

Decision-making: Section 42 Safeguarding Adults Enquiries

One day workshop
29th November 2018

Housekeeping



Fire Procedure



Breaks



Toilets



Mobile Phones / Devices



Smoking



Timekeeping and finishing time

Introduction to the day

Jane Lawson

Adviser, CHIP, Local Government Association / ADASS.

Aims of the day

Making decisions about the circumstances in which safeguarding concerns become Section 42 Enquiries.

- The basis on which these decisions are made
 - What influences, impacts on or drives those decisions
 - The consequences for people when we do / do not go down the S42 route (i.e. what difference does it make to outcomes for people?).
-

Aims of the day

Making decisions about the circumstances in which safeguarding concerns become Section 42 Enquiries

The basis on which these decisions are made

What influences impacts on or drives those decisions

The consequences for people when we do / do not go down the S42 route (i.e. what difference does it make to outcomes for people?).

A focus on people who may need safeguarding support

- How far do these decisions about S42 impact on outcomes for people? What difference does the decision make?
 - How far does the person, and their initial view on whether a concern constitutes abuse/neglect, influence the decision to go down S42 route?
-

The range of perspectives

- **Local Authorities** as decision makers on Section 42 Enquiries
 - Insights from **data professionals**. How far are data and practice aligned?
 - **Cross sector representation** How do these decisions impact across sectors? What is the impact of all organisations and their practice on decisions? How can LAs support clarity?
 - **People representing a service user perspective**
 - **SAB Chairs / managers** supporting effectiveness, development and assurance
 - **Those with a regional / national role** supporting development.
-

What do we aim to produce from the workshops?

A shared understanding of core ingredients and principles that should form the basis for these decisions.

A briefing against which local practice and guidance can be revisited and developed.

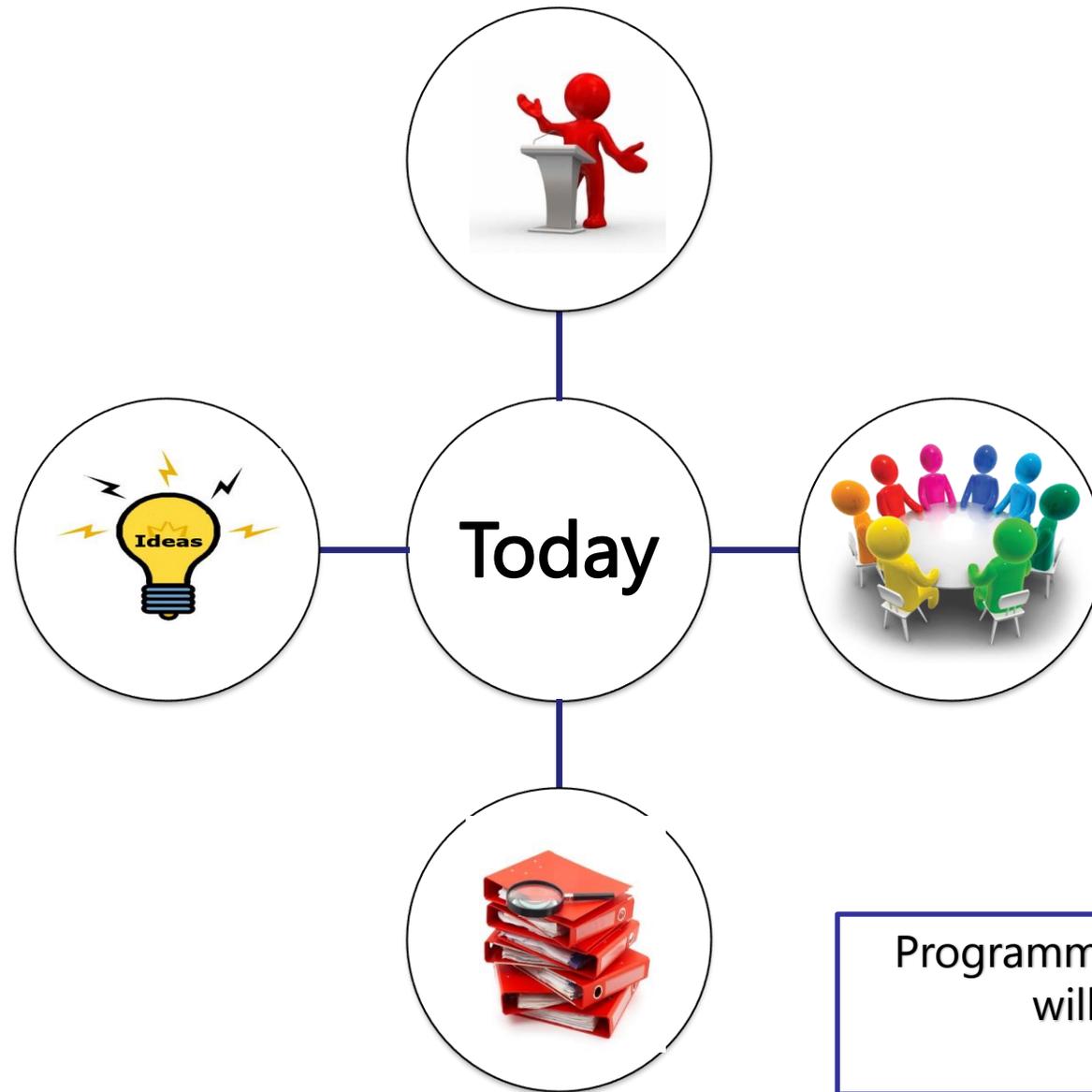
Listening, constructive discussion, not judging ...

- There is significant difference in how we approach this
 - People have offered to set out their approach and what they have learned
 - We don't have 'right answers' yet
 - People must be able to talk freely about how they do things without judgement / criticism from anyone
 - No one here is making judgements about whether people have been doing things "correctly"
-

PROCESS FOR THE DAY

Jane Hughes, Facilitator

Adult Safeguarding Consultant Making Connections IOW Ltd.



Programme and presentation slides
will be sent by email.

Care Act three years on....

Has the culture change in adult safeguarding happened in your area?



Yes

Have you embedded new ways of working in relation to adult safeguarding in your area?



Partially

Do you feel confident that s42 decision making in your area is compliant with the Care Act and statutory guidance?



No

Are adults at risk more able to lead their own safeguarding arrangements in your area?

HOW TO DEMONSTRATE LEGALLY LITERATE DECISION MAKING

Fiona Bateman

SAB Chair and Solicitor.

HOW TO DEMONSTRATE LEGALLY LITERATE DECISION MAKING

Fiona Bateman

Safeguarding and Legal Consultant and trainer

fionabateman@hotmail.com

SAFEGUARDING : UNDERLYING PRINCIPLES

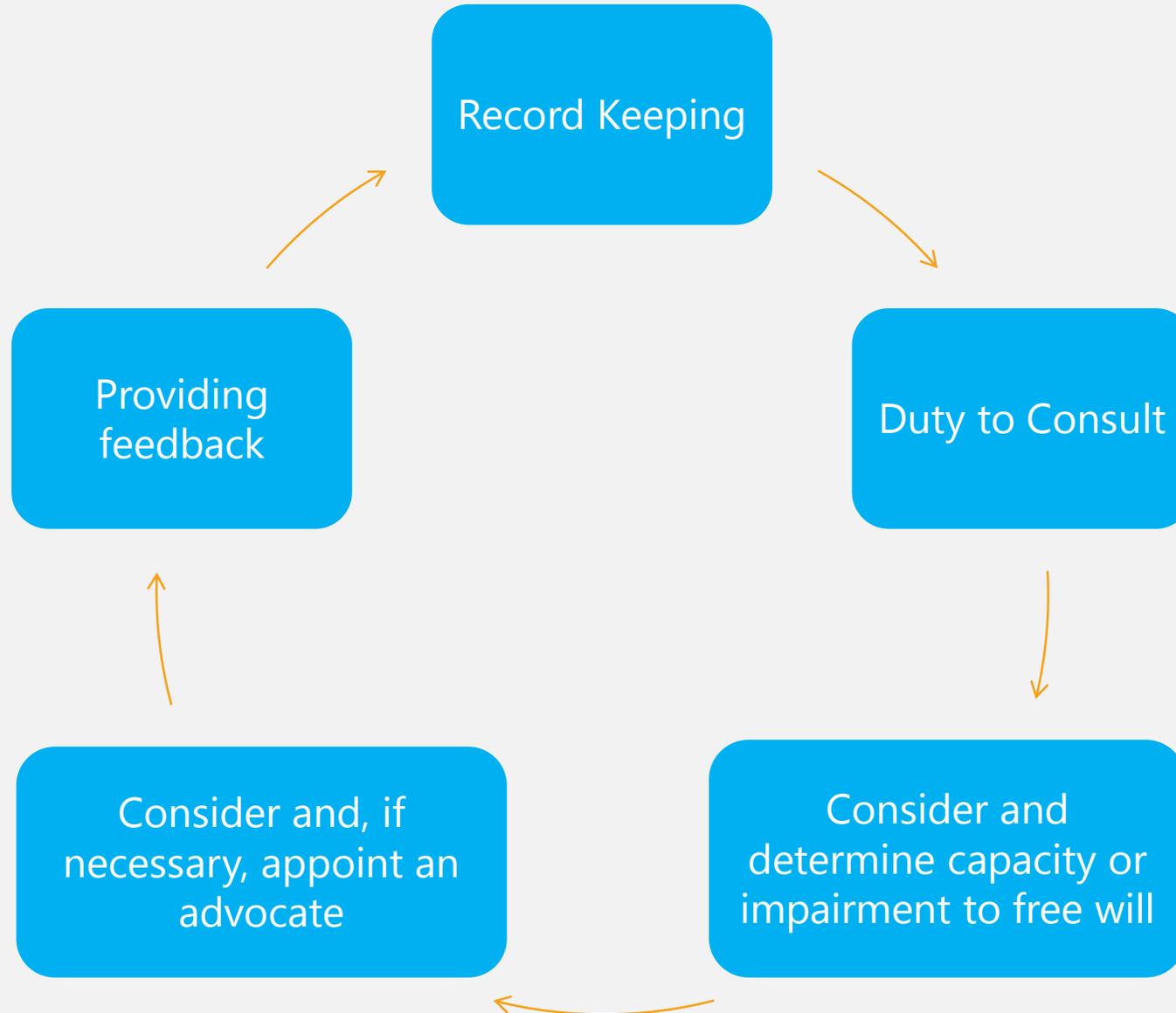
Each matter must be decided on the facts of that specific case, taking into account the duties in legislation, regulations and guidance.

These are public law decisions so practitioners must also be confident they can demonstrate, in Court if necessary, they have:

- Upheld principles that decision making is lawful, reasonable and fair
- Protected against breaches of the adult/ PACH's human rights and advanced the principles of the Equality Act 2010
- All decisions respect autonomy, where there is reasonable cause to believe a person lacks capacity all decision are made with regards to the duties set out in the Mental Capacity Act 2005, practitioners also need to be mindful of external pressures than can impair free will
- Met obligations under the Data Protection Act 2018 and regulations.



PROCEDURAL SAFEGUARDS

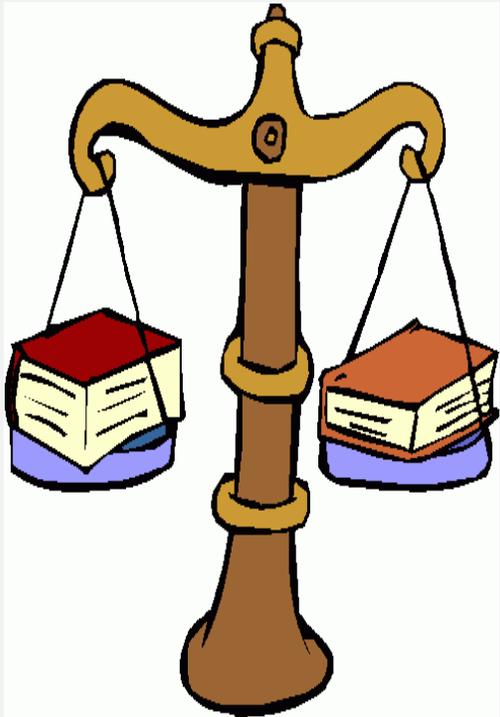


ACCOUNTABILITY FOR SAFEGUARDING DECISIONS

All safeguarding decisions, actions or omissions are public law matters so anyone affected the decision, e.g. service user, carer or person alleged to have caused harm ['PACH'] could challenge either through:

- Complaint, in line with LA Social Services and NHS Complaints Regs 2009, with recourse to Local Government Ombudsman. LGO determinations are published!
- Judicial scrutiny, including within the High Court (Judicial Review) Court of Protection and Coronial proceedings.
- Safeguarding Adults Boards, including through quality assurance work and learning reviews conducted in line with s44 Care Act.

