Agenda Item 9

96

# ADULT AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 18 JANUARY 2021

# OVERVIEW OF ADULT SAFEGUARDING ACTIVITY PRE AND DURING THE COVID PANDEMIC

# REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

## Purpose of report

1. The purpose of this report is to provide Committee members with an overview of adult safeguarding activity pre and during the Covid-19 pandemic.

## Policy Framework and Previous Decisions

2. The 'No Secrets' Guidance was replaced by the Care Act 2014 which created a legislative framework for safeguarding. The Act defines safeguarding adults as protecting an adult's right to live in safety and free from abuse and neglect and provides a legislative framework for those working in adult safeguarding stipulating that each local authority must:

- make enquiries, or ensure others do so, if it believes an adult is experiencing or is at risk of abuse or neglect; abuse or neglect can be viewed in terms of the categories defined in the Care Act;
- set up a Safeguarding Adults Board (SAB);
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or safeguarding adults review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them;
- co-operate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect.

3. The aims of adult safeguarding are to:

- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- stop abuse or neglect, wherever possible;
- safeguard adults in a way that supports them in making choices and having control about how they want to live;
- promote an approach that concentrates on improving life for the adults concerned;
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;

- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult;
- address what has caused the abuse or neglect.

4. Before the introduction of the Care Act, the initiative Making Safeguarding Personal (MSP) was introduced which aims to make safeguarding person-centred and outcomes focussed, moving away from process driven approaches to safeguarding. MSP was a sector wide initiative, which continues to aim to imbed this approach and a range of responses to support people to improve or resolve their circumstances.

5. This approach was reaffirmed by the Care Act 2014 and is now underpinned by the Leicestershire, Leicester City and Rutland (LLR) Multi-Agency Policies and Procedures (MAPP) which aim to make sure that:

- the needs and interests of adults are always respected and upheld;
- the human rights of adults are respected and upheld;
- a proportionate, timely, professional and ethical response is made to any adult who may be experiencing abuse;
- all decisions and actions are taken in line with the Mental Capacity Act 2005, where relevant/applicable;
- that each adult maintains choice and control, safety, health and wellbeing, quality of life and dignity and respect.

6. The Mental Capacity Act (MCA) 2005 provides a framework to protect and restore power to those who may lack or have reduced capacity to make certain decisions at particular times.

7. The following five principles apply for the purposes of the MCA and should inform all actions when working with, and be evidenced when taking decisions or actions on behalf of, a person who may lack or have reduced capacity:

- A person must be assumed to have capacity unless it is established that they lack capacity;
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success;
- A person is not to be treated as unable to make a decision merely because they make an unwise or bad decision;
- An act done or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests;
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action or self-determination.

**Background**

8. The purpose of the Safeguarding Adults Team is to ensure that there is a consistent and timely approach to applying safeguarding thresholds, identifying and addressing immediate risk and establishing the outcomes of the person involved, in line with 'Making Safeguarding Personal' principles. The Team in its current form was

introduced in 2018 and comprises of one Service Manager, seven Social Workers and one Community Support Worker.

9. The Safeguarding Adults Team will usually receive their alerts/referrals from the Council's Customer Service Centre (CSC). Cases that require ongoing work in relation to management of abuse or neglect, or cases that require care management are transferred to locality teams, once the Safeguarding Adults Team has addressed the short-term interventions outlined above. Locality Teams are also responsible for the completion of safeguarding enquiries for cases that are allocated to workers within the teams.

10. The Safeguarding Adults Team will provide short term intervention when issues relating to abuse or harm are indicated for an individual (usually within three working days), during which time it will aim to make enquiries to enable it to:

- apply safeguarding thresholds;
- identify and take steps to address any immediate risk;
- meet or discuss with the person involved to establish what their outcomes are in relation to the safeguarding enquiry. Where there are any doubts about the person's capacity to consent to the enquiry and advise of their outcomes, a mental capacity assessment and if necessary best interest decision in relation to this will be undertaken;
- establish who is involved with the person's care and who needs to be involved in the enquiry;
- hold a strategy meeting or discussion at a multi-agency level with relevant partners, e.g. Police, Care Provider GP.

**Safeguarding during the Covid 19 Pandemic**

11. During the initial phase of the Covid-19 pandemic, the Safeguarding Adults Team was required to adapt the way safeguarding enquiries were carried out in order to ensure compliance with the national restrictions that were in force. Prior to the pandemic, the Team would usually visit the adult at risk or discuss their concerns over the phone. However, during the initial Covid-19 period, the Team was required to gather a person's views and outcomes they wanted to achieve in different ways.

