

# Open Report on behalf of Glen Garrod, Executive Director – Adult Care and Community Wellbeing

Report to: Adults and Community Wellbeing Scrutiny Committee

Date: 6 April 2022

Subject: Review of Performance Measure "PI130 Adult Safeguarding

concerns progressing to enquiry"

A review of a Performance Measure "PI130 Adult Safeguarding concerns that progress to enquiry" was requested by the Adults and Community Wellbeing Scrutiny Committee following consideration of the performance measure and associated narrative at the scrutiny meeting in February 2022.

This report has been completed to provide the Committee with the details of that review and also incorporates wider information that may be useful to the Committee in furthering understanding of related legislation and statutory guidance which is applicable to the local authority and its partners.

The key lines of enquiry for the review were to consider whether the rationale for the measure (and how the target had been set) was still valid; reasons why the target had not been achieved; what actions had been taken and what else could be done to improve performance. It was also requested that a report should be completed for the Committee for the April 2022 meeting, setting out findings and providing an overview of relevant safeguarding duties.

The review has concluded that the current performance measure does not get to the heart of where further improvement is most needed. The current definition excludes significant amounts of adult safeguarding work and potentially penalises good practice in the way it evaluates performance.

It has been identified that local authorities in England define, report and record adult safeguarding concerns and enquiries in different ways and therefore the existing national data that allows benchmarking is diluted in usefulness, if not misleading.

The findings in the report confirm that there are prevention and protection duties on all Lincolnshire Safeguarding Adults Board (LSAB) partners and that some of these statutory duties are not being fully met consistently. In particular, there is a need to provide evidence of more consistent application of the Making Safeguarding Personal (MSP) approach to Adult Safeguarding as set out in statutory guidance. It is recommended a new performance measure should be developed in 2022-23 to monitor progress with this ambition.

The report confirms work that has already been completed by Lincolnshire County Council (LCC) and the LSAB to improve adult safeguarding practice but also identified further work in progress and to be undertaken. LSAB have established a Task and Finish Group to enable oversight of this work.

## **Actions Required:**

Following completion of the review of this performance measure, the Committee is asked to support the following recommendations, which will be made in consultation with the Executive Councillor for Adult Care and Public Health and the LSAB Executive Board:

- That the current performance measure PI130 be removed from the key indicator performance report with effect from 1 April 2022.
- That LSAB share with the Adults and Community Wellbeing Scrutiny Committee a copy of the Action Plan and timeline for improvements to be facilitated by the Task and Finish Group that has been established by the Deputy Chair of the LSAB.
- That Adult Care and Community Wellbeing, in partnership with the LSAB and the Corporate Performance Team develop an alternative Performance Measure in 2022-23 that considers whether partners are consistently demonstrating an MSP approach prior to raising a safeguarding concern with the local authority. This may be best linked to reporting from the new electronic referral system being developed.
- That the work in progress to develop a new electronic referral system for Adult Safeguarding Concerns is concluded in 2022-23 and that this should seek to filter general safeguarding information out from adult safeguarding concerns. And that a clear timeline for this initiative is confirmed with project leads.
- That LSAB policy and procedures are updated by 30 June 2022 to strengthen partner understanding of when an Adult Safeguarding Concern should be escalated to the local authority.
- That the LSAB should develop a Prevention Charter during 2022-23, that sets out clearly the prevention duties of all LSAB partners and re-confirms partners commitment to consistently practice an MSP approach and in particular, to speak to the Adult and establish what outcomes they want to achieve before formally raising an Adult Safeguarding Concern.

## 1. Background

The Adults and Wellbeing Scrutiny Committee performance report includes a Performance Measure that considers the proportion of Adult Safeguarding concerns that lead to a safeguarding enquiry. The Committee when considering performance and related commentary against this measure in February 2022 asked for a deep dive review to be completed to understand in more detail:

- Whether the rationale for the measure and how the target had been set was still valid
- Why the related target has not been achieved.
- What actions have so far been taken to improve performance.
- What further actions should be recommended.

The Committee also requested a report that would set out the findings from the deep dive review but would also provide an overview of the wider adult safeguarding agenda. This report has been completed to fulfil the Committee's request.

## 2. Methodology

The review of this indicator was completed jointly by the Assistant Director - Specialist Adult Services, Adult Care and Community Wellbeing at (LCC) and the Independent Chair of LSAB.

The methodology adopted for the review of the performance measure incorporated:

- Meetings and associated discussions with the Head of Adult Safeguarding, the Deputy Chair of LSAB and the LCC corporate performance team.
- Consideration of the Care Act 2014 and the related statutory guidance.
- Consideration of the Safeguarding Annual Collection (SAC) guidance 2021.
- Research into other relates guidance on Adult Safeguarding concerns and enquiries.
- Analysis of SAC National data 2020-21.
- Analysis of 2021-22 Adult Safeguarding concern and enquiry data.

### 3. Findings

## 3.1. The Care Act 2014 and related statutory guidance

The Care Act 2014 and the related care and support statutory guidance confirm various statutory duties on local authorities (in England) but many of these duties are also equally applicable to the local authority's partners. This is particularly evident when considering duties relevant to safeguarding adults.

