Royal College of Occupational Therapists response to Legislative options to inform the development of an Adult Protection Bill for Northern Ireland - 1st April 2021

The Royal College of Occupational Therapists (RCOT) is the professional membership organisation for occupational therapy staff across the UK with a total membership of 32,737. Of these 28,141 are professionally qualified occupational therapists across the UK (RCOT, 2018). There are 1,363 RCOT members in Northern Ireland of which 1,207 are professional members (RCOT, Feb 2021). Occupational therapists in Northern Ireland work in trusts, across health and social care services across all levels of services. They also work across other departments and sectors such as, housing, education, prisons, the voluntary and independent sectors, and vocational and employment rehabilitation services

Comments:

Thank you for the opportunity to respond to 'Legislative options to inform the development of an Adult Protection Bill for Northern Ireland', and please find our comments to the consultation questions.

1. **Do you agree with the title 'Adult Protection Bill'?**

Whilst the idea of an 'Adult Protection Bill' sounds positive and the title describes it, we have concerns about formalising this and the possibility of that it could reinforce an already over bureaucratic hierarchy. We are concerned it could create a situation to give people less protection instead of more.

We would suggest that if it is to go ahead, it could be called 'Adult Care and Protection Bill'. We would like a more proactive approach where someone is at the centre of their care, and are offered the supports they need, such as an Independent Advocate. There should be continuity of care so staff involved with the care of person can develop relationships (including with carers). This may help with someone feeling more comfortable in expressing concerns, should they need to and those involved developing a clearer sense of the overall situation, in terms of risks and available supports. The focus should also be on well trained staff, working in a values based system which is resourced. We would also emphasise proper staff diversity and skills mix ensuring that the correct range of multi-disciplinary staff including Allied Health Professionals, are identified where needed. We would also hope that an analysis of what has happened indicating failings in the system, are addressed and that there is input into decision making bodies through robust processes involving those providing services as well as service users, carers and the community.

- ***We are not convinced that systemic failings have been addressed and including the word 'care' may keep that to the forefront of what happens***

There were serious care failings that led to what happened at Dunmurry and Muckamore (1.25) and we believe that these need to be kept in focus and must be addressed. Having an Adult Protection Bill and putting legislation in place in a dysfunctional system is not going to solve the issues but detract from them. Subtle and pervasive forms of abuse can still happen no matter how much policy and legislation there is, especially if the structures and processes are not robustly in place or more importantly are not held to account. We need to

better understand how these failings could have happened and make sure they cannot happen again. An Adult Protection Bill is not going to do that on its own. Systemic lack of accountability is also neglect.

We believe the right attitudes and qualities as well as having the right skills and knowledge is of the utmost importance in health and social care. Ensuring that values, ethics and high standards of behaviour are promoted through reflection and having robust supervision structures is also of great importance.

Whilst we welcome anything that will make services better it must be front loaded with a culture change from the top down along with proper processes including training which incorporates meaningful evaluation.

Likewise if people in their own homes have an increasing array of 'professionals' who are not integrated and bureaucratic processes become more important than relationships, it may only put another layer of practice in, with a focus on concerns that boxes have been ticked and forms have been filled, as opposed to promotion of a kind and compassionate system.

- ***We believe there should be a challenge to the status quo regarding representation in Department and Trust Structures. As Allied Health Professionals (AHPs) are not included as essential members of the decision-making bodies this lack of AHP input may unfortunately only be noticed when things go wrong***

There was not a full range of a multidisciplinary team in Muckamore in 2012. (A review of Leadership and Governance at Muckamore Abbey Hospital (31 July 2020) page 59) https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mah-review.pdf

'*Staffing shortages and the lack of an MDT directly impacted on the provision of safe and effective care* (Page 69). The fact that there was no diversity in skill mix in relation to staffing should have been a concern. We are still worried that despite this awareness of the need for and benefit of therapeutic input, lessons have not been learnt. The information of what happened in Muckamore did not translate to examining where else there was a lack of allied health professionals (AHPS) such as in Care Homes. With the recent onset of the pandemic occupational therapists amongst other AHPs were deployed to Care Homes and it was only at this point that the importance of having multidisciplinary staff in Care Homes was identified. An example was given about staff in a care home asked to isolate people in their own rooms, but misinterpreted as keeping them in bed. This has had various repercussions such as deconditioning. Members are very concerned about the lack of diversity in skills mix and the need for therapeutic input, which can help ensure good practice; and how significant harm can result from situations, where the people with the right skills and knowledge are not where they should be.

Issues of safe staffing as well as ensuring the right staffing, emphasis on good practice by all staff and many other areas of concern about organisational and structural failures need to be addressed first.