12. The majority of safeguarding enquiries were completed over the phone by either talking directly to the person or, if there were issues around communication, speaking to a family member, carer or other professional, who would ask the person the questions related to the enquiry and the Social Worker or Community Support Worker would listen to their response. However, where the information could not be gathered over the phone and the person was deemed to have capacity, the safeguarding worker arranged to meet with them either by following social distancing rules or using the correct Personal Protective Equipment (PPE). Since the restrictions have eased the Safeguarding Adults Team is carrying out many more visits in line with usual practices.

13. When a safeguarding enquiry is received by the Team regarding a person that lacks mental capacity e.g. based on previous assessments or under a Deprivation of Liberty Safeguard (DoLS), a visit is usually arranged. However, during the initial stage of the pandemic, for this type of enquiry it was necessary for an individual risk assessment to be undertaken with the Service Manager to assess the risks of Covid-

19 and the type of abuse being experienced to determine whether a visit was appropriate. This remains the approach at the time of this report subject to continuous review in light of revised advice and guidance.

14. Each case continues to be reviewed on an individual basis, to determine whether a visit should be carried out or not. Examples of when a visit has been completed would be where there have been allegations of neglect in a nursing/residential home, or allegations of sexual or domestic abuse. An example of when a visit would not be carried out may be when there has been a medication error and no harm has been caused or the issue is a one off, or where harm occurred but the care provider took appropriate action. If a visit was not carried out, the Social Worker or Community Support Worker would talk to the family member or individual to gather their views.

15. In line with the Care Act, when safeguarding concerns are raised about providers, the team instructs the provider to complete their internal investigation, or cause enquiries to be made by others when it was/is safe to do so. However, if concerns are raised from the internal investigation, or if it is felt that the risks are too high from the original referral, then the Team has continued to carry out unannounced visits using the correct PPE.

16. Since the pandemic, there have been a number of whistle blower reports about nursing/residential homes where unannounced visits have been required. The Safeguarding Adults Team has worked jointly with the Quality and Contracts Team and locality teams in these cases.

**Safeguarding data**

17. Data and information detailed within this report is taken from four sources as set out below. This includes the data for the past 12 months from January to December 2020 from Tableau dashboards, current trend data from Tableau, data from reports compiled from records of the Safeguarding Adults Team for 2020 and NHS digital data for 2019-20.

    - Tableau dashboards, produced from the County Council's Data and Business Intelligence Team; This data includes year to date (data for the last 12 months), data and current trend data;
    - Data produced by the Service Manager for the Safeguarding Adults Team;
    - Records of SAR's held by the Safeguarding Adults Board Office;
    - NHS Digital Safeguarding Adults England, 2019-20. (1) This publication provides the findings from the Safeguarding Adults Collection (SAC) for the period 1 April 2019 to 31 March 2020.

18. Trend data from Tableau dashboards provides information on a range of safeguarding activity and is set out within paragraphs 20 and 23 in relation to alerts and Enquiries.

19. In relation to national data, the NHS Digital Safeguarding Adults England 2019-20 report sets out data from local authorities and shows a total of 475,560 alerts (an increase of 14.6% on the previous year) were recorded during this period. It should be noted, however, the report authors have indicated that as this data was gathered pre-March 2020, the impact of the Covid-19 pandemic has not been a material factor in this increase as the pandemic only took hold at the end of the annual reporting

period. This makes understanding the impact of the virus at a national level difficult. It is also difficult therefore to make direct comparisons with the local data, as set out below, which includes data up to December 2020. A useful overall comparison can still, however, be made.