The statutory guidance confirms that:

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."

This definition emphasises that preventing harm to adults is everyone's business.

In should be noted that the Care Act has a number of general and key duties that are applicable to the local authority and its partners but are also fundamentally important to keeping all adults safe. There are also some more specific adult safeguarding duties that are applicable to adults who meet statutory criteria. Key duties of relevance to the review of this performance measure are provided below.

### **Protecting People from Harm**

The Care Act confirms that preventing or delaying needs escalating is a key duty on local authorities and their partners. This includes preventing safeguarding risks emerging or escalation and most importantly protecting people from harm. The LSAB has produced an Adult Safeguarding Prevention Strategy alongside an action plan with prevention priorities. The strategy also recognises that safeguarding is everyone's responsibility and the importance of working together to keep people safe.

The Prevention Strategy has three levels of prevention activity that mirror those confirmed in the statutory guidance. Some of the prevention activities are targeted at whole populations whilst others are targeted at people who are at greater risk.

## **Primary Prevention**

The Care Act 2014 confirms a general duty on local authorities and their partners to promote wellbeing. Promoting wellbeing is seen as the starting point for keeping people safe and well. Wellbeing helps to provide people with resilience. Resilience in turn helps people to protect themselves from several potential safeguarding risks and can also help to prevent or delay wider care needs from emerging.

Promoting Wellbeing is a primary prevention activity. There are lots of different ways for organisations, communities, and individuals to promote wellbeing, for example, through the provision of good quality information and advice (e.g. How to avoid being scammed) or by helping to tackle loneliness or social isolation (potentially avoiding self-neglect). Public Health play a key leadership role in promoting wellbeing, but primary prevention activities are also linked to wider universal services including health services, housing and public protection services. Such services are normally available to the whole population but can include some targeting of specific populations as well.

#### **Secondary Prevention and Early Intervention**

Secondary prevention adopts more targeted interventions aimed at individuals who have an increased risk of developing needs and may have more difficulty in protecting themselves from harm. The provision of early intervention via support, resources or facilities may help slow down or reduce any further deterioration or prevent other needs and risks from developing. Some early support can help stop a person's life tipping into crisis, for example helping someone with a learning disability with moderate needs manage their money, or a few hours support to help a family carer who is caring for their son or daughter with a learning disability and behaviour that challenges at home.

Secondary prevention is again a collective duty on the local authority and its partners. The statutory guidance specifically confirms that there is a duty on partners to play their part in preventing concerns escalating to a point of crisis and therefore requiring a higher level of intervention under formal safeguarding adult procedures:

"14.66 Agencies should stress the need for preventing abuse and neglect wherever possible. Observant professionals and other staff making early, positive interventions with individuals and families can make a huge difference to their lives, preventing the deterioration of a situation or breakdown of a support network. It is often when people become increasingly isolated and cut off from families and friends that they become extremely vulnerable to abuse and neglect. Agencies should implement robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under safeguarding adult procedures."

The statutory guidance also confirms that partners should ensure that they have the mechanisms in place that enable early identification and assessment of risk through timely information sharing and targeted multi-agency intervention.

The number of ways in which partners and indeed the wider public can help to protect people from harm are almost endless. For example, the Police may complete a safe and well check on someone if a neighbour thinks there is a problem, a District Council may be able to find accommodation for someone who has been made homeless, the local mental health trust could provide counselling to someone who may be having suicidal thoughts, or the voluntary sector may be able to help someone with debt advice to avoid health and wellbeing deteriorating.

The LSAB Prevention Strategy places a great deal of focus on people at this level of the prevention framework. This includes the Team Around the Adult initiative that is an early intervention approach targeted at adults who may not meet statutory safeguarding criteria, and or may be reluctant to engage with formal safeguarding procedures but still have risks presenting that would benefit from LSAB partner interventions.

### **Tertiary Prevention**

Tertiary prevention is where Adults already have care and support needs, often being complex in nature, and formal intervention is required to minimise the impact of those needs and related risks to avoid or delay further deterioration. Where possible people should also be supported to achieve higher levels of independence. From an adult safeguarding perspective this is where additional and specific safeguarding duties are confirmed within the Care Act. In this respect each local authority must:

- Set up a safeguarding adults board.
- Make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect and if so, by who.

- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them.
- Co-operate with each of its relevant partners in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

The Care Act also confirms that the above safeguarding duties apply to an adult who meet the following criteria:

- Has needs for care and support (whether or not the local authority is meeting any of those needs).
- Is experiencing, or at risk of, abuse or neglect.
- As a result of those care and support needs is **unable to protect themselves** from either the risk of, or the experience of abuse or neglect.

It is very important to recognise that Full Safeguarding Enquiries as set out in section 42.2 of the Care Act should only be initiated where the adult meets the above statutory criteria. However, it should also be recognised that a wider range of safeguarding activity is still completed and expected by LSAB partners for those people who do not meet the above criteria.