Safeguarding concerns may also raise wider legal duties related to negligence, contractual obligations, employment law.



S.42 DUTY

Reasonable cause to suspect



Adult at risk is experiencing abuse or neglect



As result of needs unable to protect themselves



make (or cause to be made) whatever enquiries necessary



to decide whether action is necessary and if so what and by whom

S.42 DUTY: 'REASONABLE CAUSE TO SUSPECT'

Guidance [pg7.5] and Making Safeguarding Personal principles encourage preliminary enquiries to involve the adult at risk or their representative. This will enable you to explore risk in context and may identify risks or concerns beyond that originally identified within the referral.

You will also need to consider:

- What you could be reasonably expected to know- requires proportionate review of case records, relevant enquiries and that information sharing policy and practice reflects partners' duty of care!
- All available evidence and proactively look for corroborating information, reasonable to use professional judgment to weigh up value placed on information.
- Whether there is any risk to the adult of disclosing concerns to the PACH. Remember public law requires that you give people an opportunity to put their case, so if you are not going to do so this needs very careful justification: *R(AB and CD) v Haringey London Borough Council* [2013]

Not always necessary in safeguarding situations to determine the truth of every allegation if there is sufficient evidence to justify lawful intervention: *London Borough of Ealing v KS & Ors* [2008]

Type

- Abuse: Physical, discriminatory and organisational abuse
 - Neglect, including acts of omission and self neglect, self- harm and suicide
- Exploitation: sexual, psychological, financial or material abuse, including MDS

indicators

- Apply observations, third party reports and any collaborating information **objectively**. Using practice tools (e.g. power and control wheel, clutter rating index) or eligibility thresholds for services (e.g. social care outcomes or CHC decision support tool descriptors) can reduce appearance of bias or subjectively
- Utilise research findings to demonstrate why suspicions are reasonable!

Pattern

- Does the concern affect children, or other adults at risk?
- Have there been repeat allegations or repeated failings, justifying concerns of organisational abuse ?

Level

- If proven, would this constitute criminal offence?
- Is there a relationship of trust, personal, commercial or contractual relationship between the adult and alleged perpetrator?

MSP

- What insight does the adult have into the level of risk, do they understand why practitioners have concerns linked to the duty of care owed to the adult? Is vulnerability linked to need for care and support?
- Is there any evidence of incapacity, coercion, undue influence or duress?
- What outcomes matter to the adult and will this reduce/ remove risk related to the duty of care?

'MUST MAKE (OR CAUSE TO BE MADE) WHATEVER ENQUIRIES IT THINKS NECESSARY'



'DECIDE WHAT ACTION AND BY WHOM'



Practitioners must consider whether they have legal authority to act and any plan must meet all relevant partners' duty of care either by reducing risk of harm or because further action would be an unnecessary or disproportionate interference of human rights.

Consider, if not s42 enquiry how will the identified risk be mitigated and how will that be communicated to:

- Adult at risk and support network
- PACH
- Safeguarding Adults Board?

Practitioner should also advise adults at risk or their representatives about how they can access support so that the adult at risk can secure civil law remedies when they have suffered harm or been exploited.

FURTHER READING

- 'Safeguarding Adults under the Care Act 2014', Jessica Kingsley Publishers, 2017
- <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>: MCA Code of Practice
- <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>: Care Act statutory guidance
- <http://www.cps.gov.uk/legal/p-to-r/prosecuting-crimes-against-older-people/#mental>: Guidance on prosecuting crimes against adults at risk
- <https://www.gov.uk/apply-forced-marriage-protection-order>: guidance on forced marriage and duties to intervene to protect adult/ child at risk.
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance_England_Wales_V2-Interactive.pdf: Prevent Duty guidance and President's Guidance on Radicalisation: <https://www.judiciary.gov.uk/wp-content/uploads/2015/10/pfd-guidance-radicalisation-cases.pdf>

DEPARTMENT OF HEALTH AND SOCIAL CARE PERSPECTIVE

Jennica Smith, Policy Officer, Mental Capacity, Deprivation of Liberty Safeguards and Safeguarding. Andrew Ficinski, Policy Adviser and Rosemary Main, Statistician.

HEADLINE FROM THE 2017-18 PUBLICATION AND THE 2018 SAC SURVEY

Jim Butler

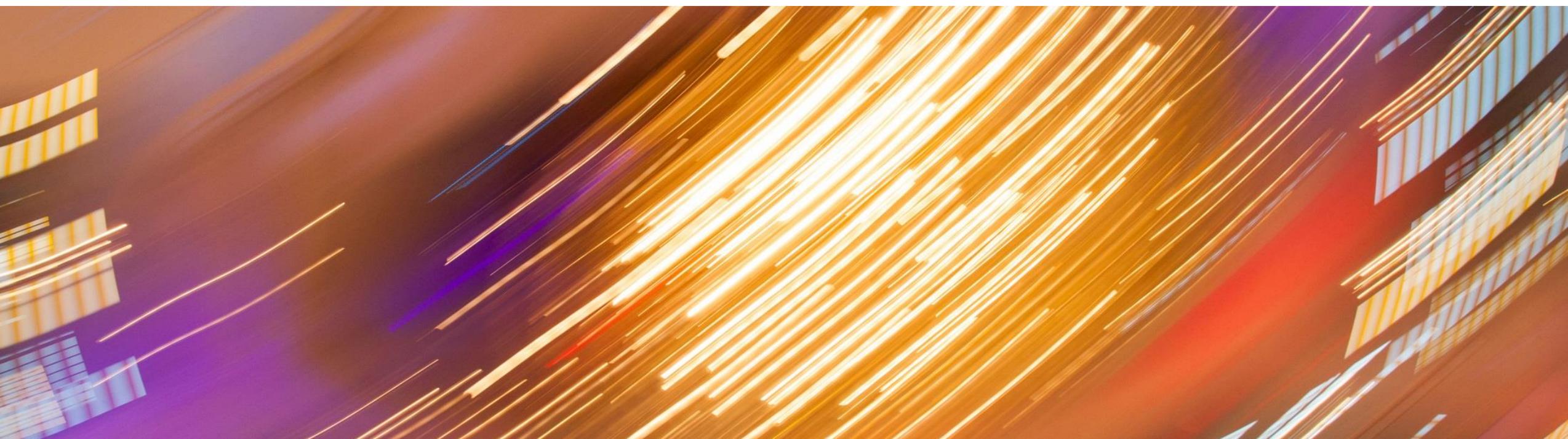
Analytical Section Head, NHS Digital.



Digital

Safeguarding Adults Collection (SAC)

A summary of the 2017-18 Publication and the 2018 SAC Survey



Information and technology
for better health and care

presented by Jim Butler,
Analytical Section Head

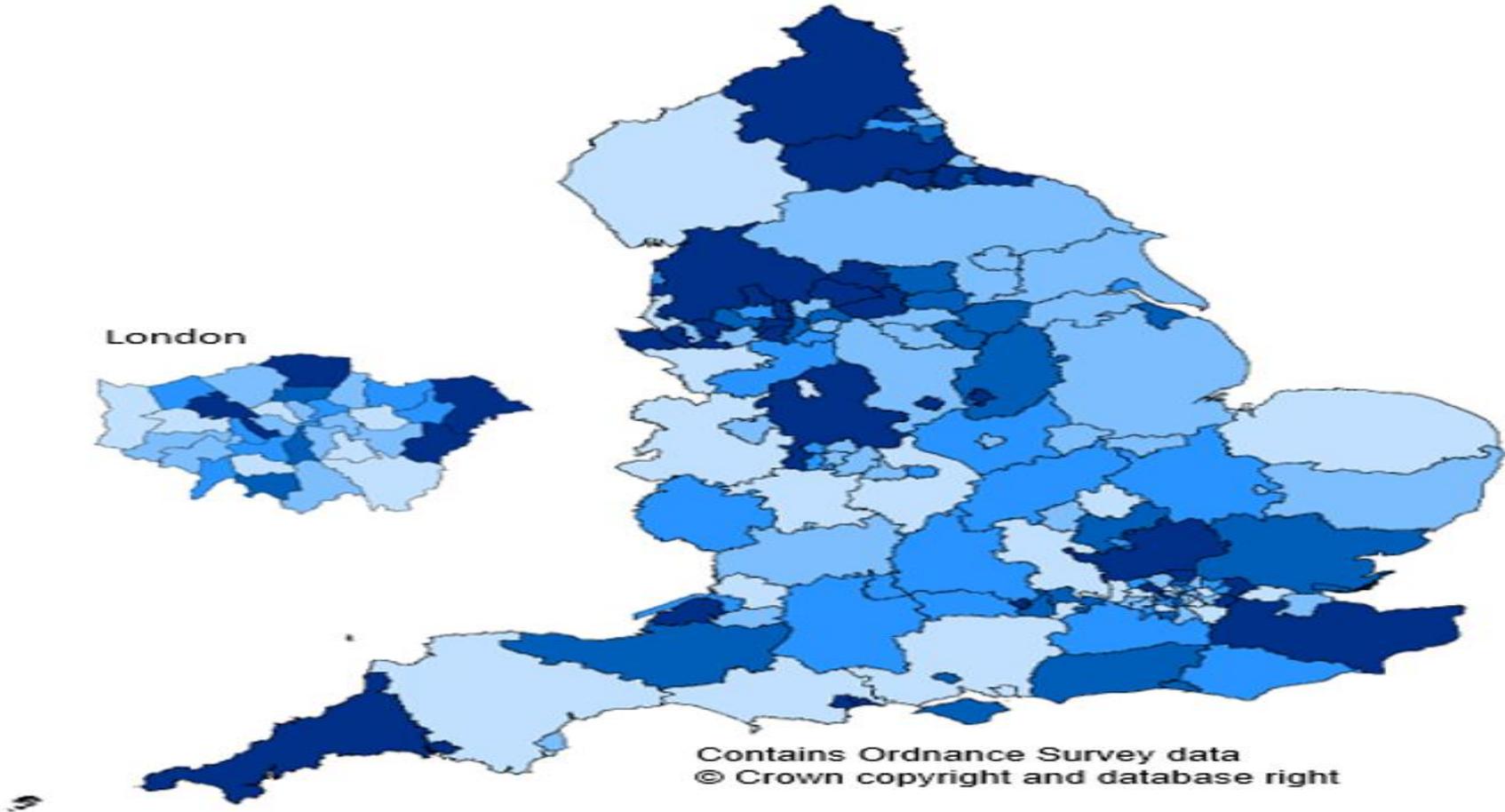
SAC 2017-18 – Key Findings



SAC 2017-18

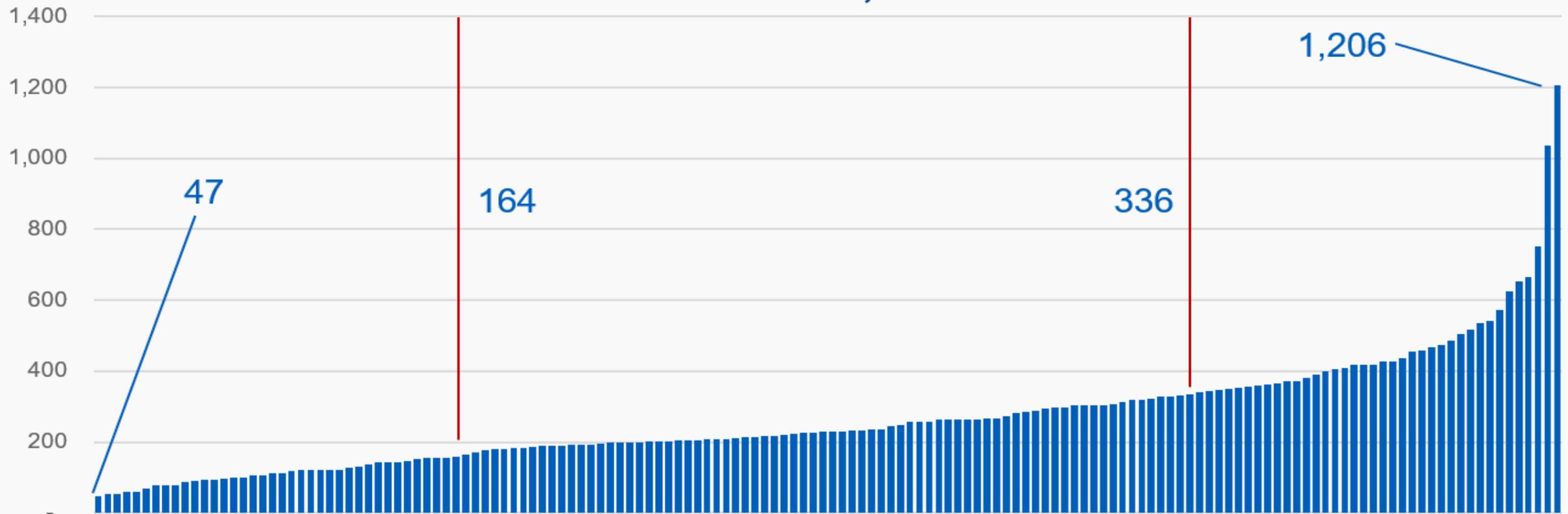
Figure 1.2: The total number of safeguarding enquiries per 100,000 of the local authority population in 2017-18

