Summary Report

Exploring and understanding safeguarding reporting across the West Midlands

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Glossary

LGA – Local Government Association

MASH – Multi Agency Safeguarding Hub

MCA – Mental Capacity Act 2005

SAC - Safeguarding Adults Collection

WMADASS – West Midlands Association of Directors of Adult Social Services.

Kate Spreadbury

Independent Reviewer

February 2023

1. Introduction.

1.1 In October 2022 West Midlands ADASS commissioned an independently facilitated regional workshop to explore what factors might influence consistency in the Safeguarding Adults Collection (SAC) data returns in the region. The workshop also explored how future regional workstreams might contribute to consistency in returns. This report captures the key learning from the workshop and preparatory activities and makes suggestions about activities which can potentially promote consistency between local authorities and help to understand individual SAC returns. This focused work will be of interest and use to other regions and local authorities in England in considering differences in returns and in understanding the narrative behind individual data returns. The report, together with the questions to support the development of a data narrative in Appendix 1, will assist the sector in preparation for CQC inspections of local authority adult social care functions.

1.2 Following the implementation of the Care Act in April 2015, local authority returns to the SAC have demonstrated significant differences across several indicators, most significantly the conversion of safeguarding concerns to enquiries under the s42 duty. The early inconsistencies were thought to be about interpretation of the new statutory guidance as well as a potential lag in the ability of electronic systems to generate data in the new configurations required post the Care Act. NHS Digital undertook a voluntary survey of local authorities[1] in 2018, 51% of English local authorities responded. The wide variety in the number of concerns submitted by local authorities and in the 'conversion rate' of concerns to enquiries (i.e. use of the s42 duty) were attributed to different configurations and approaches at the local authority 'front door' including how concerns were 'filtered' and recorded on systems. The survey also noted that local authorities were applying different levels of 'threshold' when deciding whether the s42 duty applied.

1.3 National suggested frameworks intended to support greater consistency in referral of concerns to local authorities and in local authority decision making were published by the Local Government Association in 2019[2] and 2020[3]. These frameworks reiterated the legal criteria underpinning the s42 duty and emphasised that the use of 'thresholds' was not consistent with the criteria stipulated in the Care Act legislation.

[1] https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/safeguarding-adults-collection-survey-of-local-definitions-2018

[2] In relation to safeguarding enquiries, the framework for 'Making Decisions on the duty to carry out Safeguarding Adults enquiries' was published in August 2019. Find at: https://www.local.gov.uk/making-decisions-duty-carry-out-safeguarding-adults-enquiries

[3] In relation to safeguarding concerns, the framework 'Understanding what constitutes a safeguarding concern and how to support effective outcomes' was published in September 2020 and aims to support consistent local authority decision making and achieve greater understanding across sectors of what constitutes a safeguarding concern so that people get a response that is right for them. Find at https://www.local.gov.uk/publications/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcomes

1.4 National inconsistencies in data persist and are acknowledged by the data collector, NHS Digital. These inconsistencies limit the use of the data,

"Do not use this data

- *to make judgements on how effective local authorities are at keeping adults safe from abuse and neglect.*
- *to benchmark local authorities against each other, due to the different reporting and practices used to discharge their statutory duties"* [4]

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2.Methodology

2.1 The facilitated regional workshop was informed by a questionnaire, developed with the support of a group of local adult safeguarding leads, and completed by all fourteen local authorities in the West Midlands. The questions asked can be found in Appendix 2. Workshop representatives included Principal Social Workers, safeguarding managers and Safeguarding Adults Board Chairs from the fourteen local authorities.

Workshop Objectives:

- To identify and explore the potential reasons for Safeguarding Adult Collection (SAC) data disparities between local authorities.
- Reflect on how these may impact on local data.
- Identify any common factors that might explain the reporting variance.
- Learn from each other and share good practice initiatives.
- Ask if greater consistency in data reporting is desirable and achievable.
- Identify future regional workstreams that could work toward greater consistency.

The case studies used in the workshop can be found in Appendix 3 and the full programme in Appendix 4 of this Report.

[4] https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2021-22/introduction-and-key-points

3.Summary of Findings

Respondents to the pre-workshop questionnaire and workshop participants identified factors which have either had a demonstrable impact on the SAC data from their local authority, or are thought to have had an impact. These factors are also influenced by demographic, resource and organisational culture contexts.

Concerns

- When safeguarding concerns and enquiries are recorded.
- What is recorded as a concern.
- The impact of changes in local authority procedure.
- The work undertaken with referrers.

Enquiries

- The impact of the linear nature of recording systems.
- The impact of capacity in teams undertaking an enquiry.
- How the criteria for the section 42 duty are understood by decision makers.
- Centralised or disseminated decision-making.
- Available pathways more appropriate to progressing the concern.

4.The context of safeguarding activity in the local authorities surveyed

4.1 Within the pre-workshop questionnaire respondents were asked about the local context in which the safeguarding activity took place. These responses provide useful background to the reflections in section 5 'Findings'. Three areas were explored:

Demographic influences: are there any features of your local authority area which influence the number of concerns/enquiries?

Resource issues: budgets, time, pressures on community teams

Organisational culture: including the impact on this of SARs or other local/national enquiries, the influence of other policies, the response to COVID etc.

These areas were referred to again throughout workshop discussions.

4.2. **Demographic influences**

Four questionnaire respondents could not identify any particularly significant demographic factors in their areas. Two respondents cited a significantly older population, three mentioned pockets of 'deprivation' which correlated with concerns about exploitation, poor health, substance misuse and domestic abuse. The existence of large care homes or a large

number of care homes as well as private hospitals were also identified as potential reasons for the number of concern referrals. COVID was mentioned by two respondents as impacting on the quality of care because of staffing issues and as a generator of more concerns about self-neglect and domestic abuse.