### 3.2. Overview of the Performance Measure

The performance report considered by the Adult Care and Community Wellbeing Scrutiny Committee contained the following narrative in relation to the performance measure being reviewed:

"The LCC Safeguarding Service want to encourage providers, partners and professionals to submit concerns to the local authority only where appropriate, and to ensure these concerns have already been managed and considered within the remit of their organisations and only escalated to the authority as necessary. The Safeguarding Service would therefore expect a higher proportion of concerns progressing to an enquiry, with a corresponding reduction in concerns that do not warrant a full enquiry."

The Committee did raise some questions in relation to this rationale as part of the discussion at the last meeting where this measure was considered. In particular, the Committee wanted assurance that people were not deterred from raising safeguarding concerns if these were identified. On review of the narrative above it is understood that the narrative is open to that interpretation.

In this respect the Committee should be assured that the Adult Safeguarding Team and the LSAB encourage providers, partners and professionals to raise adult safeguarding concerns with the local authority. However, there is also an expectation that providers, partners and professionals familiarise themselves with the LSAB Adult Safeguarding Policies and Procedures and that before raising an adult safeguarding concern form they utilise the check-list provided in the policies and procedures before doing so. Please also see Appendix One.

Having completed the review of this performance measure it is now considered that the above narrative and the focus of this indicator could be improved further and, going forward a greater emphasis should be provided on all LSAB partners evidencing a MSP approach. In particular, LSAB partners should be able to evidence that they have applied a MSP approach prior to raising an Adult Safeguarding Concern with the local authority. Other findings and conclusions provided within this report will support this point.

### **Definition**

This review has confirmed that the "Adult Safeguarding concerns that lead to a safeguarding enquiry" performance measure (PI130) is a locally developed measure and with a definition agreed by LCC. There is therefore no national guidance that must be followed in relation to its calculation.

The performance measure considers the number of concerns received by LCC (the denominator) and how many of these progress to an enquiry (the numerator). The result is a percentage conversion rate. A key issue that became apparent within this review is that the definition of what constitutes a concern and an enquiry varies significantly across local authorities in England. This is a matter that is re-visited in more detail later in this report.

## Performance against the Measure

It is understood that the performance measure has been utilised by Adult Care and Community Wellbeing for several years although stakeholders were not clear of the exact year of implementation.

The Performance Report considered by Adults and Community Wellbeing Scrutiny Committee in February 2022 showed that prior to 2021-22 the conversion rate fluctuated somewhere between 40% to 50% of concerns leading to enquiry between Q4 of 2018-19 and Q4 of 2020-21.

The same performance report confirmed the following cumulative conversion rates in 2021-22: Q1 was 25%, Q2 was 24.2% and Q3 was 24.2%. This level of conversion was below the cumulative target in each of these quarters. The aspirational target for 2021-22 was to achieve a conversion rate of 50% by 31 March 2022.

It is understood that the aspirational target of 50% conversion of concerns to enquiries was informed to a large extent by considering historical Lincolnshire conversion rates (prior to 2021-22) supplemented by some consideration of historical national data that enables a level of benchmarking.

### Benchmarking

The last Performance Report considered by Adults and Community Wellbeing Scrutiny Committee provided some benchmarking data for this indicator that showed Lincolnshire with a 43.1% conversion rate which was above the benchmarked average. However, this analysis is based on 2018-19 data.

It is important to note that the report also confirmed that:

"Benchmarking data is available for all councils in England in the summer following the annual submission of the Safeguarding Adults Collection (SAC). There was significant variation in the figures across the return. This is most likely to be differences in practice and interpretation of the SAC return descriptions, and many councils were unable to complete the return. For this reason, benchmarking must be treated with caution and is not necessarily a true reflection of comparative performance. As a result, the SAC return is being reviewed."

## 2020-21 Benchmarking Data

The Committee has made the point that the Benchmarking Data in the performance report was quite old and asked that this be updated by the Corporate Performance Team for future reports.

The latest national SAC data that was available to inform this review was for the 2020-21 financial year. The analysis of that data has confirmed a huge variation in the number of adult safeguarding concerns that progress to a Section 42 Safeguarding Enquiry across local authorities in England.

The lowest conversion rate of all local authorities was 3.8% with the highest conversion rate of all local authorities being 98.8%. The following table shows how Lincolnshire compared to calculated comparator group averages in 2020-21:

Table 1: Adult Safeguarding concerns that progress to an enquiry

Adult Safeguarding Concerns the	% that progress	
progress to an enquiry to enquiry		
Lincolnshire	39.2%	
Audit Family	37.6%	
East Midlands	36.4%	
England Mean	30.6%	
England Median	30.5%	

There were also significant variations in conversion rates within the comparator groups. This ranged from 10.9% to 52.9% in the East Midlands and 13.3% to 96.7% in the Audit Family Comparator Group. This finding reconfirms that there is huge variation in conversion rates across local authorities and therefore caution should be taken when seeking to benchmark in relation to this measure.