450 or more	(34)
350 to 449.99	(24)
250 to 349.99	(29)
150 to 249.99	(40)
less than 150	(25)



SAC 2017-18

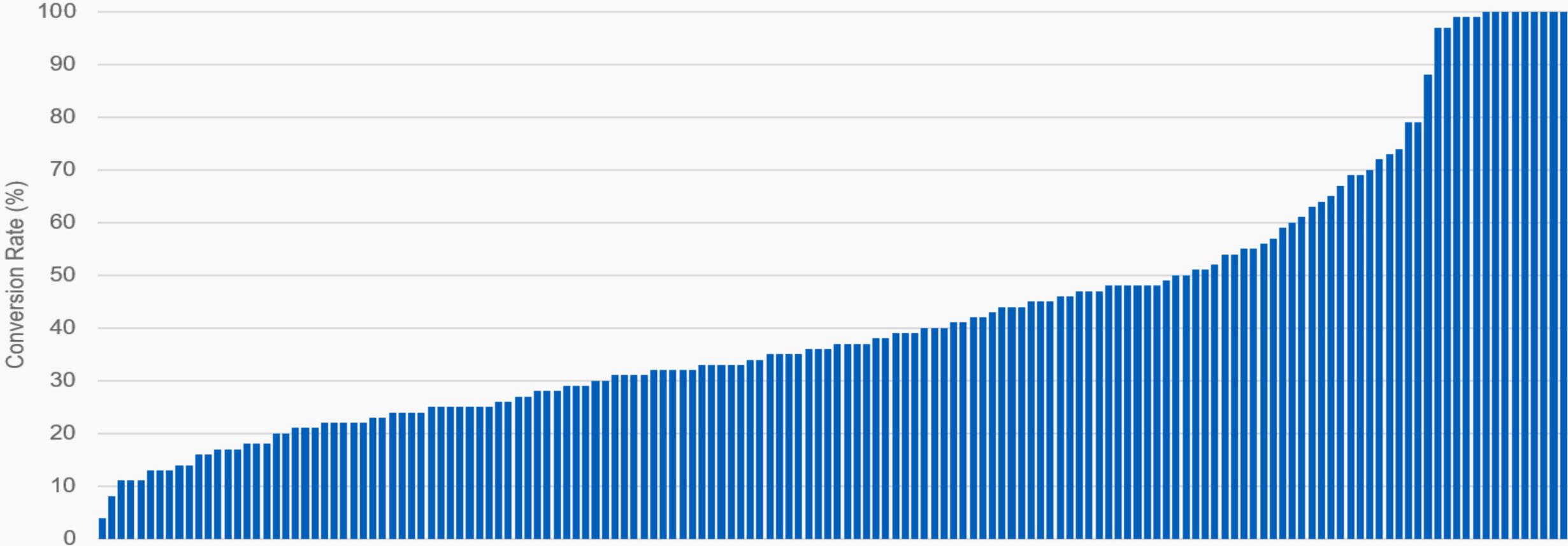
Individuals involved in Section 42 safeguarding enquiries per 100,000 adults by population and age group, directly standardised rate, 2017-18



Source: NHS Digital

SAC 2017-18

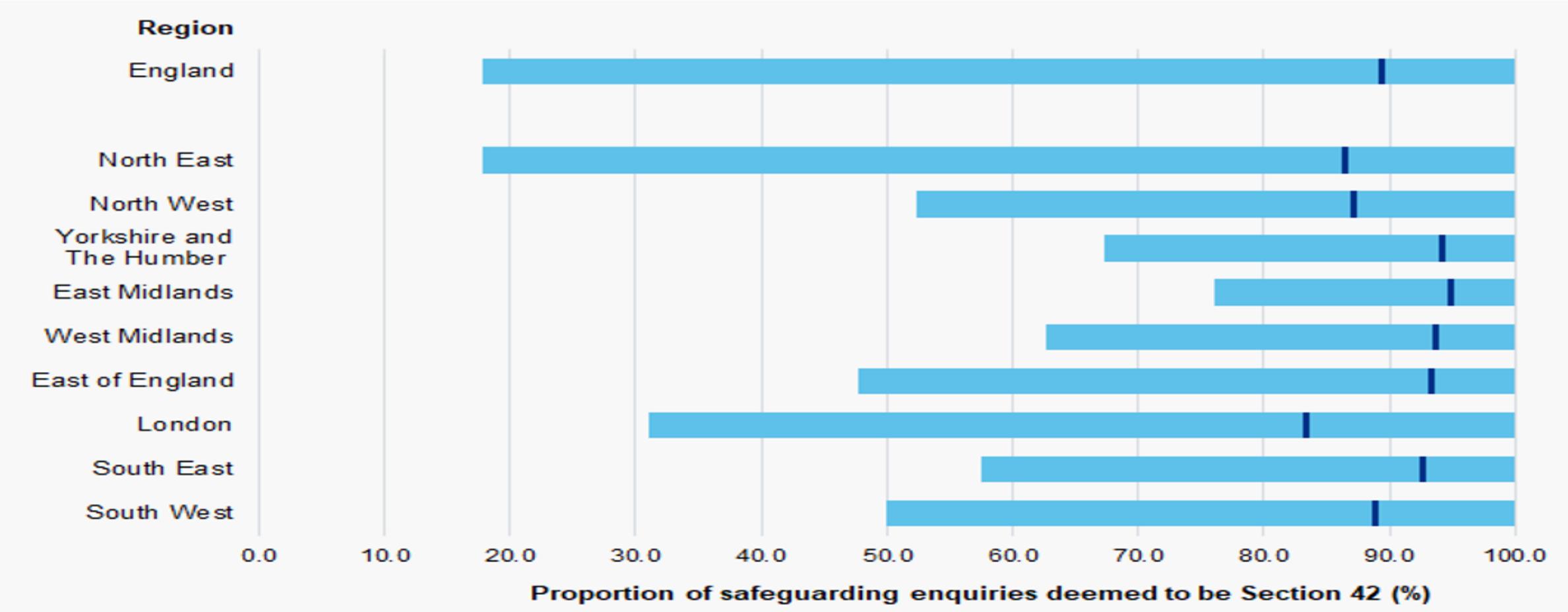
Conversion rate of Concerns to Enquiries 2017-18



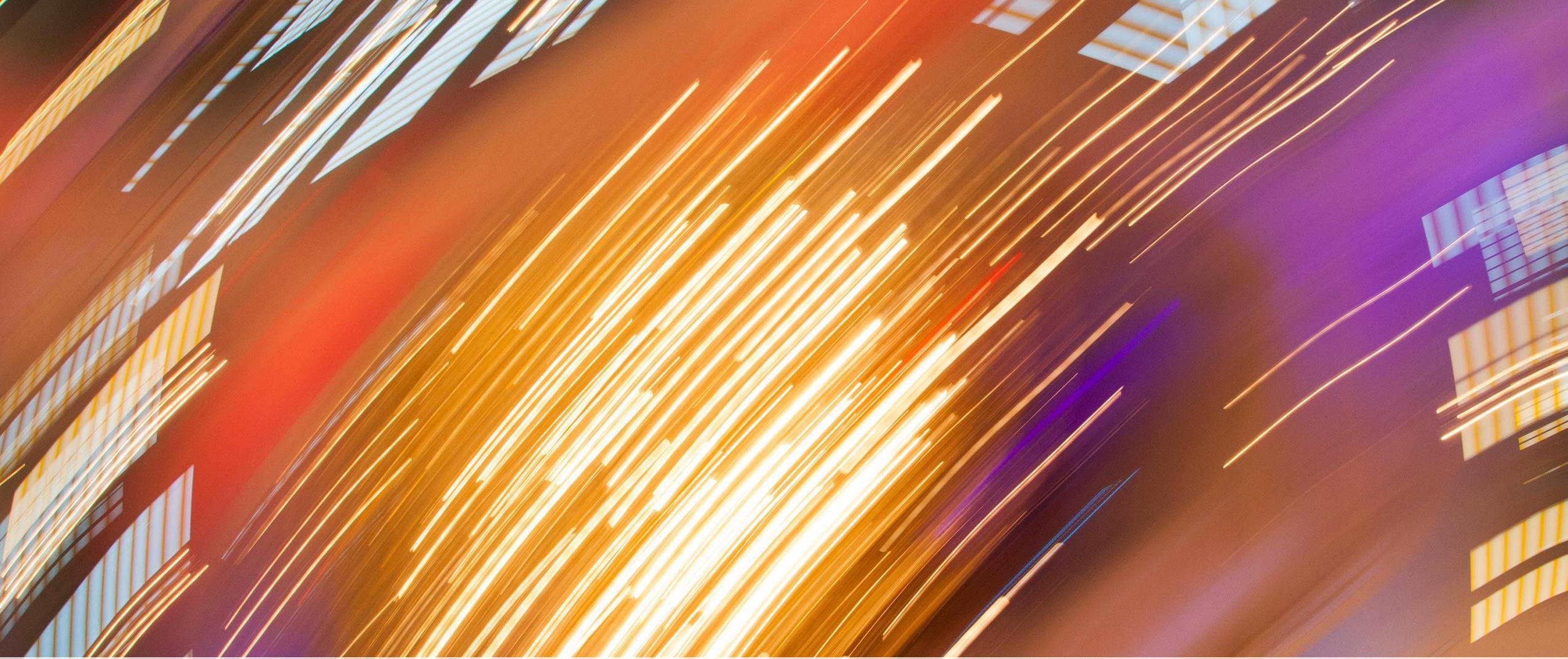
Source: NHS Digital

SAC 2017-18

Figure 1.3: The range of proportions of enquiries deemed to be Section 42 by region, 2017-18