4.3 **Resource issues.**

Respondents reported "*significant challenges"* regarding resources available to adult safeguarding including high vacancy rates, more use of agency staff and increased demand on services post COVID. Whilst "*Safeguarding is prioritised regardless of the above issues"* these pressures did influence what happened with data, an inability to allocate enquiries meant more 'enquiry work' completed at a 'concern' stage and reported as a concern only. Other impacts reported were also 'compassion fatigue' with pressure at the front door increasing the risk of inaccurate or 'distorted' recording, a loss of confidence and lack of understanding of the legal criteria in fast turnover teams as well as challenges in maintaining partnership work. Five respondents talked about "*increasing complexity"* in referrals, often through an inability for organisations to take preventative approaches during COVID or because of resource demands, but also because of increased awareness of exploitation and 'transitional safeguarding.' These areas of work required skill sets and experience which was not always available in locality teams.

4.4 **Organisational culture**

Respondents mentioned their own and other organisation's culture. COVID had impacted on ways of working and the rate of referral.

"Health-policy of disengagement after three attempts to see someone impacts issues of safety, well-being, substance misuse etc."

"Covid has impacted on co-location with partners as some are still working at home."

"Covid caused adult safeguarding referrals to fall in 2020/21, but demand picked up in 2021/22 and has seen a sustained increase in referral activity to the highest ever levels in the last six months of 2021/22 and first six months of 2022/23."

The majority of respondents were positive about learning from SARs, one respondent explained how this had significantly changed the way in which they progressed concerns about self – neglect.

Some respondents experienced challenging 'politics' around safeguarding,

"Policy is outdated and requires updating and sign up from a number of different social care teams, which is politically challenging."

Others had supportive environments,

"Opportunity to develop resources further across the partnership, agree priority areas."

"…. independent scrutiny was commissioned to ensure safeguarding remained a priority during covid and to identify good practice and learning."

4.5 These contextual factors may influence numbers of concerns and the decisions made about those concerns. These contextual factors are referred to again in section 5 '**Findings'**.

5.Findings

5.1 Factors that may influence numbers of concerns in a local authority.

Summary

There is a disparity between local authorities in numbers of concerns per 100,000 population reported both nationally and in the West Midlands region. The West Midlands SAC data return for 2021 – 2022 shows a range of concerns between 2,435 and 284 per 100,000 population. The mean for England is 1,218 per 100,000 population with a range between 4,142 and 246 per 100,000. All regions show a marked difference in the range of concerns reported between local authorities.

Workshop participants reported that how recording systems were configured had a demonstrable effect on SAC data reporting. Other factors were:

- What is recorded as a concern.
- The impact of changes in procedure.
- The work undertaken with referrers.

5.1.2 The influence of recording system configuration.

In the West Midlands

- 79% local authorities (n=11) record a concern on receipt of referral
- 21% local authorities (n=3) record a concern once the criteria for the s42 duty have been met.

The 79% of local authorities who recorded a concern on receipt of referral reported a 'funnel' effect with non-social work qualified front door staff needing to log a 'concern' on the electronic recording system in order to pass onto decision makers. This also results in a low 'conversion rate' of concerns to enquiries as numerous referrals recorded as 'concerns' are not about abuse or neglect including self-neglect.

"For Concerns, the Customer Service Centre advisors make the decision whether to log as a 'Concern' on our system. This is quite a big funnel leading to pretty high numbers of Concerns that do not then convert to Enquiry."

The remaining 21% of local authorities were able to log a 'contact' without automatically including this in the SAC return as a concern.

"Customer services will create a contact, alerting a potential safeguarding concern, and will pass this onto the relevant intake team. The intake worker will screen the safeguarding concern – if it is screened in as a safeguarding, the appropriate recording form is launched, and this concern is counted as part of the SAC return."

One respondent reported that a new recording system had resulted in an increase in reported concerns as the configuration of the system meant they could not work on a referral prior to entering it onto a 'concern' form.

"We previously recorded a referral as a concern once s42(1) was completed. Now on the new system they have to open a 'concern' episode so there is immediately a recorded concern for SAC. We had a spike in referrals and then a low conversation rate."

Another respondent had changed their practice in the opposite direction:

"We used to record everything as a concern but now only record after 'lateral checks' are undertaken and we can confirm that the three criteria are met, then its recorded as a concern. If it is obvious the three criteria are met it goes straight to being recorded as a concern."

5.1.3 Making changes to the recording system.

Workshop participants were very aware of the importance of getting the recording systems right from initiation, changes once the system is operational can be expensive and create unforeseen impacts on other parts of the adult care system. Each local authority in the region used a slightly different recording system which once purchased may have been initially adapted to local need.

These systems cannot be easily adapted once live, participants reported that making changes in response to the LGA (2018) guidance had proved difficult, whilst small elements of the system could be 'tweaked', changes to how recording progressed could be considered major and would require negotiation with the provider. Unforeseen impacts on practice as well as data collection can be a problem.

"We changed from System z to System F and did a lot of preparation but found it did not quite work as envisaged in practice. We can make internal tweaks but cannot change the front facing aspects. We cannot change the portal, only the system owner can. So we have to go for a full system change which takes forever."

"If new data is required by SAC this can be OK as the companies will make changes for free. Otherwise there are layers of decision-makers, and the costs are high. These are systems, a small change can have an impact on wider systems and create problems for the organisation further down the line."