### Inconsistency in the way that Concerns and Enquiries are reported

As part of this review, the Head of Adult Safeguarding shared details of a document produced by the Local Government Association (LGA) and the Directors of Adult Social Services (ADASS) called "Making decisions on the duty to carry out Safeguarding Adults enquiries – A suggested framework to support practice, reporting and recording".

This document identifies that there is significant variation in the way that local authorities (in England) define, record, report and manage both concerns and enquiries. The document also suggests ways in which greater consistency could be achieved if all authorities adopted the proposed framework. Summarised below are some of the key reasons why there are inconsistencies in recording and reporting of adult safeguarding concerns and enquiries:

- Local authorities have interpreted the Care Act and related statutory guidance in different ways: As identified later in this report there is a particular level of uncertainty about what constitutes an adult safeguarding concern. Some local authorities have also developed their own definitions in the absence of a clear definition in the Care Act. Some local authorities also appear to be reporting adult safeguarding enquiries in different ways.
- Safeguarding Referrals: Local authorities are adopting different strategies in relation to how they manage safeguarding referrals. Some local authorities are filtering referrals and separate out general safeguarding information from more legitimate safeguarding concerns. This means the number of safeguarding concerns recorded and reported are significantly reduced and therefore a higher proportion convert to enquiry. Lincolnshire does not currently filter safeguarding referrals to separate out general safeguarding information sharing from adult safeguarding concerns.
- Don't accept the concern if the information is incomplete: Some local authorities will
  not accept an adult safeguarding concern from partners unless it is of good quality
  and allows an informed decision to be made about whether it should progress to
  enquiry on not. Lincolnshire has considered implementing this approach previously
  but discounted it as a way forward as there may be delays in responding to legitimate
  risks that need urgent attention.
- Triage: Some local authorities have adopted a triage process for all concerns received.
   This allows them to conduct initial enquiries into the matters that have been raised and make an informed decision about whether the concern meets the criteria for a full Section 42 enquiry or should be closed following the initial enquiry. Those local authorities without a triage function will progress a significantly larger number of

concerns to a full Section 42 adult safeguarding enquiry but quite probably inappropriately, as some of these will not meet the relevant statutory criteria. Lincolnshire does operate a triage approach which significantly reduces the number of concerns that progress to a full section 42 Enquiry. This is good practice but is not acknowledged as such given the way the performance measure is currently considered.

• Some authorities are counting initial enquiries and full enquiries as part of their enquiry activity: those local authorities that report initial enquiries as well as full section 42 enquiries will have significantly larger conversion rates than those local authorities who only report on full Section 42 enquiries.

Collectively these differences in practice, recording and reporting mean that comparing one local authority to another via the available benchmarking data is probably like comparing an apple to an orange. The value of benchmarking concern and enquiry data based on the current national data is therefore significantly diluted if of any value at all. The theme of inconsistency of practice, recording and reporting of concerns and enquiries is explored in greater detail in the following sections of the report.

## 3.3. Concerns and Enquiries

The definition of what constitutes a safeguarding concern, and a safeguarding enquiry is fundamentally important to the review of this performance measure and will impact on the respective conversion rate calculated from the numerator and denominator data.

As mentioned earlier in this report local authorities are recording and reporting concerns and enquiries differently which would suggest benchmarking of this data between local authorities is currently of little benefit. This section of the report provides further findings that re-emphasise this point.

### **Adult Safeguarding Concerns**

As part of this review the Safeguarding Adult Collection (SAC) guidance 2021 was considered to see how it defines a Safeguarding Concern. The following was identified:

"For the purposes of the SAC a safeguarding concern is a sign of suspected abuse or neglect that is reported to the local authority or identified by the local authority. The SAC captures information about concerns that were raised during the reporting year, that is, the date the concern was raised with the local authority falls within the reporting year, regardless of the date the incident took place. Safeguarding concerns can include cases of domestic abuse, sexual exploitation, and modern slavery and self-neglect. Paragraph 14.17 of the Care and Support Statutory Guidance (DHSC, 2018) outlines other aspects of abuse and neglect. Ongoing work began in 2019-20, led by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), aims to achieve greater understanding and clarity across sectors of what constitutes a safeguarding concern so that people get a response that is right for them. This may have an impact on

# the data that is collected in the SAC, therefore this guidance will be revised when this work is completed."

In many ways this definition is unhelpful as "a sign of suspected abuse or neglect" is very subjective and very broad. The Adult Safeguarding section of the statutory guidance is much more specific and confirms:

"14.17 Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered; although the criteria at paragraph 14.2 will need to be met before the issue is considered as a safeguarding concern. Exploitation, in particular, is a common theme in the following list of the types of abuse and neglect."

This definition is very tight and basically suggests something should only be considered as a safeguarding concern if it meets all the relevant statutory criteria. If this definition of a concern was used by Lincolnshire then our conversion rate for the performance measure under review would likely be 90% to 100%.

There is then a huge difference between what someone may consider to be a "sign of abuse and neglect" and a safeguarding concern as defined in statutory guidance. A key role that is performed by the Adult Safeguarding Team in Lincolnshire is working through all of the referrals that "suspect abuse and neglect" and confirm which of these actually are legitimate safeguarding concerns. As the reader will note later in the report there is currently no acknowledgement of this very important work completed by the Adult Safeguarding Team within the current performance measure.