Source: NHS Digital



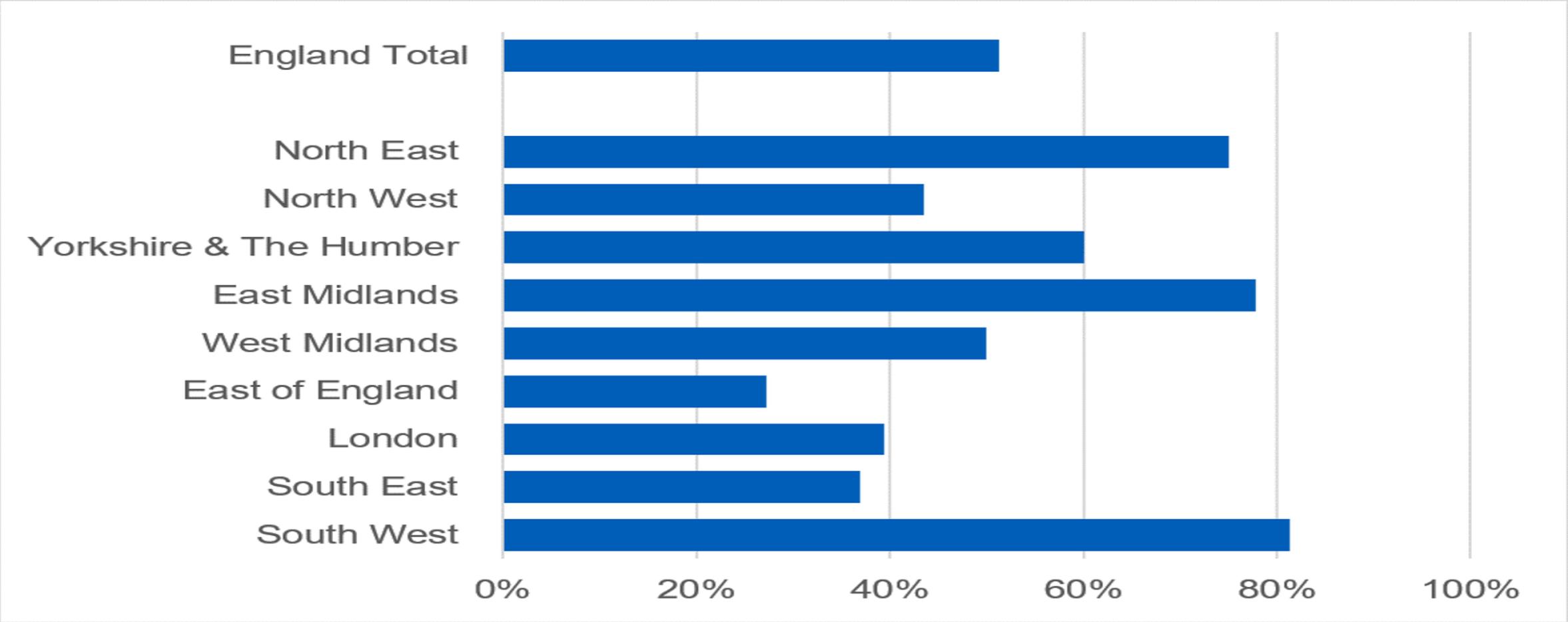
SAC Survey 2018

SAC Survey 2018

- A resource to aid interpretation of the SAC publication
- Qualitative focus
- Sector support – SAB Chairs, SAB Managers, LGA
- Voluntary, submitted online or via email
- 78 responses (51%).

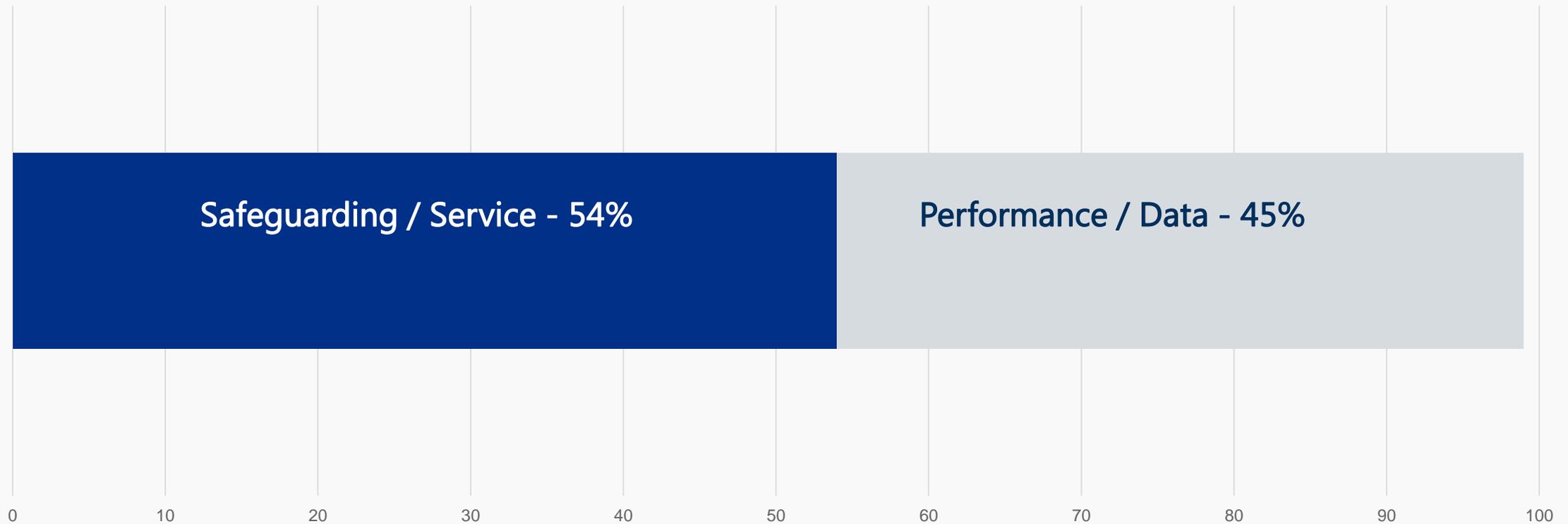
SAC Survey 2018

Figure 1. Response rate by Region.



SAC Survey 2018

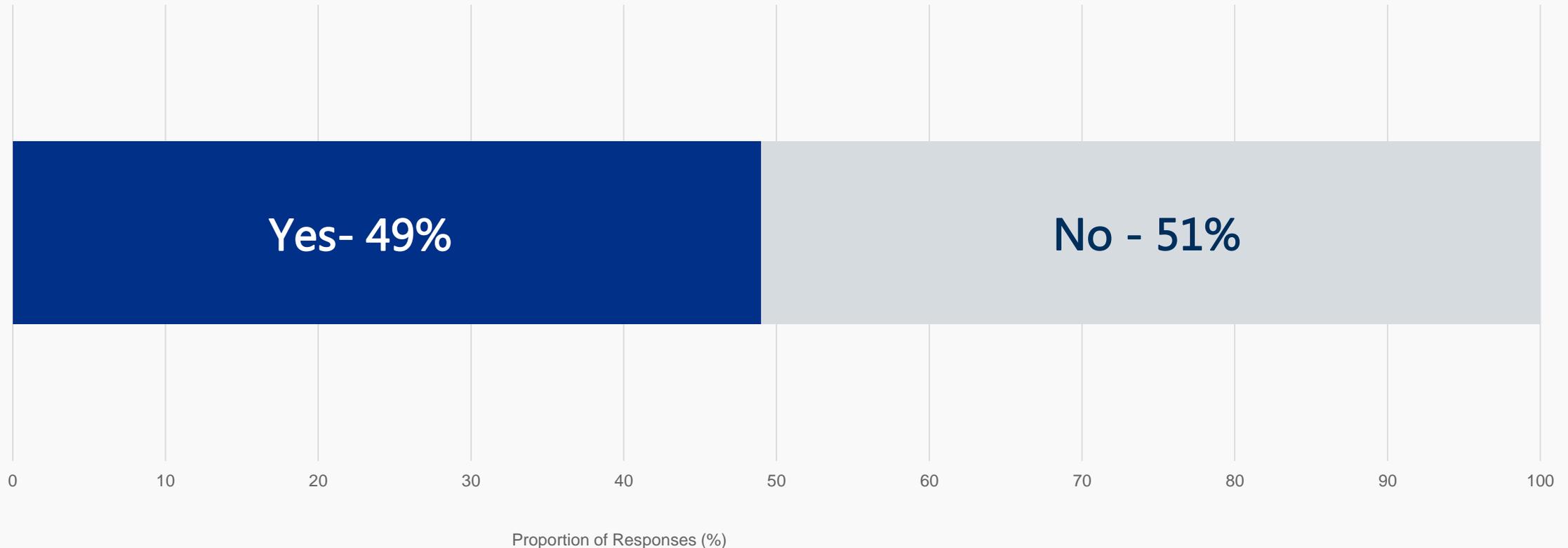
SAC Survey 2018 - Job Role of Submitting Individual



Proportion of Responses (%)

SAC Survey 2018

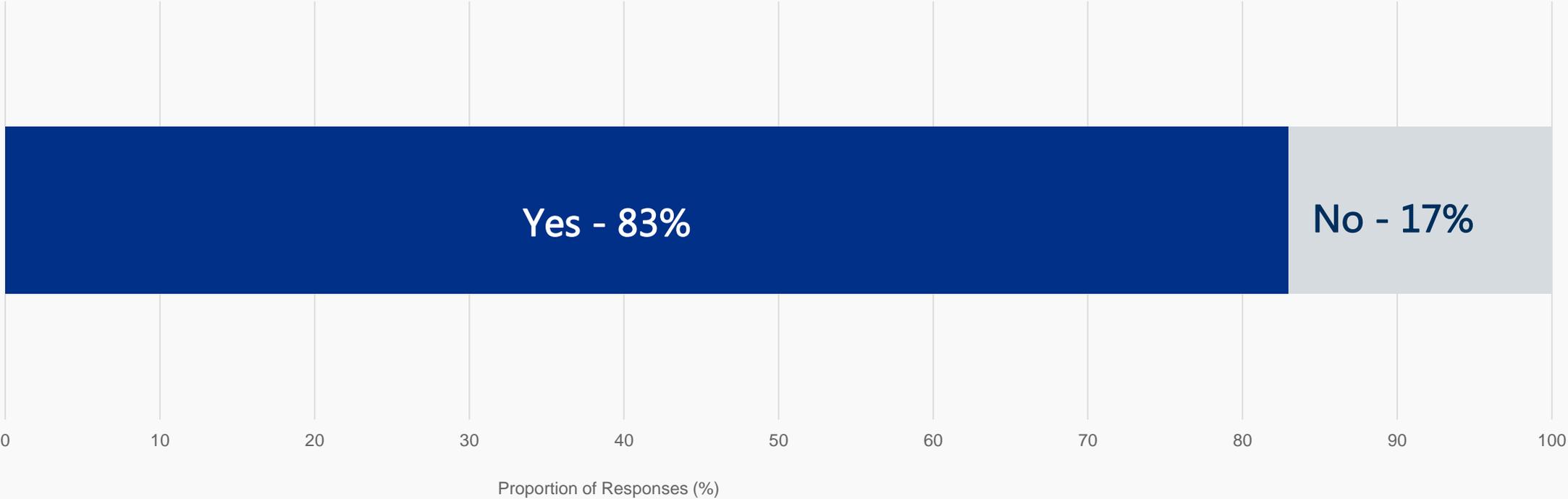
SAC Survey 2018 - Triage Processes?