"When we moved from xxSystem to YSystem we had a very short timescale to develop the system. It has been hindering practice. We have just had a meeting with (the new provider) and are in the process of reviewing it based on recommendations and LGA guidance."

5.1.4 Ease of SAC data collection

Participants in the workshop noted that the requirements of the SAC return were not the usual starting point for system design. Some local authorities found it difficult to extract the necessary data from their recording system:

"Sometimes the safeguarding process can feel like it is driven by the recording system, and it is often difficult to abstract the safeguarding activity from the system."

"We use System C. This is an improvement of previous systems as safeguarding episodes are clearly identifiable and all decisions/lateral checks held within. However it is proving difficult to collect necessary data from this system and it is also hard to see closed safeguarding concerns after 90 days when they are effectively archived from view."

Other local authorities reported well-functioning SAC data collection.

"Our digital system is streamlined and tailored to providing one continuous referral form in four parts-referral, lateral checks, enquiry, evaluation of enquiry. This form and our recording system comprehensively capture all relevant information."

5.1.5 What is recorded as a concern.

Organisational abuse and work undertaken with entire services was impossible for the majority of respondents to record as either a safeguarding concern or enquiry.

"We cannot progress as organisational abuse on the recording system as it only picks up enquiry for one person. Theoretically you could put forty people on – but that is resource heavy."

However one local authority reported that they had,

"Dedicated safeguarding modules that allows us to separate organisational and individual safeguarding."

How self-neglect referrals are recorded also has an impact on the number of concerns logged. In some local authorities a differentiation was made between people who were prepared to accept support and those who were not:

"There is a process at our front door Customer Service Centre that is predicated on whether the adult is receptive and agreeing to provision of assessment and support. Where the adult is receptive and agrees to assessment/support, the referral is not logged as a self-neglect concern for the SAC (i.e. the person is NOT demonstrating they are unable to protect themselves from self-neglect or the risk of it). Where self-neglect is identified and the adult refuses any relevant offer of assessment or support, or cannot be contacted, the referral is

logged as self-neglect concern and passed to Adult Social Care to progress - and will be recorded in the SAC. We have done this to try to apply proportionality in our responses, but there are elements of organisational design that affects response and recording here also."

Whether something is logged as a safeguarding concern can also be influenced by developments in practice, in one local authority learning from Safeguarding Adult Reviews resulted in all referrals regarding self-neglect being recorded as adult safeguarding concerns in order to progress through a s42(1) decision making stage:

"All self-neglect will go through a section 42(1) process as a result of local SARs and will be logged as a safeguarding concern as a result."

In another local authority the practical need to allocate a referral to a specific team has resulted in all referrals from the Ambulance Trust being recorded as concerns in order to allocate them to a hospital team leader for decision making as to next steps.

5.1.6 Impact of changes in procedure.

One local authority had developed a pathway for incident reporting which had markedly reduced the number of concern referrals during that particular year.

"We introduced a change in process at the Customer Service Centre in 2019 in response to volumes of referrals where care providers were calling to notify the local authority of untoward incidents where the risk had been managed (versus concerns where the adult was at any ongoing risk of abuse/neglect- i.e. a safeguarding referral). These were typically medication errors, incidents of resident-to-resident aggression in care homes, falls..... previously had no pathway to record these as incidents and so were recording as safeguarding concerns. We established a new pathway for incident reporting, and this initially led to a 25% drop in Adult Safeguarding Concerns logged. This is visible in the SAC return. Numbers of cases going into the Incident Notification pathway has remained static/increased over time, and adult safeguarding concern figures have increased back to numbers seen prior to this change, indicating a real term increase in referral demand since 2019/20."

5.1.7 Working with referring partners.

How partners understand what an adult safeguarding concern is and what they need to refer to the local authority was thought to have a significant impact on referral numbers. Workshop participants noted that if all concern referrals are badged as safeguarding at a generic front door there can be a significant impact on numbers from referring organisations who do not understand the criteria. Several local authorities were engaged in dialogue with partners about what was 'appropriate 'to refer into adult safeguarding. Some local authorities described '*inappropriate*' referrals, often linked to emergency services, which can overwhelm front door services and distort the local picture. Some local authorities had undertaken detailed audits with emergency services colleagues or were engaged in discussion about referral processes. Workshop participants were concerned that

an overwhelming volume of safeguarding concerns should not lead to the idea of an 'inappropriate' referral.

"We have to remember that referrals are never 'inappropriate' and can contain high critical risks."

Five workshop participants discussed work undertaken with Care Providers on preventing abuse and on when to refer a concern. There were concerns that the local guidance used may not be consistent with the approach taken by the regulator, the Care Quality Commission (CQC) and participants said that the regulator's attitude had influence over what provider's referred.

"We have a guidance document for care providers, we have to hold our nerve locally on what CQC wants us to do and what the local authority wants to do."

One local authority had seen a reduction in concerns reported by social care providers as a result of their work,

"Interacting with care providers and undertaking preventative training in care homes has reduced the number of adult safeguarding concerns reported by the provider sector. There is a recognised value in working with providers on prevention and what to refer. We want to give autonomy and decision making to providers, but how are CQC about this?"

The range of work with partners described that could influence referrals included:

- Telephone advice line/advice and guidance.
- A variety of opportunities to meet.
- Working together in a MASH or via a multi-agency meeting framework.
- Co-creating documents and procedures.
- Training.
- Specific audits of referrals with the West Midlands Ambulance Service and the Fire Service.
- Feedback on inappropriate referrals.
- Not much targeted work/no formal arrangements in place.