It should also be noted that that there are clear requirements in the Care Act and reenforced via the LSAB policies and procedures that partners should play a key role in establishing whether "a sign of abuse or neglect" does actually meet the relevant statutory criteria before they raise a concern with the local authority. As previously mentioned the statutory guidance confirms:

"14.66 Agencies should stress the need for preventing abuse and neglect wherever possible. Observant professionals and other staff making early, positive interventions with individuals and families can make a huge difference to their lives, preventing the deterioration of a situation or breakdown of a support network. It is often when people become increasingly isolated and cut off from families and friends that they become extremely vulnerable to abuse and neglect. Agencies should implement robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under safeguarding adult procedures."

Partners also have a duty to take action to protect the adult if this is necessary whether the statutory criteria are met or not. Appendix One provides details of a pre-concern checklist that LSAB partners should consider before raising the relevant safeguarding adult concern form.

If partners neglect these responsibilities and raise concerns with the local authority without practicing a MSP approach they are effectively passing their statutory duties onto the local authority to perform for them. Lincolnshire currently considers adult safeguarding concerns in line with the wider SAC definition and counts all Adult Safeguarding Referrals received by the Council's Customer Service Centre (CSC) that are progressed to the Adult Care Safeguarding Team as Adult Safeguarding Concerns. LCC is therefore likely to record many more concerns than other local authorities that have tighter definitions and mechanisms for filtering of general information.

## **Safeguarding Enquiries**

The relevant section of the statutory guidance confirms that:

"14.77 An enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action. Whatever the course of subsequent action, the professional concerned should record the concern, the adult's views, wishes, and any immediate action has taken and the reasons for those actions."

This definition confirms that there can be two stages to an enquiry. The first stage is effectively establishing whether the criteria for a formal enquiry has been met (this is also known as an Initial Enquiry or Part A Enquiry) and a second more formal enquiry when there is reasonable assurance that the criteria are evident and there is a necessity to conduct an enquiry to inform potential protection actions (this is known as a full section 42 Enquiry or a part B enquiry).

It has been confirmed as part of this review that Lincolnshire only count full section 42 enquiries within the numerator of the Performance Measure in question and do not consider any of the Initial Enquiries completed by the Adult Safeguarding Team as part of the enquiry activity.

This is an important finding as the LCC Adult Safeguarding Team utilise a significant amount of capacity in completing initial enquiries that is currently not being acknowledged as part of the way the current Performance Measure is counted. The initial enquiry is not only properly establishing whether the statutory safeguarding criteria apply but also allows the team to do lower-level prevention work with the Adult who the concern is about as well as providing advice to those who have made the referral. This work normally includes liaising with adults who have not been spoken to by the person who has raised the concern to establish whether the Adult gives consent to the enquiry and what outcomes the Adult wants to achieve.

The current way that the performance measure is defined and calculated therefore significantly under-represents the true level of enquiry activity that is undertaken by the Adult Safeguarding Team.

### 3.4. Safeguarding Principles and Making Safeguarding Personal

Prior to the Care Act, Adult Safeguarding activities operated with reference to national guidance called "No Secrets". Those former arrangements have been criticised for imposing a ridged process and procedure on people often without consent and fundamentally lacking a personalised approach.

The Care Act and the Safeguarding Adults Statutory guidance confirms a much more personalised approach must be adopted and also confirms six key principles that puts the person at the centre of the safeguarding activity and better considers the outcomes they wish to achieve. The six key principles that must apply to all adult safeguarding activity are as follows:

- **Empowerment**: People being supported and encouraged to make their own decisions and informed consent. This means "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens".
- **Prevention:** It is better to take action before harm occurs. This means "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help".
- **Proportionality:** The least intrusive response appropriate to the risk presented. This means "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed".
- **Protection:** Support and representation for those in greatest need. This means "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."
- Partnership: Local solutions through services working with their communities.
  Communities have a part to play in preventing, detecting and reporting neglect and abuse. This means that "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."
- **Accountability:** Accountability and transparency in delivering safeguarding. This means "I understand the role of everyone involved in my life and so do they."

The above safeguarding principles should be applied by all partners when considering whether to raise a safeguarding referral following a concern being raised and during the application of any protection activity.

## Making Safeguarding Personal (MSP)

In addition to the above safeguarding principles the statutory guidance also confirms that local authorities and their partners must adopt an MSP approach to all safeguarding activities. The statutory guidance confirms:

"Making safeguarding personal means safeguarding practice should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety."

"Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process."

Unlike Children's services, the Adult Care service have a right to choose whether a safeguarding process should be initiated or not. Consent should only be over-ridden where there is a defensible decision to do so and where there is a public interest in doing so for example where other people may be at risk.

It is important to understand that not all adults will want safeguarding processes to be initiated as it often involves sensitive confidential information about them being shared, recorded and stored. There may also be concerns that the process may impact negatively on relationships that the adult may have with family members, friends, carers or other people. Refusing to give consent and choosing to remain in a situation of risk can sometimes be referred to as "the Adults right to make unwise decisions".