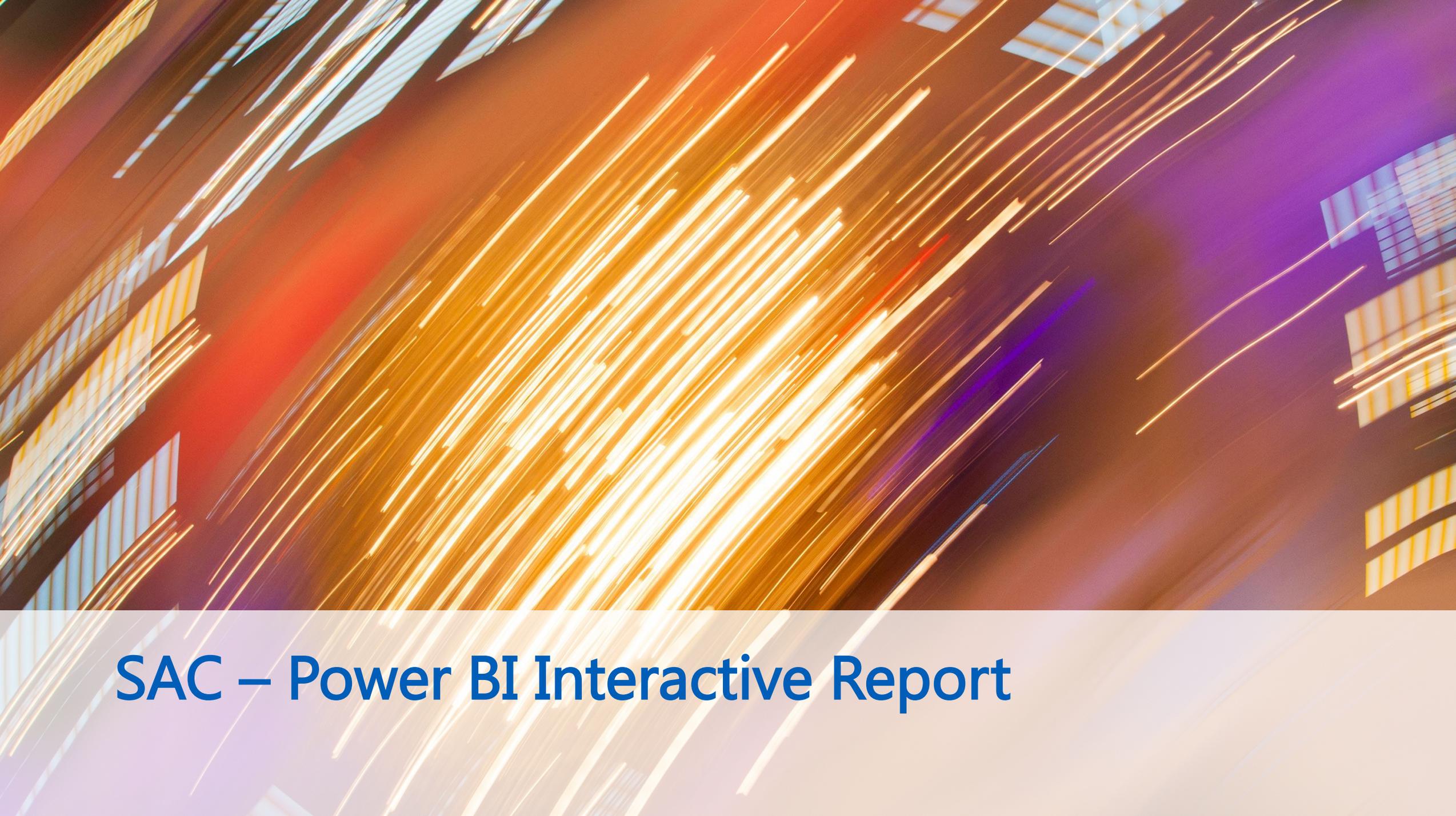
Are there processes in place in your local authority that result in some safeguarding concerns being addressed before they reach the safeguarding team and therefore are not reported in the SAC?

SAC Survey 2018

SAC Survey 2018 - Defined Threshold for Safeguarding Enquiries?



Do you have a defined process for the safeguarding team to determine the threshold at which a concern becomes an enquiry?

The background features a dynamic, abstract composition of light trails in shades of orange, yellow, and purple, creating a sense of motion and energy. A semi-transparent white rectangular box is positioned at the bottom of the image, containing the text.

SAC – Power BI Interactive Report

SAC – Power BI Interactive Report



Map of key measures



Quartile ● 1st to 25th percentile ● 26th to 50th percentile ● 51st to 75th percentile ● 76th to 100th percentile

Figure 1: Number of new safeguarding cases by selected measure per local authority in England, 2017-18

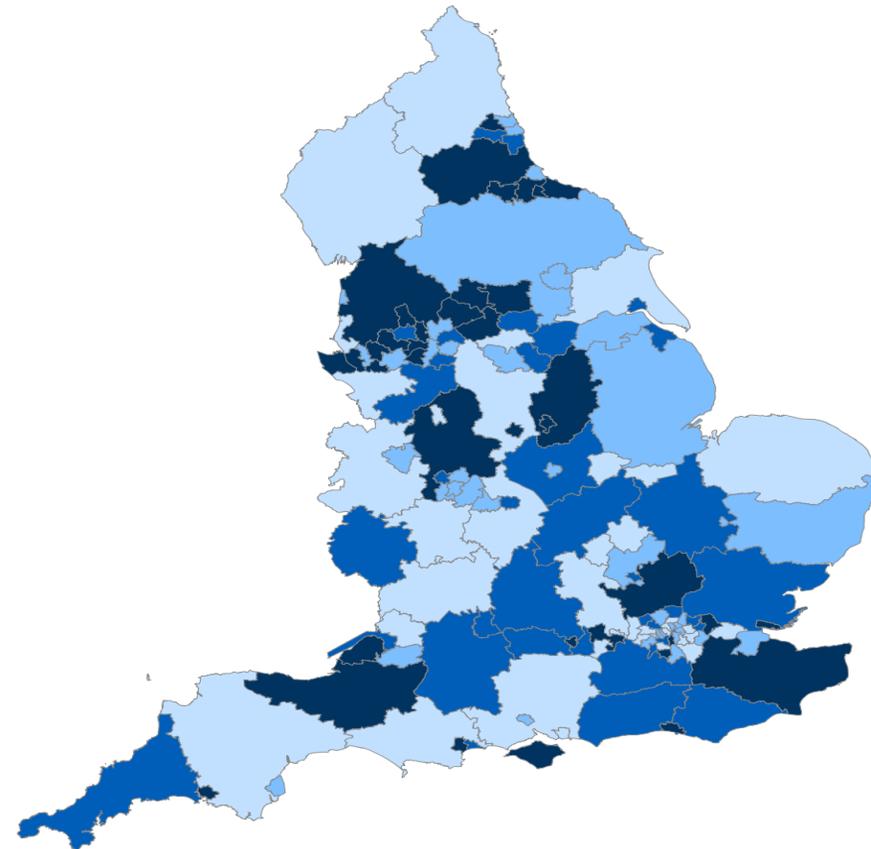
By selecting one of the measures listed in the menu below, the user can view the patterns of activity per local authority during 2017-18 for the selected measure.

Please hover over specific areas to view their name and associated values.

Please note darker shading represents higher values but this does not reflect good or bad performance.

Please select a measure

- 1. Concerns per 100,000 Adults
- 2. Section 42 Enquiries per 100,000 Adults
- 3. Other Enquiries per 100,000 Adults



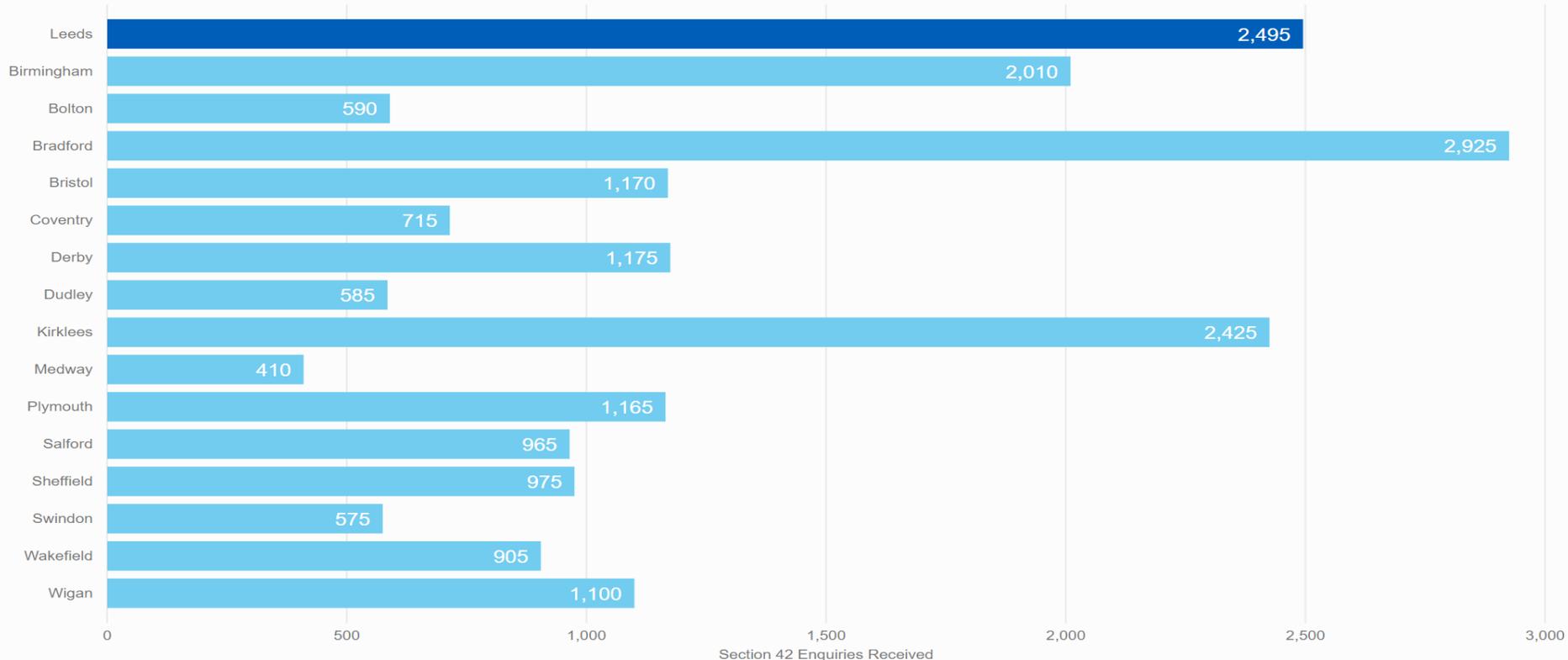
SAC - Power BI Interactive Report



Section 42 enquiries

The analysis presented on this page relates to **Section 42 enquiries commenced during 2017-18**. Data relating to the local authority selected from the menu on the left side of the screen as well as that local authority's neighbours in respect to **CIPFA's nearest neighbours model** or **region** are displayed in Figure 3.

Figure 3: Number of Section 42 safeguarding enquiries commenced per local authority in England, 2017-18



Please select a peer grouping

Please select one local authority

Leeds

Total number of Section 42 enquiries commenced during 2017-18 in England

131,860

Please contact us

enquiries@nhsdigital.nhs.uk

(FAO: Adult Social Care Statistics Team)

Adult social care statistics homepage:

<https://digital.nhs.uk/data-and-information/areas-of-interest/social-care>

Power BI Hub: http://bit.ly/SocialCare_HUB

NHS Digital SAC Survey 2018: <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>

www.digital.nhs.uk

 [@nhsdigital](https://twitter.com/nhsdigital)

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Refreshments

**You have a table number
on your badge.
Please move to this table
after break.**



Group discussions

Your table has a facilitator to guide you through the questions.



Principles

A principle is a general belief that you have about the way you should behave.

Morally correct behaviour and attitudes.

A fundamental source or basis of something.

A determining characteristic of something.

An adopted rule or method of application in action.

Ingredients

A constituent element of anything; component.

The ingredients of political success.

Component part or element of something.

An important part of anything.

A quality you need to achieve something.

SECTION 42'S AND THE YORKSHIRE AND HUMBER

Dave Roddis

ADASS Yorkshire and Humber, Programme Director.