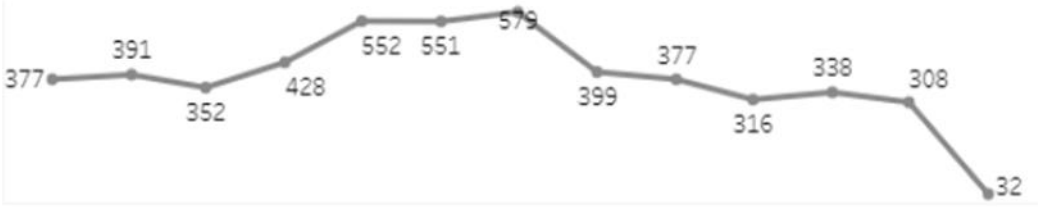
Local Alerts

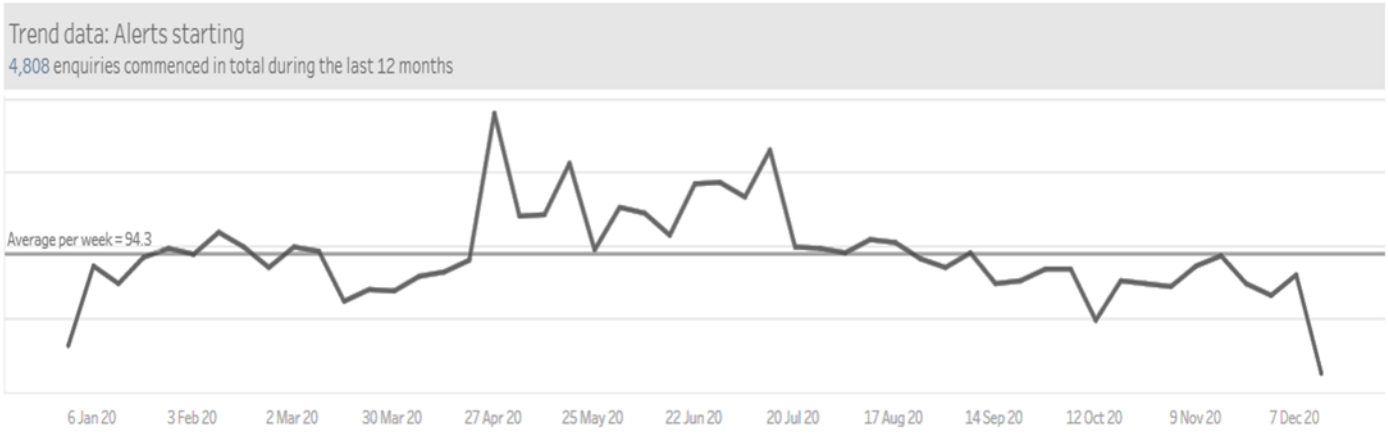
20. Alert volumes for the year to date stand at 3,880 and is set out in the table below. Numbers per month vary from a high in July 2020 of 579, to a low of 308 in December 2020. On average there were 94 alerts per week. This is an increase of 782 or 25% on the previous year which is higher than that reported nationally for the previous 12 months (an increase of 14.6% on the previous year), though it is important to note that there remain three months of local data to report on for the year 2020-21.

ALERTS RECEIVED

| FY 2019/20 | FY 2020/21 | Difference | % Difference |
|---|---|---|---|
| 3,098 | 3,880 | 782 | 25.2% |

ALERTS RECEIVED BY MONTH




21. An alert is defined as the passing on of a concern that someone may be being abused to an appropriate person. As highlighted this information is usually received into the CSC - the CSC received the highest number of alerts (3,578 or 74% of the total alerts received during 2020). Many (59%) of the current open alerts have been open for a duration of less than two weeks. It should be noted that an alert can include any concern for welfare and will often require a response from the Authority, but not necessarily in relation to safeguarding.

Section 42 Enquiries

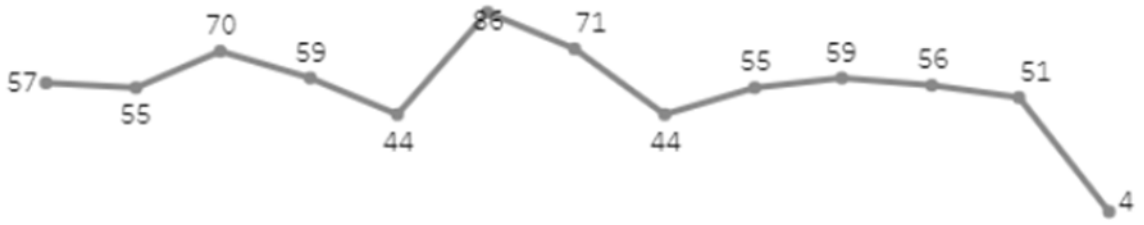
22. When the Safeguarding Adults Team receive an alert, officers from the Team will establish if safeguarding thresholds are met and will evidence this in case records before commencing an Enquiry or transferring the case to the appropriate locality team where the case will be allocated to a worker or team for them to commence the Enquiry. The thresholds guidance was developed across LLR and seeks to provide practitioners with support in making a decision about whether a referral regarding an adult who may be experiencing abuse or neglect, may require further Safeguarding Adults Enquiry. Consistent threshold decisions play a crucial role in ensuring that safeguarding enquiries are undertaken for adults at risk who may be unable to protect themselves, and for identifying that alternative means of addressing risk can be considered where this is not the case.