Partners and individuals need to be mindful that sharing personal confidential information and or subjecting someone to a safeguarding process and procedure without their consent can be viewed as a fundamental breach of the persons human rights, and therefore there could also be legal consequences of not seeking proper consent.

The "acid test" of whether partners are practicing an MSP approach prior to raising an adult safeguarding concern with the local authority is whether they have spoken to the individual and established what outcomes they want to achieve. It is also an opportunity for all partners to reassure people that positive outcomes can be achieved via safeguarding processes. Engaging hard to reach Adults is also a key theme in the LSAB prevention strategy.

Clearly if partners are not consistently evidencing an MSP approach prior to raising safeguarding concerns they are effectively passing on their statutory duties to the local authority where consent and the outcomes the person wants to achieve must still be

established. This also places additional demands on limited resources for the local authority. Partners more consistently adopting an MSP approach would help to ensure adults are properly engaged but will also offer the opportunity to implement protection initiatives earlier and not have to wait for a formal safeguarding enquiry to confirm these as necessary.

## 3.5. Quality Assurance

The LSAB has an annual quality assurance programme and during 2019-20 the assurance programme included an Audit of MSP practice across partners. In summary the key finding was that partners of the LSAB and the local authority were not consistently applying a MSP approach. In particular, there was limited evidence of partners having a conversation with the adult prior to raising a safeguarding concern with the Council. Partners were asked to consider the findings of the audit and to take further action to improve practice. The intention of the LSAB is to re-run the audit in 2022-23 to see what progress has been made.

## **Adult Safeguarding Team MSP Performance**

Making Safeguarding Personal Responses for Concluded Section 42 Safeguarding Enquiries

The Adult Safeguarding Team employed by LCC who respond to safeguarding concerns and who lead on initial and full enquiries has worked really hard to develop a MSP approach. The table below shows that for the 2020-21 financial year, 99.52% of people who progressed to a full section 42 enquiry were asked what outcomes they wanted to achieve and that 98.55% did confirm what outcomes they wanted to achieve. The table also confirms that 96.14% of people had their outcomes fully or partially met. This performance compared very well against all England, East Midlands and Audit Family comparators. It has also been identified as an area of good practice during the recent Adult Care Annual Conversation exercise.

										table, in h	10
ONS Area	CASSR	CASSR Name	Council Type /	Yes, they	Yes, they	No (%)	Don't	Not	Total Yes	Fully	Ī
Code	Code		Region Name	were asked	were asked		Know (%)	Recorded	(%)	Achieved	Į,
				and	but no			(%)			١
				outcomes	outcomes						١
				were	were						١
				expressed	expressed						١
				(%)	(%)						١
E9200000	-	-	England	63.29%	14.33%	15.25%	2.97%	4.17%	77.62%	47,915	İ
E1200000	4-	-	East Midlands	57.40%	14.52%	20.30%	2.74%	5.03%	71.93%	3,160	Ī
			Audit Family	63.09%	11.28%	20.53%	2.01%	3.08%	74.38%	7,455	I
F1000001	503	Lincolnshire County Council	Fast Midlands	98 55%	0.97%	0.48%	0.00%	0.00%	99 52%	575	ſ

Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases were the desired outcomes achieved?						
Fully	Partially	Not	Fully of	% Fully or		
Achieved	Achieved	Achieved	Partially	Partially		
			Achieved	Achieved		
47,915	18,770	3,690	66,685	59.29%		
3,160	1,600	265	4,760	54.43%		
7,455	3,060	700	10,515	59.47%		
575	420	40	995	96.14%		

### **Audits of Decision Making**

In addition to the LSAB MSP Audits there have also been Audits on the decisions made by the Adult Safeguarding Team during the triage function where initial enquiries are completed to establish whether the statutory criteria apply to allow progress to a full Section 42 Enquiry.

The current LSAB Independent Chair has previously been included in these case audits and there are plans to include the Deputy Chair and the new LSAB Chair (when appointed) in these Audits going forward. In addition to the LSAB Audits, during 2020 and 2021, the Adult Care and Community Well-being Quality Assurance team also performed fortnightly audits of the triage decisions and the outcome of these audits were shared with LSAB. The Head of Safeguarding continues to undertake monthly audits of cases which have been concluded as no further action.

In summary these audits have consistently confirmed that the decision making by the Adult Safeguarding Team is good and cases that do not progress to a full Section 42 Enquiry do not meet the statutory criteria necessary.

It is important to re-confirm that the Adult Safeguarding Team have also completed preventative work as part of the initial enquiry process for many cases that do not meet the statutory criteria. There is also an opportunity for the Safeguarding Team to make recommendations to partners to consider protection activities that could be implemented as part of the LSAB prevention strategy for those concerns that do not progress to a full enquiry. This intelligence is also utilised to inform the setting of prevention priorities for LSAB.