SECTION 42'S AND THE YORKSHIRE & HUMBER

Dave Roddis

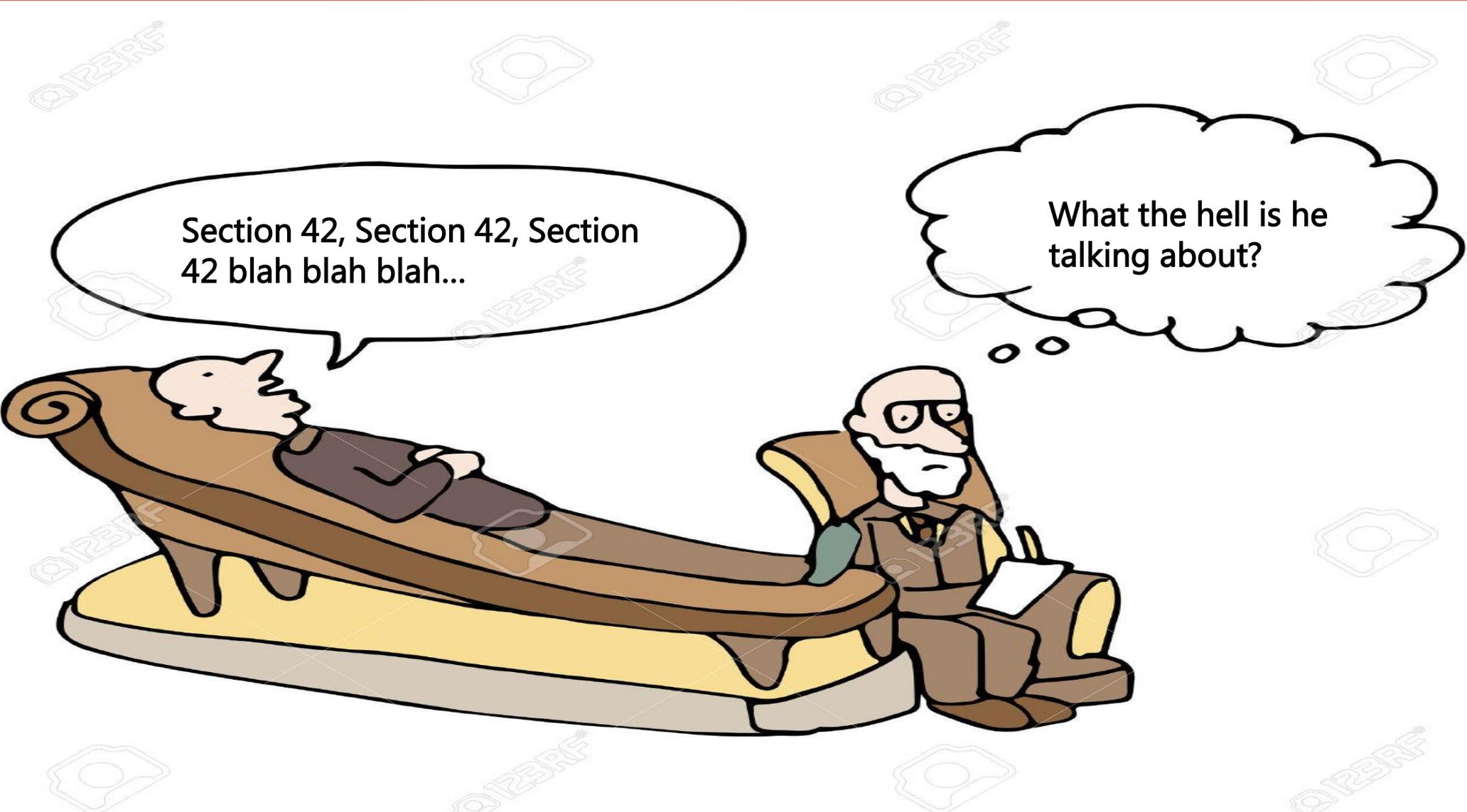
ADASS Yorkshire & Humber, Programme Director

28th & 29th November

London

The logo for ADASS (Adult Social Services) Yorkshire & Humber. It features the text 'directors of' in a small, dark blue font above the word 'adass' in a large, bold, dark blue font. Below 'adass' is the text 'adult social services' in a smaller, dark blue font, and at the bottom is 'Yorkshire & Humber' in a bold, dark blue font. The entire logo is contained within a white rectangular box.

directors of
adass
adult social services
Yorkshire & Humber



Section 42, Section 42, Section
42 blah blah blah...

What the hell is he
talking about?

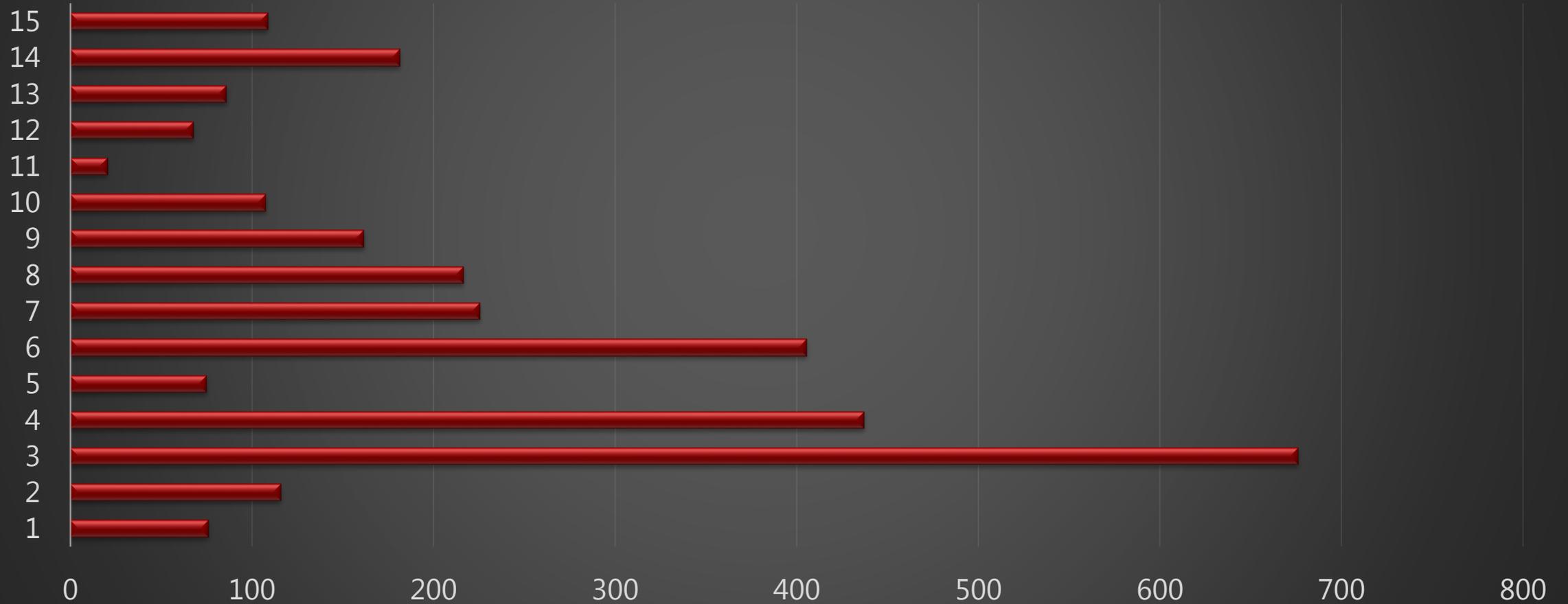
- ❑ MSP Stocktake – Performance Management needs strengthening
- ❑ Established benchmarking data as part of Dashboard
- ❑ Outliers – Section 42 – 16/17
- ❑ Development of the Regional Principles – Dr Adi Cooper Support
- ❑ IT Stocktake
- ❑ Outliers remain – 17/18
- ❑ Regional Safeguarding Decision Making Stocktake
- ❑ Regional Case Study Exercise/Workshop

- ❑ Differing points of access to report safeguarding concerns
- ❑ Who makes the decision to take into safeguarding also varies between authorities?
- ❑ There is inconsistency with the use of or recording of concerns which do not progress to formal enquiries.
- ❑ What do we mean by NFA
- ❑ Differing opinions on dealing with section 42 enquiries by telephone.
- ❑ **Recommendation:**

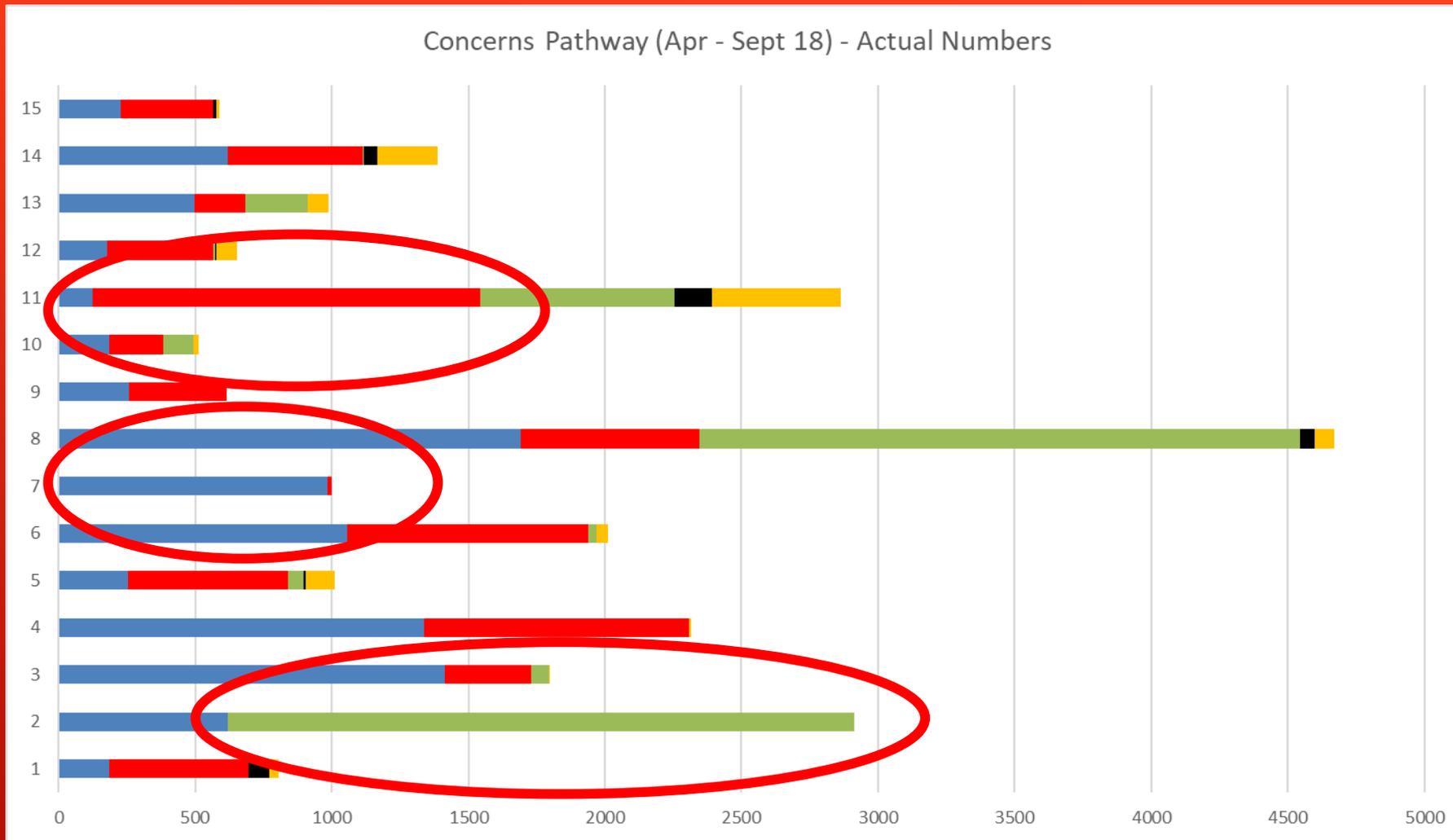
To conduct a “deep dive” exercise using actual case studies provided by authorities within the region to better understand decision making and identify areas of consistency/difference.

Y&H S42 JOURNEY

Section 42's per 100,000 population (April - Sept 2018)



S42'S AND Y&H – DATA CURRENT POSITION



Section 42

NFA – No
Further Action

Signposted

Other Enquiry

Awaiting
Decision

S42'S AND Y&H – DATA CURRENT POSITION

- ❑ Developed through a regional task and finish group
- ❑ Supported by the ADASS Yorkshire & Humber Branch, the regional Safeguarding Co-ordination meeting and the regional Safeguarding Adult Board Managers network
- ❑ Sixteen real scenarios have been provided by four local authorities
- ❑ The aim of the exercise:
 - ❑ Work with the relevant safeguarding practitioners in their local area to assess each scenario
 - ❑ Determine the decision they would have made on each one
 - ❑ Explaining the rationale behind their decision

S42'S AND Y&H – THE EXERCISE

- Explore the collective answers, look at themes and to examine the rationale behind the decisions made.
- Use the learning to further enhance the regional principles for dealing with Section 42's that we currently have in place.
- Importantly, there is no right or wrong answer in this exercise, however.....
 - We need a discussion about the rationale behind decisions - this will allow us to reach some regional consensus about what triggers a Section 42 enquiry.
 - Feed into national discussions taking place in London 28/29 November
 - Build a set of principles or the scaffold that support decision making
- Sector Led Improvement – opportunity to learn from each other and work as a collective regional group to improve practice and iron out any inconsistencies

REGIONAL WORKSHOP

- ❑ Local inconsistency due to interpretation of Section 42
- ❑ Issues around medication errors – how many would come into safeguarding from hospitals?
- ❑ Local debate over the 3 point test and how recording systems link to additional forms/tasks once it is selected that a concern meets criteria (are authorities undertaking initial enquiries/screening to prevent progressing to S42)
- ❑ What point concerns progress into enquiry.
- ❑ Questions still exist around second stage in 3 point test - challenges against MSP if screening out.
- ❑ Can be impacted by differing levels of expertise in safeguarding
- ❑ Positive/useful experience

KEY ISSUES IN DOING THIS EXERCISE?