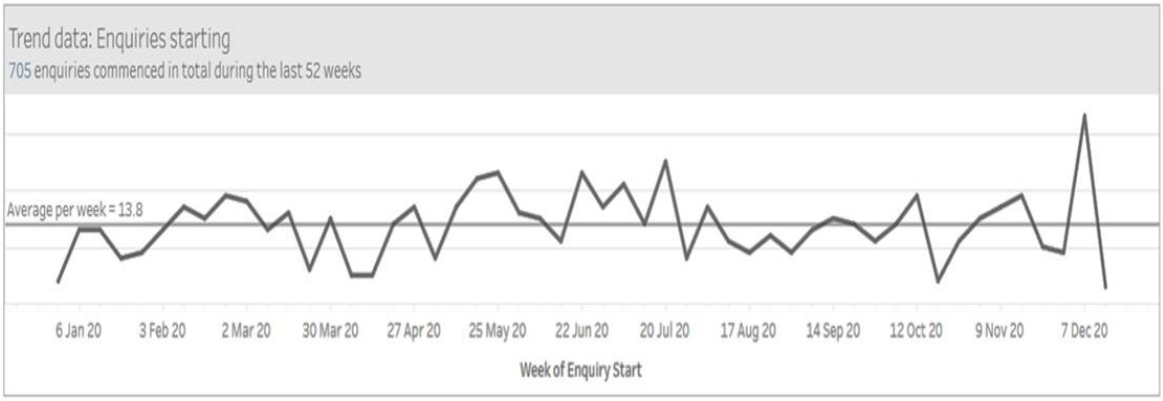
23. Year to date data indicates that for 2020-21 there have been 529 completed enquiries whereas for the full year 2019/20 there were 703 completed enquiries. The year to date figures are therefore consistent with previous years. The highest number of enquiries concluded for this year to date was in June 2020 a figure of 86 with the lowest numbers being 44 in the months of May and August. It is important to remember that some of the enquiries will be currently ongoing hence the figure of four for the month of January 2021. The full year's data will not be available until after March 2021.

ENQUIRIES COMPLETED

| FY 2019/20 | FY 2020/21 | Difference | % Change |
|---|---|---|---|
| 703 | 529 | -174 | -24.8% |

ENQUIRIES COMPLETED BY MONTH




24. Neglect remains the most reported type of abuse. During 2018/19, neglect made up 34% of risks whilst in 2019/20, it constituted 30% followed by psychological abuse,

financial abuse and physical abuse. Again, comparing with NHS Digital data nationally the most common type of risk in Section 42 Enquiries that concluded in the year was Neglect and Acts of Omission, which accounted for 31.8% of risks. This indicates that the Department's reporting is in line with national trends regarding neglect in relation to previous years.

25. Based on current local trend data from Tableau dashboards for the year 2020-21, neglect is the joint highest reported form of abuse at 22%, however psychological abuse is also standing at 22%. This shows a reduction in the proportion of safeguarding reports indicating neglect and an increase in other forms of abuse.

Outcomes

26. From the NHS Digital Safeguarding Adults England 2019-20 report, 89.5% of concluded Section 42 enquiries where a risk was identified, the reported outcome was that risk was reduced or removed.

27. In relation to the recording of outcomes, the Department has adopted the above recording process during 2020/21, therefore in future years the Department will be able to compare these outcomes with national data.

**Data regarding activity generated by the Safeguarding Adults Team**

28. The tables below show cases that have been transferred to the Safeguarding Adults Team during the last year and variances in these figures. These have been broken down to community cases and Organisational Safeguarding Adult (OSA) cases.

29. During the pandemic, officers in the Safeguarding Adults Team and localities have undertaken several large scale enquiries relating to externally contracted care homes and more recently supported living accommodation. Large scale organisational enquiries will involve management of concerns with the Care Quality Commission and the Department's Strategy and Commissioning function, who are responsible for managing contractual arrangements with external providers. When comparing the financial years 2019/20 and 2020/21 the figures for organisational safeguarding enquiries are very similar (42% and 41%).