5.2 Factors which may influence the number of enquiries.

5.2.1 Summary

There is a disparity between how many s42 enquiries are undertaken nationally. The West Midlands SAC data return for 2021 – 2022 shows a rate of enquiries of between 51 and 453 per 100,000 population. The 2021- 2022 mean for England is 364 enquiries per 100,000

population with a range between 51 and 1533 per 100,000. All regions showing a marked difference in the 'conversion' of concerns to enquiries.

How many concerns become enquiries under s42 appears to be influenced by a number of factors, including the context in which adult safeguarding activity is carried out as discussed in **section 4**.

Influences also include,

- The impact of the linear nature of recording systems.
- The impact of capacity in teams undertaking an enquiry.
- How the criteria for the section 42 duty are understood by decision makers**.**
- Centralised or disseminated decision-making.
- Available pathways more appropriate to progressing the concern.

Workshop participants were clear about the purpose of an enquiry, i.e.

The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult paragraph 14.78[5]

Sometimes the way forward is already known:

"We have to remember what an enquiry is – sometimes it is not needed to determine the best way forward."

100% of questionnaire respondents said that they recorded an Enquiry for the purpose of the SAC return once the decision to progress to s42(2) had been made.

Eleven local authorities (79%) caused other organisations to undertake enquiries, ten reported these caused enquiries as 'Enquiries' in the SAC return.

5.2.2 The impact of the linear nature of recording systems.

Whilst LGA (2019) guidance emphasises the dynamic nature of decision making[6], the linear nature of the recording systems remains an issue. Several local authorities reported that they were unable to record activities undertaken whilst information gathering under s42(1) to establish whether the s42 duty are met.

"We are very influenced by our systems, in (recording system) the decision to go to s42 is quite far down the line, a lot of work has happened before then."

This difficulty is recognised by the NHS Digital SAC:

[5] 'DHSC Care and Support Statutory Guidance' available at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

[6] In relation to safeguarding enquiries, the framework for 'Making Decisions on the duty to carry out Safeguarding Adults enquiries' was published in August 2019. Find at: https://www.local.gov.uk/making-decisions-duty-carry-out-safeguarding-adults-enquiries

"*The SAC does not reflect significant and effective early intervention and prevention in safeguarding people which takes place after a concern has been raised and within S42(1) information gathering, to find out whether there is reasonable cause to suspect that the three statutory criteria are met."*[7]

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Workshop participants said that.

"We do a great deal of work before entering something as an enquiry." "We have 'further conversations' but these are not considered an enquiry."

Another noted that:

"There is a massive amount of work that is not being recorded, maybe there needs to be new guidance around recording, both for LAs and for recording system providers. Sadly we will never have a region wide recording system."

Whether a concern became an enquiry reported to the SAC return could depend on how much work was done at the s42(1) 'information gathering' stage. Workshop participants reported that this could include discussing the situation with the person and ascertaining further information regarding the concern or agreeing mitigation measures, it could mean contacting other organisations and discovering further information or agreeing risk mitigation plans. This activity was often described as a 'mini enquiry' and in some local authorities was supported by the form used:

"The Concern form creates quite a good space for recording and is quite useful for staff. It also asks the for the view of the adult in relation to the concern raised- we see this as good practice in getting the person's voice at as early a stage as possible, and as a way of promoting their involvement in what happens next, including whether the case moves to s42 Enquiry. This probably contributes to "mini enquiries" being undertaken at the Concern stage and being reported as such, but not progressing to Enquiry if the person does not wish for this to happen."

Others call these 'proportionate enquiries,'

"Recorded as an enquiry at SA1 (concern) stage because we have completed a proportionate enquiry."

5.2.3 The impact of capacity in teams undertaking an enquiry.

In some local authorities a new form or 'episode' must be created to send a concern onto another team to progress a s42(2) enquiry. This 'new episode' is not completed whilst the decision- making team still retains the case. In times of high demand it is not always

[7] https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2021-22/introduction-and-key-points

possible to pass a case onto another team to progress an enquiry, and although the work may be carried out it will not be recorded as an enquiry.

"We have a rule that all Enquiries need to be allocated to a named worker. At times of high demand, the capacity to allocate is limited which leads to a larger number of cases having to be dealt with by Duty. They tend to be managed at Concern stage on duty, and this can lead to delay in converting to Enquiries, and in some cases completion of the case to resolution on duty recorded at the Concern stage only."

"Recent increase in demand means we are currently running a waiting list to allocate concerns (for enquiry)."

Some local authorities worked in systems where enquiries were passed onto local teams who did not have the capacity to undertake a high volume of enquiries. One workshop participant spoke about trying to understand what a 'fair' conversion rate was.

"There needs to be a conversation at strategic level to agree what is 'fair.' We work hard to ensure that something does not become an enquiry, but this is not then recorded."

The capacity of teams to undertake an enquiry may influence how many enquiries are progressed, and how many are retained by decision makers and progressed without being recorded as enquiries under s42(2).

Other respondents indicated that pressure on capacity did not change the conversion rate of concerns to enquiries in their area but could impact on timescales,

"Budget constraints and existing pressures on community teams are impacting hugely. Staffing is having a big impact on timescales."

Delays were also caused by capacity issues in partner organisations,

"We have delays with completion of caused enquiries due to competing demands of other organisations."

5.2.4 How the criteria for the section 42 duty are understood by decision makers.

A local authority must have 'reasonable cause to suspect' that three criteria are met regarding 'an adult in its area':

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it[8].

[8] Care Act 2014 section 42. Read at https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

We explored any regional differences in interpretation of legal criteria a) and c) in the pre-workshop questionnaire and via a case study in the workshop.

5.2.4.1 Criteria a) Within the questionnaire five respondents (35%) identified 'substance misuse' as a potential care and support need.