- All 15 Local Authorities have participated
- All indicated that they have had sessions where practitioners involved
- Some are implementing new practices/procedures as we speak or in the very near future
- Lots of positive comments received from participants
- Range of response (out of 16 – how many were classed as s42)
 - 15 – A
 - 14 – B,C,D
 - 13 – E
 - 12 – F,G
 - 10 - H
 - 9 – I, J
 - 8 – K
 - 7 – L
 - 6 – M
 - 5 – N
 - 4 - O

THE EXERCISE HEADLINES

- Terminology – are we all talking about the same thing?
- Screening
- What does a Section 42 involve?
 - Minimal Response
 - Full Blown Investigation
 - Resolving at initial enquiry
 - S42 Telephone enquiries
- Further information needed – assumptions made
- Some local authorities seem to be using threshold documents to aid decision making
- Sub-regional procedures – do they improve consistency?
- Must remember that these are real stories involving real people.

- Chatham House Rules
- Safe house – are we happy to share your decisions with each other?

AREAS FOR EXPLORATION

CASE STUDY 2 – MRS SMITH FALL

Case Details

- Unwitnessed Fall – Care Home
- Mrs Smith has dementia and requires a hoist
- Son – no further investigation needed

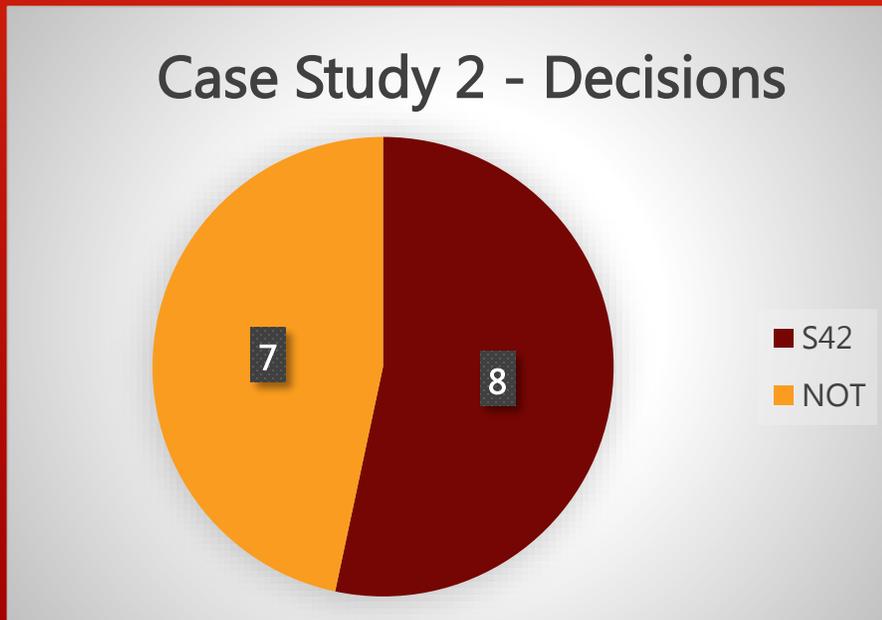
Rationale:

S42

- Neglect/Act of Omission
- Staffing levels
- Other people could be at risk
- Unexplained fall

NOT

- Family don't want it progressing
- It was an accident
- Can't be prevented
- No evidence of neglect



CASE STUDY 4 – FRED AND BOB ALTERCATION

Case Details

- Unprovoked attack by Fred on Bob
- Fred (Vascular Dementia) Bob (Alzheimers)
- Witnessed by Fred's Son
- No signs of harm to Bob

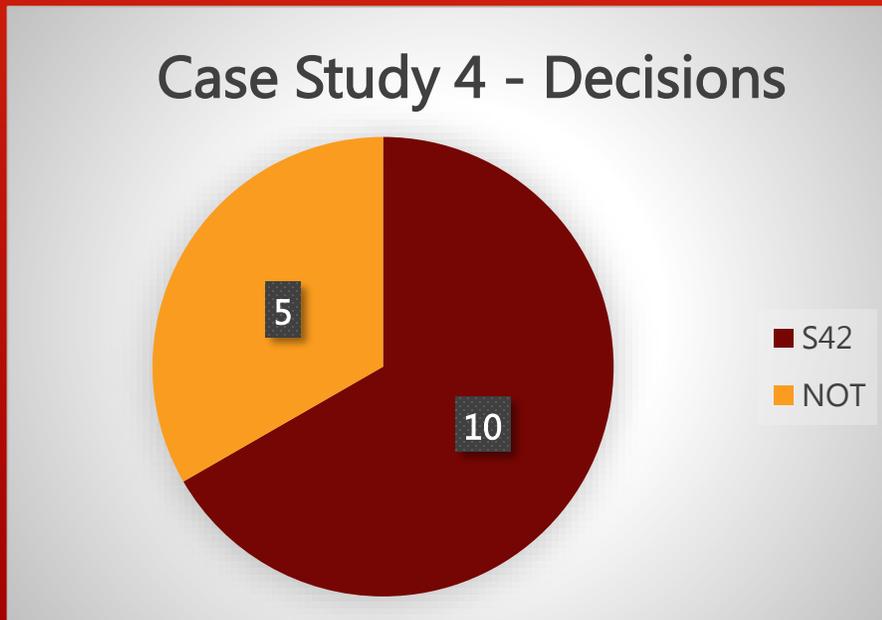
Rationale:

S42

- Fred assaulted Bob
- Physical abuse
- Both lack mental capacity
- Risk assessment needed

NOT

- No harm sustained
- Resident on resident
- Appropriate action taken to mitigate risk



CASE STUDY 7 – PETER PINCHED ARM

Case Details

- Peter – Severe Autism/LD
- Day Care 3 days a week
- Pinched on arm by another service user
- Bus stopped and separated

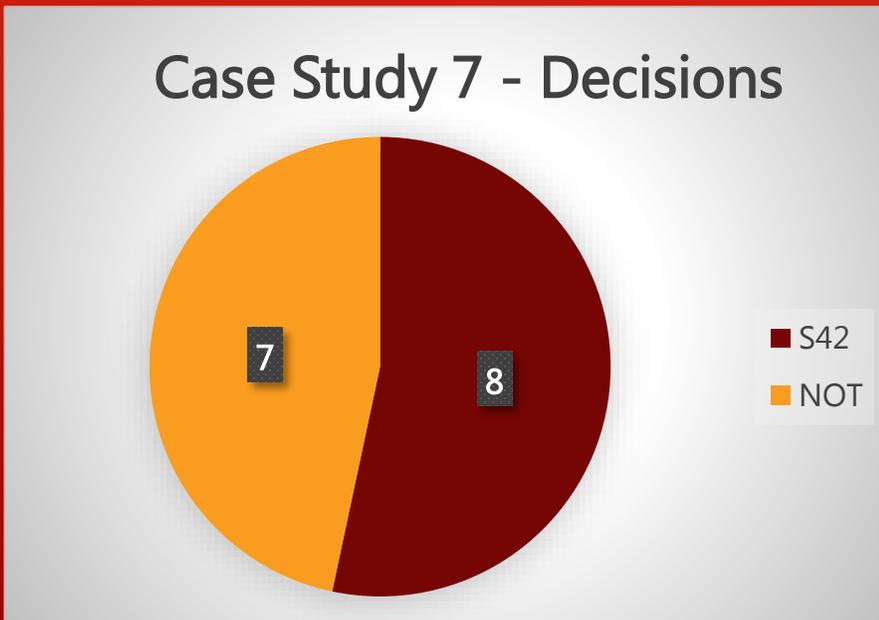
Rationale:

S42

- Physical abuse – caused harm
- Not able to protect himself
- Distressed
- Protect from further abuse

NOT

- Appropriate action taken
- Superficial injury only
- Risk management approach



CASE STUDY 11 – MEDICATION ERROR

Case Details

- ❑ Medication changed
- ❑ Old and new medication administered in error
- ❑ GP contacted – should be fine
- ❑ X did not feel any different

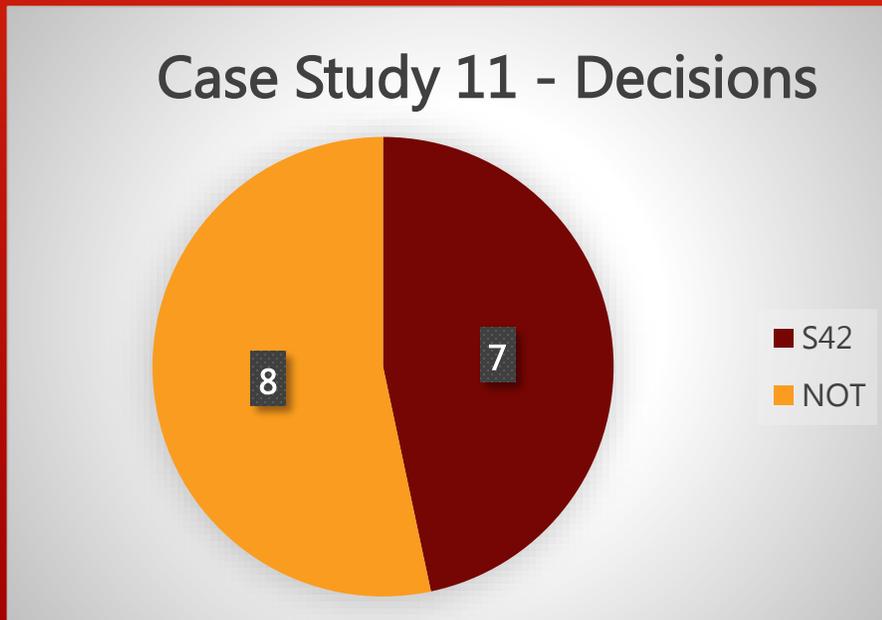
Rationale:

S42

- Person could not protect themselves from neglect
- Poor practice
- Others may be at risk

NOT

- One-off incident
- Appropriate action taken
- No harm
- No abuse/no neglect



- CASE STUDY 1 (Health) – 12 / 3
- CASE STUDY 2 – (Fall) 08 / 7
- CASE STUDY 3 – (Fall) 1 / 14
- CASE STUDY 4 – (Altercation) 10 / 5
- CASE STUDY 5 – (Indecency) 0 / 15
- CASE STUDY 6 – (Sexual Assault) 14 / 0 / 1
- CASE STUDY 7 – (Physical Assault) 8 / 7
- CASE STUDY 8 – (Medicine) 15 / 0
- CASE STUDY 9 – (Fall) 10 / 5
- CASE STUDY 10 – (Medicine) 12 / 3
- CASE STUDY 11 – (Medicine) 7 / 8
- CASE STUDY 12 – (Scam) 10 / 4 / 1
- CASE STUDY 13 – (Neglect) 11 / 3 / 1
- CASE STUDY 14 – (Altercation) 11 / 4
- CASE STUDY 15 – (Gen. Care) 15 / 0
- CASE STUDY 16 – (Sexual Abuse) 8 / 4 / 3

OVERALL RESULTS

- People seem to be doing similar things on the ground however:-
- Two significant views:
 - If it meets the 3 point test then it's a Section 42!!!
 - All concerns are assessed/triaged and action takes place accordingly – this may result in not progressing to Section 42 even if it meets the 3 point test. Proportionate response
- Local guidance, local decision making tools and THRESHOLDS
- The three point test is not being applied consistently – its clear but needs more guidance – or we could count everything
- The system/process is maybe dictating what happens
- Data doesn't reflect the activity on the ground
- Section 42 = resources = work???
- Is Section 42 enquiry an indication of the extent of safeguarding/abuse that is taking place?
- Ban Thresholds!!!!