30. An OSA relates to alerts that are received regarding a care provider, individual alerts are added to a record against the provider. The highest number of cases received regarding OSAs being in June and July at 65 and the lowest in April at 30. These cases relate to referrals received where services are delivered through external contractual arrangements. The lowest number of referrals is at the point following the national lockdown being implemented.

31. Tables 1 and 2 overleaf show the number of alerts that have been managed by the Safeguarding Adults Team and the outcome in relation to how the alerts have been addressed.

32. As the data indicates, there was a large reduction in the number of alerts/referrals received in March and April for community cases and in April for OSA cases.

**Table 1** – shows the number of cases that are linked to regulated activity

| **OSA CASES (2020)** | Cases received | Safeguarding Closed by Safeguarding Adults Team | Did not meet the threshold | Cases linked to OSA's transferred to Locality | Cases not closed on the system |
|---|---|---|---|---|---|
| January | 50 | 16 (32%) | 32 (64%) | 2 (4%) | 0 |
| February | 51 | 19 (37%) | 27 (52%) | 5 (10%) | 0 |
| March | 56 | 25 (44%) | 24 (42%) | 9 (14%) | 0 |
| April | 30 | 14 (49%) | 16 (51%) | 0 | 0 |
| May | 62 | 20 (32%) | 33 (40%) | 9 (14%) | 0 |
| June | 65 | 18 (27.7%) | 45 (65%) | 2 (3%) | 0 |
| July | 65 | 6 (9%) | 52 (80%) | 6 (9%) | 1 |
| August | 49 | 6 (12.2%) | 35 (71.5%) | 8 (16.3%) | 0 |
| September | 44 | 5 (11.3%) | 32 (72.27%) | 8 (18.1%) | 0 |
| October | 34 | 6 (17.6%) | 17 (50%) | 10 (29.4%) | 2 |
| November | 42 | 4 (9.5%) | 26 (62%) | 2 (4.7%) | 10 |
| **Total** | **548** | **139 (25.3%)** | **339 (61.8%)** | **61 (11.1%)** | **13** |

**Table 2** – shows the number of cases that are linked to safeguarding referrals received by the team for those people living in the community where allegations of abuse are not linked to the provision of regulated activities, for example domestic abuse, financial abuse by family etc.

| **COMMUNITY CASES (2020)** | Cases received | Safeguarding Closed | Did not meet the threshold | Community cases transferred to Locality | Cases not closed on the system |
|---|---|---|---|---|---|
| January | 61 | 23 (37%) | 32 (52%) | 6 (10%) | 0 |
| February | 44 | 21 (48%) | 20 (46%) | 2 (4%) | 0 |
| March | 23 | 8 (34%) | 12 (52%) | 3 (13%) | 0 |
| April | 15 | 5 (36%) | 6 (39%) | 3 (21%) | 0 |
| May | 38 | 4 (10%) | 24 (63%) | 10 (26%) | 0 |
| June | 85 | 21 (24.7%) | 52 (61.1%) | 16 (18.8%) | 0 |
| July | 97 | 10 (10.3%) | 70 (72.1%) | 17 (17.5%) | 0 |
| August | 76 | 9 (11.8%) | 53 (69.7%) | 14 (18.4%) | 0 |
| September | 59 | 5 (8.4%) | 38 (64.4%) | 15 (25.4%) | 0 |
| October | 48 | 1 (2%) | 35 72.9%) | 11 (22.9%) | 1 |
| November | 54 | 1 (1.8%) | 42 (77.7%) | 6 (11.1%) | 5 |
| **Total** | **600** | **100 (16.6%)** | **384 (64%)** | **100 (16.6%)** | **6** |

## SAR Reviews

33. The Care Act 2014 states that SABs must arrange for a SAR to be conducted when either an adult in its area with needs for care and support dies as a result of abuse or neglect (which is either known or suspected) and there is reasonable cause for concern that partner agencies could have worked more effectively to protect the adult or when an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of a SAR it would be considered that there was serious abuse or neglect where, for example:

- the individual would have been likely to have died but for an intervention;
- suffered permanent harm;
- has reduced capacity or quality of life (whether because of physical or psychological effects).

34. From March 2020, 11 referrals have been received for potential SARs. Themes include concerns of self-neglect, substance misuse and or self-harm. There is no comparable data at the time of writing the report for SAR referrals for other Local Authorities for volumes of SAR referrals during the pandemic.