"Where an adult requires assistance or support to complete activities as a result of a physical/mental health need - including substance misuse and sensory impairment."

Three respondents (21%) mentioned 'carers' but not 'substance misuse'.

"Our localised definition is Care and Support as the mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent - including older people, people with a disability or long-term illness, people with mental health problems, and carers."

Two respondents referred to the over-arching West Midlands guidance for a definition, three thought the definition was as contained in the Care Act, one correctly cited the definition contained in the statutory guidance glossary. This local authority differentiated between the definition and the best approach in practice,

"We would work to the definition given in the Glossary of the Care and Support statutory guidance. In practice, I think most LA social work practitioners would apply the rule of thumb that anyone who is struggling to live independently without any support is someone who may have needs for care and support. This question has made me think about how other agencies would consider/define a care and support need."

Workshop participants discussed national and local developments about who is considered as having 'a care and support need,' including the tension between 'traditional views' and areas of work unfamiliar to practitioners,

"At an operational level we perhaps still have a fairly traditional, limited view of care and support needs as those who require direct services and therefore limit those who are unable to protect himself or herself from abuse. We have extended our workforce's understanding of care and support needs through the Transitional Safeguarding, Domestic abuse and exploitation agendas. This has brought people into our safeguarding arena that we have not traditionally worked with, but challenge is still required with some workers, particularly around working with those with who are difficult to engage as a consequence of trauma or previous experience."

The disparity in how care and support needs are defined may influence who the local authority considers it does and does not have a duty toward under s42.

5.2.4.2 Criteria c) There is no definition of 'unable to protect' in either the care and support statutory guidance or in the West Midlands overarching guidance. In the questionnaire respondents indicated a range of interpretations. Some indicated that the person's mental capacity would be a factor:

"This would be the impact of care and supports needs and the individual's ability to protect themselves from the situation. This would be dependent on mental capacity."

"Often this is defined by an MCA assessment and in conversation with the individual."

How the Mental Capacity Act is used in defining a person's ability to protect themselves was challenged both in the workshop and in questionnaire responses:

"We do encourage staff to think about this quite broadly, and to consider the impact of the person's disability or illness and the way this impacts their concepts of choice and independence. While we do want consideration of mental capacity to be a golden thread through practice, I think there is sometimes a tendency to consider this question in quite a narrow way only in terms of mental capacity to make choices around their safety or lifestyle."

Others mentioned 'Making Safeguarding Personal' and a range of other factors to be taken into account.

"As per LGA enquiry guidance - consideration of the following: What insight does the adult have into the level of risk, do they understand why practitioners have concerns? Is there any evidence of incapacity, coercion, undue influence or duress? What outcomes matter to the adult and will this reduce/remove the risk?"

Two respondents indicated that they had no fixed definition but relied on "*professional judgement."*

5.2.4.3 The variation in how the three criteria are defined locally can have some impact on who the s42 is thought to apply to. One workshop participant described the impact of reasserting the statutory criteria to decision making teams,

"We have been re-asserting the statutory guidance with teams and as a result the conversion rate has changed slightly. We realise we also need to spend time at the frontline looking at team cultures and the pressures that build up as a result of limited resources. These can lead to practitioners taking short cuts."

Ensuring a consistency of decision-making was harder when there was a high turnover of staff.

"Turnover of staff [frontline and managerial] and pandemic also appears to have impacted on staff confidence and understanding of safeguarding both locally and Care Act compliance-wise. This is a huge challenge to overcome due to fragmentation of teams - MASH reach threshold however adult social care teams lead on enquiries."

"Recruitment and retention of staff, high use of agency social workers, skills, knowledge and experience can be a challenge in respect of complex safeguarding."

This was thought to be perhaps more problematic if the decision to use the s42 duty was disseminated rather than made by a centralised decision-making team (see 5.2.5).

Other participants thought it worthwhile having a definition of 'unable to protect' as this criteria is relevant in making a decision as to whether the s42 duty is indicated. "*We are all seeing this differently."* Participants would also welcome guidance about which factors, alongside mental capacity, are relevant in understanding 'unable to protect,' the most frequent factors mentioned at the workshop being trauma, addiction, duress and coercion including coercion as part of domestic abuse coercive control.

5.2.5 Centralised or disseminated decision-making.

64% (n=9) of questionnaire respondents had 'centralised' decision-making arrangements, i.e. the decision as to whether the s42 duty applied was made by one team. 21% (n=3) had 'disseminated' decision -making, the decision about the s42 duty was made by separate teams, usually the locality team who would undertake the enquiry. Two local authorities had 'hybrid' arrangements, in one area using disseminated decision making for people who were referred as 'self-neglecting,' and in another using centralised decision -making via a MASH for non-allocated cases.

During the workshop we explored the data return implications of disseminated or centralised decision-making. Generally the consensus was that gaining assurance about consistency was easier with centralised decision making, although within some centralised teams, i.e. MASH, there were inconsistencies in decision making related to the skill set and experience of MASH partners. Whilst centralised systems gave more opportunity for good governance and data monitoring, they could also be overwhelmed, experience 'compassion fatigue' and develop a 'tick box' culture. Guidance has a key role in disseminated decision making, but participants also acknowledged that teams can be fragmented and have a range of experience. "*When staff come in from other local authorities they take a while to get the new LA guidance."*

"Micro issues become more prevalent in disseminated decision making models."

"It is difficult to get the practice responses right around self-neglect and a lot of these difficulties are around the disseminated decision model."

One participant thought that decision making at locality level can jeopardise other work such as crisis response and can be influenced by the team's awareness of how much work they have. Centralised decision-making teams may also be aware of pressures and waiting lists in locality teams and work hard to reduce the need for the allocation of an enquiry.