At risk of harm and at risk of significant harm

Occupational therapists are concerned about the difference in at 'risk of harm' and 'at risk of significant harm' and where the threshold lies. They said it was important not to just look at single significant events. They are concerned about what may be seen as minor harm that occurs constantly but has an ongoing accumulative effect. There needs to be an overview of these more minor reports and patterns of actions or complaints against staff or others to see if there are subtle patterns.

They would like to see a way of ensuring that all reports of harm are monitored, so that no matter what, information to identify trends can be picked up. Also it should be made as easy as possible for all staff (including non-clinical) to know where to go to report poor practice or concerns of harm. They also felt that whistleblowers should receive more protection and legislation in this area should be strengthened. It is important that there is a well-functioning process across a continuum, so staff reporting issues can see that there is monitoring and review and /or effective action is being taken.

Occupational therapists also mentioned such issues as, 'Who I live with?' and 'What I eat?' may be considered as areas that could be 'significant harm' for some people. 'Significant harm' could be different for different people and this must be kept in mind.

There needs to be consideration of 'the possibility of subtle as well as blatant forms of controlling influence' https://pmj.bmj.com/content/80/943/277.

There needs to be an acknowledgement that people may be strongly influenced by what is being put across by a medical or health and social care professional. In particular if a person is in the position of 'less power,' (such as in a bed and unwell or does not have the means to communicate), others can be in a position of 'more power' and may unduly influence decisions as they consider that 'they know what is best' for someone else. This too could lead to 'significant harm' for that person, being persuaded to have an intervention they perhaps were not keen to have. Training for staff to ensure they are aware of the impact of their role and what they may say can have is very important.

When there is a hierarchical medical model which ignores what the person wants and does what it feels should be done, this too can lead to another form of exploitation.

2. What are your views on a definition of 'adult at risk and in need of protection'?

We agree that the definition will be extremely important, if it is going to trigger different powers and duties. We are concerned again about who will be deciding on this definition for a person and that it should not bring about a 'system that decides what is best' for whoever falls into the category. Also how are people in this higher threshold to be monitored in terms of recording? Who and how is it decided that they are in this category of risk(2.6) will be extremely important to get right. What will it mean if they are assessed to be in this category?

If this legislation is to be for only very 'significant harm' – abuse, neglect or exploitation at a level where it is likely a serious intervention or criminal proceeding are to take place then that needs to be more clearly laid out. We believe it is more optimal for it to result in being

pre-emptive and preventative, or when needed, triggering a care response in relation to protection for someone at risk by trained and knowledgeable professionals and staff who excel in good practice, benefit from regular supervision and operate in a supportive value based system that is resourced. We would like to see more details on how it is to be blended into existing safeguarding policy.

We can see the definitions in 2.9 and believe that this is so important, it cannot perhaps be decided through a consultation response. There needs to be more substantial discussion about the different thresholds and have more examples and case studies of how that could look in practice as well as get more information about how similar legislation is working in the rest of the UK.

We do not feel there is enough in the way of safeguards presented in this consultation.

3. **Do you agree with the list of principles proposed? If no, what would you suggest as an alternative approach?**

If these are already in the current regional safeguarding policy it may be best to continue to reflect these. The outline approach in 2.24 looks reasonable but may need some additional thought on the principles and what and how they are explained such as:

> *People at the centre*: Adults have the right to decide things for themselves and should be supported to do this as much as possible. If needed, other people who have their best interests at heart such as a main carer or advocate can support them to get across what they need or want to. If they need help with a translator or to communicate, that should be provided.
>
> *Rights*: Adults under this legislation have the same rights as everyone else. Everyone should feel safe and secure and safe from harm and if any extra protection is required, it should be balanced and reflect the level of what is needed in the situation.

Again we question if enough has been done to create the environment in which this Bill would have the hoped for impact. We also reiterate points made in the answer to the first question.

We would suggest that the principles are written in very plain English and also Easy Read versions with clear explanations for ease of understanding for everyone. Using language which may be unfamiliar is creating a barrier to ensuring that the principles will be understood and used by everyone.

Carers in the majority of cases can also have a very positive role in protecting those they care for. We notice that 'the views of others who have an interest in his or her safety and well-being' are to be taken into account in one of the current principles, however we feel there should be more detail outlined as to how this Bill could impact on carers and where they fit into this. Where would the balance be in a situation where the carer disagreed with the professional or vice versa. Again, more detail on safeguards is needed.

4. **What are your views on principles being set out on the face of legislation or in Statutory Guidance?**

If this Bill is developed we agree with this.