35. Details of SAR referrals, SAR's commenced and completed SAR's can be found in Table 3 below:

**Table 3** - date pertaining to referrals commencement

| | **2018/19** | **2019/20** | **2020/21*** |
|---|---|---|---|
| SAR referrals | 2 | 4 | 13 |
| SARs commenced** | 2 | 2 | 5 |
| SARs completed*** | 2 | 1 | 4 |

*As at 11 Dec 2020
**may have been referred in previous years
***almost all commenced in previous years

36. Two further SARs will be completed by January 2021 leaving four SARs in progress, all of which have only just commenced.

37. Themes relating to SAR's over the past two years are highlighted below. There are seven key themes. The themes relate to SAR referrals pre and during the pandemic.

a. ***Theme 1 – Understanding Mental Capacity -*** In cases reviewed evidence of application of the MCA was not always available. Staff should have knowledge of the MCA relevant to their role; however, in practice, staff are supporting decision making all the time, so need to assume capacity unless there are indicators to the contrary for that individual. Staff should be clear who is assessing capacity and what the impact of lack of capacity is on daily living and should make good records of decision making.

b. ***Theme 2 – Join up across different multi-agency processes -*** In complex cases many different multi-agency processes may be underway regarding the case, such as community safety, domestic abuse, care plan approach, child safeguarding and adult safeguarding. It was identified that there is a need to improve awareness and operation of multi-agency meetings and assessment

processes to support understanding of the full picture of needs and risks for an individual and support joined up of activity.

c. ***Theme 3 – Understanding Domestic Abuse-*** Staff to be reminded that in assessing Domestic Abuse situations they have a good understanding of aspects and impact of domestic abuse and consider specific vulnerabilities and relationship dynamics for individuals.

d. ***Theme 4 – The impact of Substance and Alcohol misuse -*** Supporting people who misuse drugs and alcohol can be challenging, complex and unpredictable. Staff should additionally consider resources and expert advice available and how they may be accessed, including information for children of parents who misuse alcohol.

e. ***Theme 5 – Clear plans -*** The need for clear 'end of life' care plans, understood by all concerned.

f. ***Theme 6 – Focus on individuals -*** The needs of individuals for care, support and safeguarding can be 'lost' through a focus on their presenting issues, or an approach based upon the structure of services.

g. ***Theme 7 – Autistic Spectrum Disorder -*** An understanding of additional needs and risks relating to Autistic Spectrum Disorder is required broadly across the workforce to effectively support and safeguard individuals.

**Resource Implications**

38. In the past three years, the County Council has received 19 referrals to be considered under the criteria for a SAR. These cases are considered by the Case Review Group (CRG) who will then make recommendations to the SAB as to whether the criteria is met and that a review should take place. It is the Chair of the SAB that will ultimately agree that a SAR should be commenced.

39. The cost to the County Council over the last three years is £28,436. This figure does not include the costs of some of the SARs that are in progress for 2020/21 and does not include Safeguarding Board Officer time, nor the time or costs associated with those that sit on the CRG and/or officer time to assist with the SAR process. The costs for 2018/19, 2019/20 and 2020/21 are as follows:

**Table 4** – Costs of Independent SAR's

| **Year** | **2018/19** | **2019/20** | **2020/21*** |
|---|---|---|---|
| Amount spent on SAR independent reviewers | £15,505 | £8,256 | £4,675 |

40. The staffing costs per annum for the Safeguarding Adults Team is £148,585. It is not possible to provide estimates of the costs of safeguarding work in locality teams, because each team undertakes a range of activities on behalf of the Department, not just safeguarding activity. Such work may make up between 0 to 25% of their workload at any one time, making it difficult to separate and apportion.

## Background papers

NHS Digital report November 2020
https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2019-20

## Circulation under the Local Issues Alert Procedure

None

## Equality and Human Rights Implications

41. The Coronavirus Act 2020 made easements to the Care Act 2014 in England and the Social Services and Well-being (Wales) Act 2014 to enable local authorities to prioritise the services they offer to ensure the most urgent and serious care needs are met. Safeguarding duties are not affected by the Care Act Easements and any changes in service must not lead to a breach in human rights. Any impact in relation to the impact of the Covid-19 pandemic on safeguarding will be considered in line with the Department's Covid Equality and Human Rights Impact Assessment.

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