5.2.6 Availability of pathways more appropriate to progressing the concern.

When a decision was that the s42 duty did not apply, local authorities used a range of responses to safeguarding concerns. The most common perhaps of these 'pathways' is section 9 of the Care Act; an assessment of the person's care and support needs rather than an enquiry under the s42 duty.

Workshop participants emphasised that not using the s42 duty does not mean that no action is taken, or that the person is not getting the support that they need.

"Decision making is thorough with full exploration that determines the pathway, don't assume that because something is not s42 then it is not dealt with."

Understanding the person, using Making Safeguarding Personal approaches, can help to determine the best pathway to use to work with them.

"Sometimes determining the pathway is about focusing on the person or their history, thinking about the best way to engage them, actual risks, social and emotional functioning. How best to be working with the person will lead to a better outcome."

The workshop case study on self -neglect (see appendix 3) led to different outcomes according to local pathways that had developed in each local authority. In one local authority all self-neglect concerns will go through a section 42(1) process as a result of local SARs, in others a self-neglect concern will go through a case management pathway if there has been no previous engagement. This may involve use of section 9 or section 11 of the Care Act 2014[9].

Other pathways mentioned by workshop participants include:

- Complex care or 'high risk' – a specific team and pathway
- Vulnerable Adult Risk Management/Complex Adult Risk Management or multi-agency meeting.
- Self-Neglect pathway (23%. N=3 describe a 'self-neglect pathway)
- Carers assessments – often used when there are concerns about neglect by unpaid carers.
- Exploitation pathway.

[9] Care Act 2014 section 42. Read at https://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted and https://www.legislation.gov.uk/ukpga/2014/23/section/11/enacted

6.Analysis and areas for further consideration.

These considerations can be developed further via learning workshops in the region for local authorities to define and share best practice together.

6.1 The different recording systems used by each local authority made a demonstrable difference to how SAC data was reported. Some representatives described struggles to get the system 'right' or to change systems to make them compatible with the SAC as well as supportive of practice. Others could see an advantage in a regional or even a national standard recording system for adult safeguarding. System providers could benefit from guidance on the basic requirements for any system recording safeguarding adults information, this would need to be a national standard and may support more consistent reporting to national data sets.

Consideration 1.

Councils in the West Midlands should consider whether they wish to recommend to the national ADASS safeguarding policy network that electronic system providers must give assurance on a basic standard for recording safeguarding activity for the SAC return.

In thinking about the considerations below careful thought will need to be given to the impact on operational capacity to deliver services.

6.2 Local authorities in the region differed in the amount of work they were able to undertake with referring organisations. Working with referrers was reported to create a discernible change in the number and type of concern referrals received or/and created a more respectful and 'empowering' partnership with referrers.

Consideration 2.

Councils in the West Midlands region may consider learning from work undertaken with referrers by local authorities that has demonstrated an impact on either referral rate or improvements in partnership working.

6.3 Local authorities in the region are using disparate definitions of 'care and support' and 'unable to protect.' Some groups may be omitted or included from consideration of the s42 duty as a result of the diverse definitions. With regard to 'care and support,' workshop participants debated whether the subject of case study 1 (Gillian) had care and support needs, some seeing her substance misuse and health needs as significant when considering the s42 duty, others asking if those factors had led to a disability which they would consider as a care and support need. Regionally and nationally, some areas are including substance misuse as suggested by SCIE (2018) and in LGA (2020) guidance.

"Safeguarding duties apply regardless of whether a person's care and support needs are being met, whether by the local authority or anyone else. They also apply to people who pay for their own care and support services. An adult with care and support needs may be:

- *an older person*

- *a person with a physical disability, a learning difficulty or a sensory impairment*
- *someone with mental health needs, including dementia or a personality disorder.*
- *a person with a long-term health condition*
- *someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.' (Adult Safeguarding Practice Questions, SCIE, July 2018)*[10]

Consideration of this need for care and support must be person-centred (for example, not all older people will be in need of care and support but those who are 'frail due to ill health, physical disability or cognitive impairment' may be. ***The above is not an exhaustive list, and it must be considered alongside the impact of needs on the individual's wellbeing."***[11]

Other local authorities are using similar definitions as that given in the West Midlands Policy and Procedures [12].

There are also variances in how local authorities are interpreting the third criteria for use of the section 42 duty, 'as a result of (care and support needs) is unable to protect themselves'. There is no definition of 'unable to protect' in the care and support statutory guidance and this has led to a wide variance in understanding regionally and nationally.

Consideration 3.

Councils in the West Midlands region may consider reviewing the definitions which inform the three criteria for use of the s42 duty within the West Midlands regional Policy and Procedure.

The region may also wish to recommend the need for a clarification of the 'unable to protect' criteria to the national ADASS safeguarding policy network.

6.4 In the majority of local authorities in the region a concern about potential self-neglect is least likely to be considered under s42(1) unless the person has not taken up a recent offer of support. Alternative pathways are used and thought to be more proportionate for people in this situation. However as a result of learning from SARs on self-neglect one local authority uses s42(1) to gather further information and risk assess the situation before determining the pathway to be used. The use of s42(1) in order to determine the best pathway for people who are allegedly self-neglecting has been recommended in a number

[10] https://www.scie.org.uk/safeguarding/adults/practice/questions
[11] LGA 2020 Ibid - Find at https://www.local.gov.uk/publications/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcomes

[12] West Midlands Policy and Procedures (2019) https://www.safeguardingwarwickshire.co.uk/images/downloads/West-Midlands-Policy-and-Procedure/WM_Adult_Safeguarding_PP_v20_Nov_2019.pdf

of recent SARs[13]. It is worthwhile sharing this learning across the region to enable other local authorities to consider whether they should introduce this step into determinations about the best and most proportionate approach.