5. **Do you agree with mandatory reporting? Should there be a new duty to report to the HSC Trust where there is a reasonable cause to suspect that an 'adult is at risk and in need of protection'?**

We agree there should be mandatory reporting. It will be important to develop the skill of all professionals and staff groups so that the right things are being reported. It is imperative it is accompanied by training, support, supervision, evaluation, case studies in developing skills/ judgement of how to respond in various scenarios (to develop good practice and skilled professionals to prevent over reporting.) We have been told this has not always been the case in relation to the existing safeguarding policy.

There are existing safeguarding processes in place and alongside this there could be an evaluation of how well they are working and what needs to be further improved across the whole area.

6. **Should a new duty be placed on HSC Trusts to make follow up enquiries?**

We agree there should be a duty to make follow up enquiries.

7. **What are your views on a new power of entry to allow a HSC professional access to interview an adult in private? Do you think any additional powers should be available on entry?**

Occupational therapists felt that one interview in private will not always be sufficient to clearly establish if the person is at risk of harm as a person may not open up, but it may work in some cases. It could also potentially put someone at increased risk. However, it should be one of a number of things and would have to be considered in the whole context of the case. Occupational therapists also felt what was really important was having consistency and continuity in staff – such as a long term support worker or a named professional.

The example in 2.57 is not very clear. We would ask various questions about this example as to how an assessment was carried out and that despite the concerns of the relative and being in a serious state of neglect as to how it was ascertained the person was deemed to have mental capacity at that time. However, we agree if this is an example that could have given an opportunity to interview the person, then in this context it would have been positive to have a power of access for private interview.

We think there should be consideration of something similar to the 'Banning Order in Scotland'. Occupational therapists felt that it should not always be the person removed if this is possible, but the perpetrator if it is in a home situation or a staff member in a care home type situation.

They also said that extremely serious consideration should be given, if considering removing people, where due to their condition moving from a familiar place, or out of a routine would be extremely disturbing for them and detrimental to their overall health and wellbeing.

8. **How many times in the last 12 months, have you been aware of a situation where, had a power of entry existed, it would have been appropriate to use it? What were the circumstances?**

No, we have not been informed of a situation like this.

9. **What are your views on statutory provision for independent advocacy in the context of adult protection?**

We very strongly agree with plans to have Independent Advocates. Members have said that where it has started in relation to the Mental Capacity Act, they have felt it has been very positive.

10. **Do you agree that an Independent Adult Protection Board should be established and placed on a statutory footing?**

Yes, we agree. Members have mentioned a number of areas where they have felt there should also be a central place or a satellite model which can capture information and can identify patterns and trends. They felt that even if it is decided not to do something in a particular situation, it should continue to be monitored and reviewed.

11. **Do you agree with the introduction of Serious Case Reviews?**

We agree and there should be transparency and real opportunities for learning to ensure that the same things are not repeated.

12. **Do you agree with the proposal to introduce a duty to cooperate? Are there any aspects of the duty that you would change?**

Yes, we strongly agree there needs to be improved information communication across the system.

13. **Do you think there should be a new power to access an adult's financial records as part of an adult protection enquiry? If yes, which organisation(s) should be given this power?**

We are concerned about gaps in these areas of people's lives. We are aware for example that a person can appear capacious in a clinic setting to a professional who is seeing them on an irregular basis, but in day to day life the person may not remember to eat as they may have early stage dementia and live alone. Again we would suggest there is more examination of proactive good practice and who should be involved.

Access to financial records should only be in the most extreme of circumstances and safeguards built in that must be carried out first.

14. **Do you agree that new offences of ill treatment and wilful neglect should be introduced?**

Yes, we agree they should be introduced.

We would like more detail on how all of the legislation is to interface with each other such as this proposed legislation, the 'Mental Capacity Act' and the proposed 'Domestic Abuse and Family Proceedings Bill'.

15. **Are there any other new offences that should be considered?**

Organisational Neglect: There must be accountability for organisations to ensure there is good care and protection of people who need it. Significant harm also happens due to organisational and systemic failings.

16. Finally, are there any other provisions that you would like to see included in the Adult Protection Bill?

- We would like to see more on safeguards
- We would like whistle-blower protections to be strengthened.
- Acknowledgement of wider multi- disciplinary involvement in both assessment and decision making in the area of adult protection.
- Robust provisions in whatever is formulated, including compliance and accountability along with action to improve where there are issues which have the potential to lead to safeguarding concerns.
- Training and refresher training must be available and accessible to all health and social care staff. We have been informed from one Trust that it was difficult for allied health professional to avail of this, in relation to safeguarding policy
- We want to see more proactive provisions on how to ensure prevention, good practice, quality assurance as a requirement and ensure that services are the best they can be