when to involve advocates and your understanding of the use of the Safeguarding adult leaflets which are given to people you are receiving social work intervention due to safeguarding issues. We would be grateful if you could complete the questions below. Thank you in advance.

Research Code:

1. Please state you the service user group you work with (please tick):

Older people

Adult

People who experience mental ill health

Other (please specify below)

---

2. Are you:

a), A Social Worker?

b). A Manager?

c). Other (please state you job role below)

3. How often do you give the leaflet to people you are working with who you are supporting?

a). Approximately 0-25% of the time?

b). Approximately 25-50% of the time?

c) Approximately 50--75% of the time?

d). Approximately 75-100% of the time?

e). Never 

4. If you give the leaflet out less than 100%, please tell us why this is?

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5. If you give the leaflet to service users, in your experience do they find it:

a). Very useful 

b). Useful 

c). Somewhat useful 

d). Not useful 

e). No comments given 

6. Do you explain the leaflet to service users/their advocates/carers?

a). Yes 

b). Sometimes 

c). No 

If you don't always explain the leaflet, please tell us why below:

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7. If there are any changes to the leaflet that you feel would improve it, please tell us what these are below:

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8. How would you describe your level of knowledge around assessing mental capacity having undertaken the training?

a). Very good

b). Good

c). Adequate

d). Limited

e). No knowledge of this

9. Has the training changed the way in which you assess mental capacity

a). Yes

b). In some ways

c). No, I had adequate knowledge prior to the training

d). No, my knowledge/confidence has not improved following the training

10. If you have answered questions a). or b). above, please how the way in which you determine mental capacity has changed following the training

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11. Do you experience challenges when assessing mental capacity?

a). Yes

b). No

c). Sometimes

12. If you have indicated that you experience challenges when assessing mental capacity, please tell us what these are below

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13. Please tell us below what would make assessing mental capacity easier for you

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14. How would you describe your level of knowledge around assessing Best Interests having undertaken the training?

a). Very good

b). Good

c). Adequate

d). Limited

e). No knowledge of this

15. Has the training changed the way in which you assess Best Interests?

a). Yes

b). In some ways

c). No, I had adequate knowledge prior to the training

d). No, my knowledge/confidence has not improved following the training

16. If you have answered questions a). or b). above, please indicate how the way in which you determine Best Interests has changed following the training

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17. Do you experience challenges when assessing Best Interests?

a). Yes

b). No

c) Sometimes

18. If you have indicated that you experience challenges when assessing Best Interests, please tell us what these are below

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19. Please tell us below what would make assessing Best Interests easier for you

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20. How confident do you feel in assessing when to involve an advocate following the training?

a). Very confident

b). Reasonably confident

c). Confident but often need to ask for guidance

d). Not very confident

e). Not confident at all

Please explain your response to the above question – what makes you feel more confident or less confident?

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21. Has the training changed the way in which you assess when to involve an advocate?

a). Yes

b). In some ways

c). No, I had adequate knowledge prior to the training

d). No, my knowledge/confidence has not improved following the training

22. If you have answered questions a). or b). above, please tell us the way in which you how you determine whether to involve an advocate has changed following the training

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23. What would help to increase your confidence further?

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_____

Please add any further comments you would like to make below:

Thank you for completing this questionnaire