Unfortunately, the current LSAB Chairman ends her role with Lincolnshire on 31 March 2022 and will not be available to attend the Scrutiny Committee meeting where this report will be considered in April 2022. However, the Chairman kindly agreed to provide the following testimony in relation to the effectiveness of decision making by the Adult Safeguarding Team as demonstrated by the above audit work:

"Multi-agency audits are a key part of the LSAB assurance framework, and I have personally taken part in audits to examine the decision-making process in relation to safeguarding concerns. In particular, the focus of audits is upon whether there is a consistent approach, clear rationale and the identification of any themes and trends when the triaging process was undertaken. It is also important to ensure that where decisions were made that a Section 42(2) enquiry is not appropriate that individuals are supported outside of the statutory process. As a result of the multi-agency audit and other audits shared with LSAB over the last two years there is a high degree of confidence in the decision-making process. The SAC data nationally and the performance indicator relied upon here does not fully reflect the practice that takes place nor the outcomes for people".

Heather Roach – Independent Chair of LSAB

## **Adult Safeguarding Referrals**

The LSAB and the Adult Safeguarding Team have also at various times completed quality audits on Adult Safeguarding Referrals received by the Council's Customer Services Centre (CSC).

These Audits have consistently identified that partners do not always utilise the designated Safeguarding Concerns Form but instead send information through to the Customer Service Centre (CSC) via e-mail and or by phone. The CSC do take details provided down and record them on an electronic version of the form before sharing with the Adult Safeguarding Team but not all necessary information to inform a decision is always captured or provided.

In addition, where the Safeguarding Concern Form has been utilised these are often of poor quality in terms of the information provided with the reason for the concern being unclear and vital information like the adult's contact details being omitted. Again, there is normally limited evidence that the referrer has had a conversation with the adult prior to submitting the referrals, whether consent has been received and/or what outcomes need to be achieved.

The Head of Adult Safeguarding is currently having input to a joint piece of work between the CSC, Children's Services and Adult Care and Community Well-being that would see a new electronic referral system implemented and replacing the existing referral form procedure. This will offer the referrer the opportunity to confirm whether they are sharing safeguarding information or raising a Safeguarding Concern. It will also provide the local authority with the opportunity to include some standard questions on the referral system about whether the referrer has spoken to the Adult and whether their outcomes have been expressed and if so, identify what these are. This will help to re-enforce the MSP duties applicable to all partners.

This approach would also fit with the following ADASS Guidance as identified by the Independent Chair of the LSAB:

"The local authority and the Safeguarding Adults Board (SAB) need to find ways of recording and capturing information on early work under S42(1), which is currently not captured in the SAC, to evidence the decision making, impact. and effectiveness of safeguarding support from prevention through to intervention, resolution and recovery."

### 3.6. Changes to practice

The findings within this report confirm that prior to 2021-22 the conversion rate of concerns to enquiries was significantly higher although still only in the region of 40% to 50%. It was considered that it would add value to the review by identifying any changes to practice that may have caused the decrease in conversion rate. This section of the report shares associated findings.

# Covid-19

The LSAB also monitors the number of concerns that are raised with LCC and how many of these progress to enquiry. The same definitions are utilised as for the performance measure that is reported to the Adults and Wellbeing Scrutiny Committee and therefore the findings in this report are also relevant for LSAB consideration when it comes to agreeing future Performance Measures to report on.

LSAB are aware that the conversion rate of concerns to enquiries has reduced significantly during 2021-22 compared to previous years. The LSAB has also requested and considered an additional analysis of who is raising the most adult safeguarding concerns and what % of the concerns they are raising progress to a full Section 42 Enquiry. The table below shows the most recent analysis of the top 10 sources of concerns that are raised a the number and % that progress to a full Section 42 Enquiry.

2021-22 (upto Feb 2022)

Concerns From:	Concerns	Full Section	Total of	% of All	Cumumaltive	%	
	raised not	Section 42	Concerns	Concerns	% of All	Progress	
	progressing	Enquiry	received		Concerns	to S42	
	to a full						
	Section 42						
	Enquiry						
1 Residential care staff	395	61	456	12.1%	12.1%	13.4%	
2 East Midlands Ambulance Service	272	102	374	9.9%	22.0%	27.3%	
3 Care Worker / Care Manager	224	92	316	8.4%	30.3%	29.1%	
4 Police	256	50	306	8.1%	38.4%	16.3%	
5 Family member	155	111	266	7.0%	45.4%	41.7%	
6 United Lincolnshire Health Trust	162	58	220	5.8%	51.3%	26.4%	
7 Day care staff	158	43	201	5.3%	56.6%	21.4%	
8 Other worker	135	54	189	5.0%	61.6%	28.6%	
9 Care Quality Commission	122	65	187	4.9%	66.5%	34.8%	
0 Lincolnshire Partnership NHS Foundation Trust	143	42	185	4.9%	71.4%	22.7%	

The LSAB Executive have acknowledged that there is work do with all partners to ensure they are clear of their statutory duties, are consistently evidencing an MSP approach and that Senior Responsible Officers and their teams are clear of when a concern is likely to meet the statutory criteria for a safeguarding enquiry or not.