Consideration 4.

Councils in the West Midlands region should consider how learning from SARs on decision -making on use of the s42 duty or other appropriate pathways in cases of self -neglect can be disseminated and understood. This will enable other local authorities to review their processes in the light of SAR learning.

6.5 Workshop participants shared useful approaches to explore local consistency in decision-making and to audit the outcomes of non – s42 pathways. Local authorities should use tested approaches to ascertain the outcomes of non-s42 pathways in order to develop these approaches and consider their interface with safeguarding, other statutory duties and work with partner organisations. This is consistent with the wishes of workshop participants:

"We need to develop a narrative about how we are working with people outside of the s42 duty to protect and support and develop this regionally."

Consideration 5.

Councils in the West Midlands region should consider how they will audit decision -making on cases referred as safeguarding concerns that are referred onto non 42 pathways for support. SABs will receive information about safeguarding trends but should also require reports on outcomes for people referred as a safeguarding concern who are offered a response assessed as more appropriate to their situation. This could produce rich learning about the wider safeguarding system.

6.6 Workshop participants also wished to use the learning from the workshop activities to deepen the narrative behind their individual SAC returns. The list of questions in Appendix 1 will contribute to this work and can be used to inform conversations with practitioners and managers as well as other auditing activity.

Consideration 6.

The West Midlands safeguarding network should consider how to continue to enable the development of the narrative around the SAC data. The network can build on the learning from the workshops and subsequent learning from individual local authorities' narrative about the SAC data, as well as from future regional learning workshops.

[13] SARs published by Worcestershire SAB. Elsewhere – SAR Sam at https://www.hampshiresab.org.uk/wp-content/uploads/Final-version-HSAB-Self-Neglect-Thematic-SAR-March-2022.pdf

Appendix 1 Developing a narrative about the data.

The questions below are derived from the influences on SAC data identified in the pre-workshop questionnaires and at the workshop. The questions can be used to inform thinking about influences on the data, create auditing frameworks or act as a starting point for further data comparison or interrogation.

1. Has the data in your SAC return changed over the last four years? What are the key reasons for the data changes?

(*These might include changes in local procedure, new or revised recording systems, the impact of COVID, any other factors*)

2. Are there any contextual factors in your area that are influencing the data?

(*These might be demographic, national or local lessons learned, resource/capacity issues, organisational issues, any other factors*)

3. At what stage in the safeguarding process is a referral logged as a concern and reported as such in the SAC return? How does this influence the number of concerns and the number of enquiries recorded?

4. Do you have any local policies about what is recorded as a concern?

(*For example, a different process for a specific organisation or for a type of abuse in specific circumstances?)* What is the rationale for this?

1. Has a change in guidance or procedures influenced how many referrals are recorded as concerns?

(*For example using an incident notification procedure? Guidance to organisations about what to refer? A new multi-agency pathway?)*

2. Has work undertaken with specific organisations changed what is being referred as a safeguarding concern?
3. Does your recording and/or allocation process influence how enquiries are recorded and progressed?

(For example it is not possible to record significant work undertaken at a s42(1) stage as an enquiry under s 42(2) without allocation to a different team.)

4. Does available capacity to allocate affect the number of enquiries recorded for the purpose of the SAC return?
5. What is considered a 'care and support' need in your local authority? Does this impact on the number of concerns which progress to enquiry?

6. How is ‘unable to protect’ defined and considered in your local authority? Does this impact on the number of concerns which progress to enquiry?
7. How are decision makers using the three criteria for the s42 duty? How do you explore consistency and reliability in decision making? What are the outcomes of audit/research or conversations about decision making? If these outcomes are concerning what action has been taken to address these?
8. How is decision making configured? (*Centralised, disseminated, hybrid.*) What impact do these configurations have on consistency and reliability of decision making? What are the outcomes of audit/research or conversations about decision making? If these outcomes are concerning what action has been taken to address these?
9. If a concern does not meet the criteria for the s42 duty or an enquiry is not necessary, what other approaches/pathways are used to support the person?
10. How is assurance given that other approaches/pathways are timely and effective? What are the outcomes of audits, case samples, individual, family or organisation’s feedback?

Appendix 2 Pre-workshop questionnaire

West Midlands Survey Monkey - Questions and notes on rationale for questions.

1. Name of your local authority

Note: The name of your local authority will not be included in post workshop written reports.

2. What specific outcomes do you want from attending the workshop?

Policy Influences in your local authority.

3. What does your local authority consider a 'care and support 'need?

Note: Local authorities do vary nationally, in who they consider as having a care and support need, for example whether they consider someone with an addiction or with a mental health need as 'having a care and support need.'

4. How do you define 'a*s a result of (care and support) … needs is unable to protect himself or herself against the abuse or neglect or the risk of it*'?

Note: In decision making, what is considered to constitute an inability to protect oneself?

5. How do you define 'organisational abuse'?
6. How do you differentiate between organisational abuse and 'quality concerns' in your local authority?

Procedural influences in your local authority

7. How are concerns about self-neglect progressed?

Note: Some local authorities use a specific pathway for concerns about self-neglect, often using section 9 of the care act to explore support needed, others may determine the pathway after using s42(1), others may have a 'multi agency risk management' structure to enable concerned organisations to work together – there are many potential pathways.

8. How do you cause other organisations to undertake an enquiry? Which organisations? Do you have specific guidance for them to use?
9. How do you respond to organisational abuse concerns? Are other local authority teams or external organisations involved?