Initial discussions with partners have suggested that the national Covid-19 Pandemic has increased work pressures on all partners over the last 18 months and has therefore impacted to some extent on their resource availability to practice an MSP approach consistently during 2021-22.

The Head of Adult Safeguarding has also confirmed that there has been a growth in concerns being raised from those partners who already had a relatively low conversion rate of concerns to referrals which has consolidated matters further.

The Chair of LSAB has also commented that her understanding is that agencies have had less face-to-face contact with the public during the Covid-19 Pandemic and therefore have had to communicate via other mechanisms that make a MSP approach more challenging. Visiting to hospitals and care homes has also been restricted meaning more concerns may have been raised without the chance to speak to the Adult in person. However now the restrictions are lifted this should allow a MSP approach to be re-established.

### **Adult Safeguarding Team Practice**

Whilst the Adult Safeguarding Team have operated a triage function for some time, the Head of Service for Adult Safeguarding Team confirmed as part of this review that the team have implemented a number of improvements over the last 18 months, to the way that the triage function operates including initial safeguarding enquiries.

This has incorporated a greater focus on team members to consistently evidence an MSP approach and engaging with adults in early conversations about consent and what outcomes they want to achieve. The 2020-21 MSP performance shared earlier in this report has confirmed that this approach is now working very well within the LCC Adult Safeguarding team. The triage function is now also supported by all the Safeguarding Team Principal Practitioners, rather than the previous arrangements where this was manged via two identified Principals. Initial discussion with the adult and the wider completion of initial enquiries are therefore being completed more efficiently.

## Impact of these changes in practice

These changes in practice are seen as the key reasons for the change in conversion rates of concerns to enquiries during 2021-22.

The fall-off in MSP practice by partners is a negative outcome. It also impacts adversely on LCC as there has been an increase in inappropriate concerns being raised that resulted in additional work pressures for the Adult Safeguarding Team but also the CSC.

The change in practice implemented by the Adult Safeguarding team has also increased the fall off in conversion rate of concerns to enquiries, but this is a positive development as the team are operating more effectively but ironically it has had a negative impact on the conversion rate, based on the current way that the Performance Measure is constructed.

#### 2. Conclusion

On the basis, of the findings from this review it is concluded that the current rationale for the performance measure (and the way it is defined) fails to get to the heart of the improvement work that is still required. In particular, there is a need for an evidence base that LSAB partners are more consistently evidencing an MSP approach to adult safeguarding activities prior to raising adult safeguarding concerns with the local authority.

The number of adult safeguarding concerns that are reported to the Council are likely to be significantly over-stated because of the absence of consistent MSP and because LCC does not currently filter out general information sharing at or prior to the referral stage whilst other local authorities do so.

The current performance definition fails to acknowledge the significant amount of work completed by the Adult Safeguarding Team during triage and initial enquiry. This prevention activity is so important to ascertaining whether the statutory criteria apply, to ensure consent is present, to identify the outcomes people want to achieve and that prevention priorities are identified. The current performance measure potentially penalises this good practice.

There are significant differences in the way that local authorities and recording and reporting on concern and enquiry activity and therefore the benchmarking data currently available is very diluted in usefulness if not misleading. The rationale for how the current target for the performance measure is set is therefore no longer valid.

In consideration of these points the existing performance measure should be discontinued as it does not have the correct strategic focus, adds little value and may drive the wrong behaviours.

There are clear statutory responsibilities on the local authority but also on LSAB partners to protect adults from harm via prevention activity at primary, secondary and tertiary levels. This duty is not dependent on the local authority completing an Adult Safeguarding Section 42 Enquiry but rather the statutory guidance confirms that partners of the local authority should practice an MSP approach prior to raising concerns.

There is a risk that key stakeholders see raising an Adult Safeguarding Concern as the starting point for protecting an Adult who may be at risk. In this respect there is a need for the LSAB to reconfirm the statutory duties of all partners. The local authority and LSAB should continue to encourage key stakeholders to raise Adult Safeguarding Concerns but should also remind key stakeholders to ensure they are familiar with the LSAB policy and procedures and to utilise the pre-concern check list provided.

Quality Assurance work has confirmed that LSAB Partners are not consistently evidencing MSP practice. This probably means that partners are not fulfilling their statutory duties and instead the local authority is having to do so on their behalf and incurring additional workloads as a consequence. This also suggests that some opportunities for early intervention and protection of adults from harm are being missed by LSAB partners.

On this basis it would be sensible to develop an alternative performance measure that has a greater focus on an MSP practice particularly prior to raising adult safeguarding concerns. This would also be in line with ADASS guidance.

### 3. Appendices

These are listed below and attached at the back of the report:				
Appendix 1 LSAB Safeguarding concern pre-referral checklist.				

## 4. Background Papers

Document title	Where the document can be viewed					
Care Act 2014	Care Act 2014 (legislation.gov.uk)					
Care and Support Statutory Guidance	Care and support statutory guidance - GOV.UK (www.gov.uk)					
Safeguarding Annual Collection (SAC)	Social care collection materials 2021 - NHS Digital					
Guidance 2021						

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