Note: Some local authorities have a range of responses to concerns about organisational abuse which may involve health colleagues from ICB or provider safeguarding teams, and/or social care or health commissioners.

Safeguarding Arrangements in your local authority

10. How can people make a safeguarding concern referral?
11. How are 'front door' services and safeguarding services configured?

Note: Again, there are many different permutations, concern referrals may be 'screened' by qualified or non-qualified staff at the front door, there may be qualified safeguarding

practitioners at the front door undertaking 'screening.' Cases may be referred into a MASH, or a specialist LA team for s42.1 decisions etc.

12. Who makes the decision that the Local Authority safeguarding duty applies?
13. What guidance and support are available to s42 decision makers?

Partnership Arrangements in your local authority

14. How do you work with external organisations to understand in what circumstances a safeguarding concern must be referred?

Note: This may be through guidance or training, and /or through having a dedicated phoneline or contacts for organisational leads to use, or in other ways.

15. Are there organisations in your area who have formal arrangements to make decisions on whether the criteria for the s42 duty may be met before referral?

16. asks – if so, which organisations?

Note: In some local authorities, internal safeguarding teams in acute or mental health trusts 'filter' concerns before making a referral to the local authority.

Recording arrangements in your local authority.

17. Please describe how your recording systems helps and/or hinders in supporting and recording safeguarding activity?

18. At what point do you record a referral as a safeguarding concern?

19. At what point do you record a safeguarding enquiry?

20. Does this include enquiries you have caused others to undertake?

Other influences that may affect safeguarding activity in your local authority.

21. Demographic influences: are there any features of your local authority area which influence the number of concerns/enquiries?

Note: Could be high number of hospitals, care homes, private hospitals?

22. Resource issues: budgets, time, pressures on community teams?

23. Organisational culture: including the impact on this of SARs or other local/national enquiries, the influence of other policies, response to COVID etc.

24. Anything else that you would like to tell us about safeguarding activity in your local authority?

Appendix 3 Case studies used in the workshop.

Case Study 1 The three criteria for the use of the s42 duty.

Question: do you think that Gillian's current situation meets the three criteria for use of the local authority s42 duty?

Discuss your thinking about whether she meets the criteria or not. Is Gillian unable to protect herself as a result of her care and support needs?

Are there areas that need to be clarified in guidance or practice to support these decisions?

Case Study

A third sector organisation, which supports women who have addiction issues, has sent a safeguarding concern about Gillian's self-neglect.

Gillian lives alone in a housing association flat. She is 45 years old and a long-term user of heroin and crack. The referrer is concerned that Gillian has self -discharged from hospital where she was being treated for infected sores. She is at risk from sepsis as her treatment has not been completed.

In addition Gillian's environment has also deteriorated. Her toilet is currently blocked, and she has no hot water. Her flat is described by the referrer as 'filthy' and very unhygienic.

You gather information from partners. The acute trust advises that Gillian was given a heroin substitute but was distressed on the ward and they believe that she left in order to recommence drug use. They had no reason to believe that Gillian lacked capacity to make the decision to self-discharge and the doctor who spoke with her thought that she understood the risks she was taking in doing so. The housing association and neighbourhood police advise that drug dealers often use Gillian's flat, she is viewed as a source of anti-social behaviour as well as a vulnerable person. Gillian's phone is out of service, she cannot be contacted.

Case study 2 Poor quality or organisational abuse?

Thinking about the arrangements in your local authority, who would lead the approach to address concerns about Blue Skies care home?

In what circumstances would you record this case as an 'organisational abuse' enquiry?

Case study

You are discussing Blue Skies Care Home in a regular meeting with quality assurance colleagues.

The care home has another new manager, the third in a year. Blue Skies is a 40-bed care home which supports people with dementia, nursing needs, learning disabilities and mental health issues. As well as your own local authority two adjoining local authorities fund placements there.

Family members and visiting professional have reported over the last two years that the furniture and bedding is old and worn in the home and the rooms feel chilly at night. Food is not great quality, often overcooked and hard to chew.

In the last six months visiting professionals have reported three adult safeguarding concerns. In March inappropriate food was given to a resident with swallowing difficulties, contrary to SALT assessment and plan. In June a minor injury was caused by poor manual handling. In August a failure to maintain hydration charts for residents at risk of dehydration was reported. No harm ensued from these incidents and the manager(s) took action to make sure learning was put immediately into action.

The care home has now reported an incident of resident-to-resident abuse where a younger man who has learning disabilities has pushed an older woman, causing her to fall. She is now in hospital with a fractured neck of femur.

Appendix 4 Workshop Programme

West Midlands Region Adult Safeguarding Concerns Workshop

9.30	**Introduction**	
9.40	Introduction to the workshop: - Purpose of the workshop. - Participants outcomes. - Workshop principles. - Programme.	Facilitator
10.00	The context we currently work in. - Feedback from the survey	Discussion
10.20	From the survey: when do we record concerns or enquiries? What difference does it make?	Discussion
11.00	**BREAK**	
11.15	Does the way in which we define aspects of adult safeguarding make a difference?	Small groups: case studies and feedback discussion
12.00	Local differences: Decision making models. How we work with self-neglect Causing enquiries	Discussion with practice examples from participants.
1.00	**LUNCH**	
1.30	Local differences continued as needed followed by Recording Systems.	Discussion.
2.00	What are the factors you have thought about today which may be influencing how your data appears/how the regional data appears?	Small groups followed by feedback discussion.

2.45	What can we take forward, regionally and locally, from today's workshop. Next steps	Discussion.
3.30	**CLOSE**	