CONCLUSIONS AND OBSERVATIONS

- Take back any learning locally
- Report findings to the regional branch and safeguarding networks
- Revise and update the regional protocol
- Produce a summary of the outcomes of the exercise to provide additional guidance
- Share our exercise nationally
- Share our experience and feed into the discussions at the national workshop

NEXT STEPS



Group discussions

Your table has a facilitator to guide you through the questions.



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A principle is a general belief that you have about the way you should behave.

Morally correct behaviour and attitudes.

A fundamental source or basis of something.

A determining characteristic of something.

An adopted rule or method of application in action.

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A constituent element of anything; component.

The ingredients of political success.

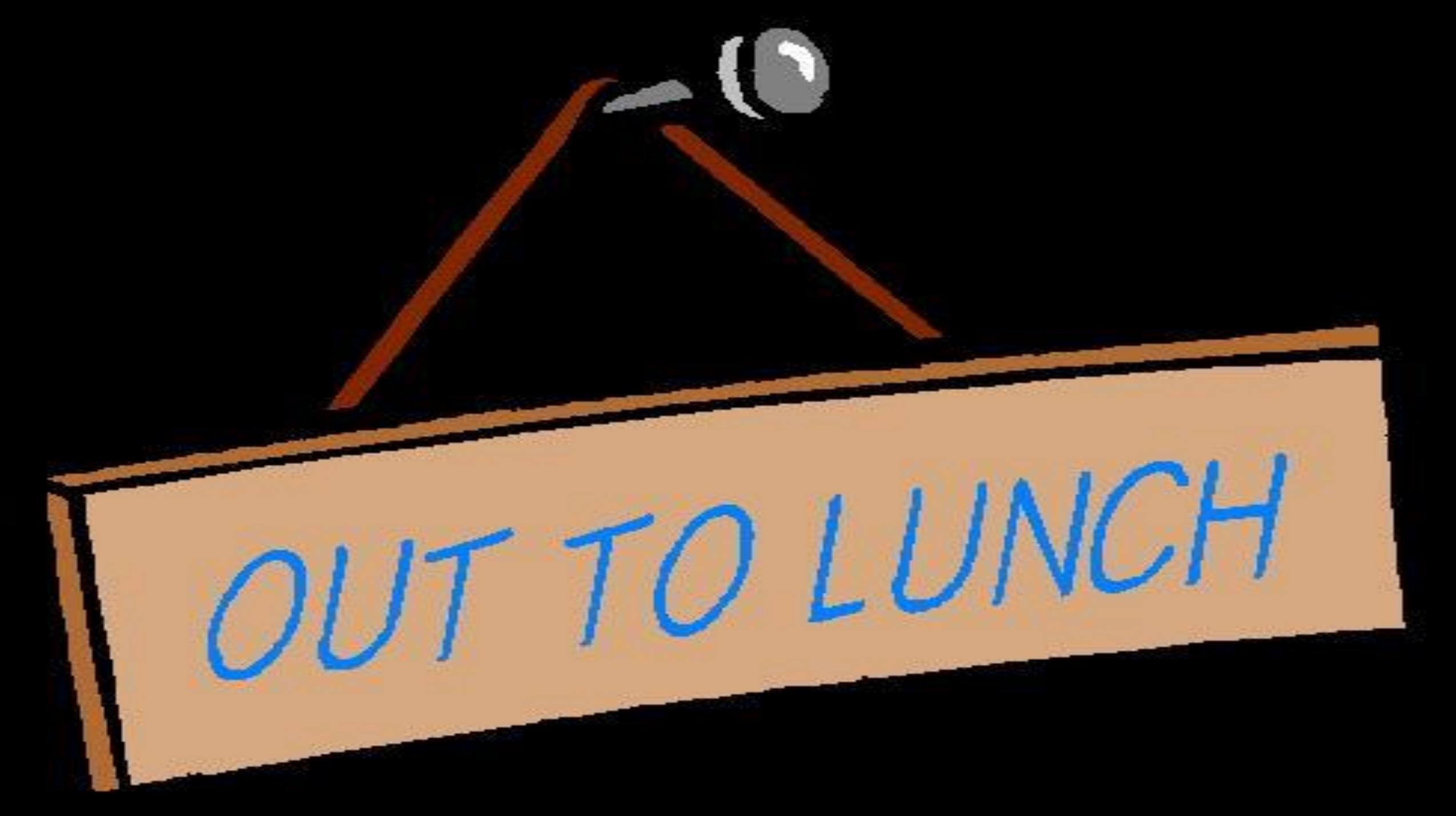
Component part or element of something.

An important part of anything.

A quality you need to achieve something.



**You have a table number on your badge.
Please move to this table after lunch.
Thanks you.**



OUT TO LUNCH

Introduction to the afternoon session

Jane Lawson

Adviser, CHIP, Local Government Association / ADASS.

REFLECTIONS ON HOW TWO APPROACHES TO SAFEGUARDING CAN IMPACT ON CONVERSION FROM CONCERNS TO S42 ENQUIRIES

Claire Bruin, Care & Health Improvement Adviser, East of England, Local Government Association.

Keith Dodd, Head of Adult Safeguarding and DoLS, Hertfordshire County Council.

Reflections on how two approaches to safeguarding can impact on conversion from concerns to S42 enquiries

Claire Bruin, Care & Health Improvement
Adviser, East of England, LGA

Keith Dodd, Head of Adult Safeguarding &
DoLS, Hertfordshire County Council

Two different approaches

- An Authority with a MASH, where media interest was triggered by the report by Action on Elder Abuse
- An Authority without a MASH where safeguarding concerns are managed through service led operational teams.

In the media spotlight

Patchwork of Practice - report by Action on Elder Abuse December 2017

Using the Safeguarding Adults Collection (SAC) 2016-17, concluded

- A postcode lottery
- 10 Councils 'converted' 100% of safeguarding concerns into S42 enquiries
- Some Councils, less than 10%
- Demonstrates differences in how an abuse concern is addressed
- BUT could also mean that older people & their families are being denied proper investigations
- Is it lack of resources, expertise or simply an unwillingness to investigate?

Local media attention

- Local Authority with only 14% of abuse concerns being 'converted' into S42 enquiries
- Media questions about vulnerable people not being protected from abuse
- Easy to defend that this was not the case – all concerns looked into thoroughly
- MASH accepts all concerns with any suggestion of safeguarding issues – all logged as concerns, including concerns about the same person from different sources
- MASH then carries out triage
 - about 70% of concerns did not meet the 3 point test for safeguarding and were signposted elsewhere
 - Of the remaining 30%
 - About half were addressed without the need for a multi-agency meeting, often dealt with in the MASH
 - About half were passed to Locality Teams to lead on a multi-agency meeting & logged as a S42 enquiry.

Reflections

- Does having a MASH increase the number of concerns logged and therefore reduce the conversion rate to S42 enquiries?
- Activity in a MASH to triage concerns that are definitely not safeguarding is not reflected in SAC – but may be reported locally
- How is the **activity** to address concerns where MASH has triaged and there is potential abuse/neglect being defined?
- S42 of the Care Act does not define what constitutes an enquiry, but requires the Local Authority to “.....make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case.....”
- Therefore, are **ALL the actions** taken by the MASH in connection with concerns that are triaged as potential safeguarding enacted under the duties of S42 of the Care Act?
- If so, this would have doubled the conversion rate from concerns to S42 enquiries in this case and would have reflected the actual number of enquiries made into potential abuse/neglect.

Issues post Care Act – LA with no MASH

- Inconsistent decision making - Large number of decision makers across different localities and care groups
- Locally developed practices - Different approaches to dealing with concerns coming in leading varying response times and quality of response
- Offline safeguarding – Safeguarding enquiries taking place but not being recorded. This impacted on reporting and ability to audit and quality check safeguarding work.

Action taken



Redesigned our decision making pathway and recording system to improve consistency and accountability of decision making.

- How:
 - Clear guidance on recording of concerns for all entry points
 - Only trained managers able to decide on whether a concern becomes a S42 enquiry.
 - No thresholds for an S42 enquiry but eligibility based on the 3 questions

THE PERSON

Has needs for care and support (whether or not the local authority is meeting any of those needs)

and

Is experiencing, or is at risk of, abuse or neglect

and

As a result of those needs is unable to protect themselves against the abuse or neglect or the risk of it

Safeguarding Concerns

- Any referral received where the referrer is clear that they want to raise a safeguarding concern (whether it will meet the criteria or not).
- Any referral contain concerns around abuse or neglect whether or not the referrer has identified them.
- Do not need to raise just because information is sent in on a safeguarding form if what is being requested is something else e.g. a request for an OT assessment.

S42 and Other Safeguarding Enquiries

S42 Enquiries

- All concerns that meet the 3 safeguarding questions
- A S42 enquiry can be as little as asking the adult at risk what they want to a full investigation. If closed at individual's request this will still constitute a S42 enquiry
- Individual outcomes are sought from the adult at risk and are recorded whether achievable or not.

Other Safeguarding Enquiries

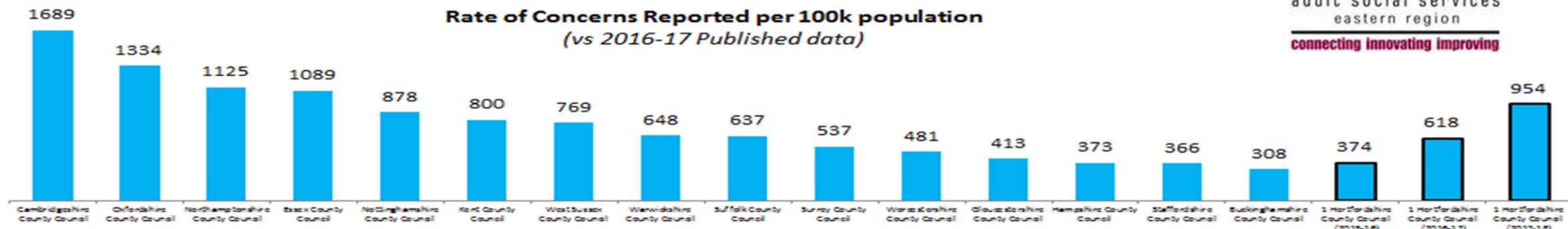
- When not all 3 eligibility decisions are met but it is decided that a safeguarding enquiry is required.
- After eligibility decision follows the same process a S42 enquiry
- Does not cover other work such as a Care Act assessment or review.

Impact of changes

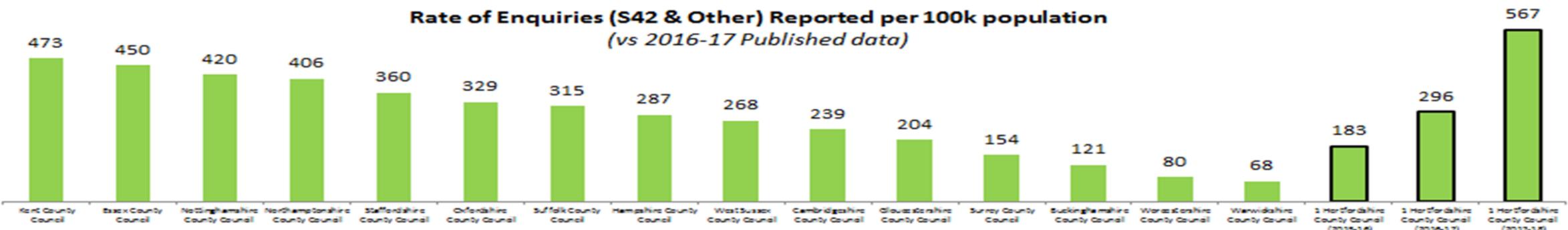
- Before we made the changes in Herts our reported number of concerns put us as one of the lowest compared to regional and national comparators.
- Our conversion rate from Concern to S42 enquiry was around 48%
- Since the change the numbers of reported concerns have increased significantly and the conversion rate has also increased.

How do we Compare?

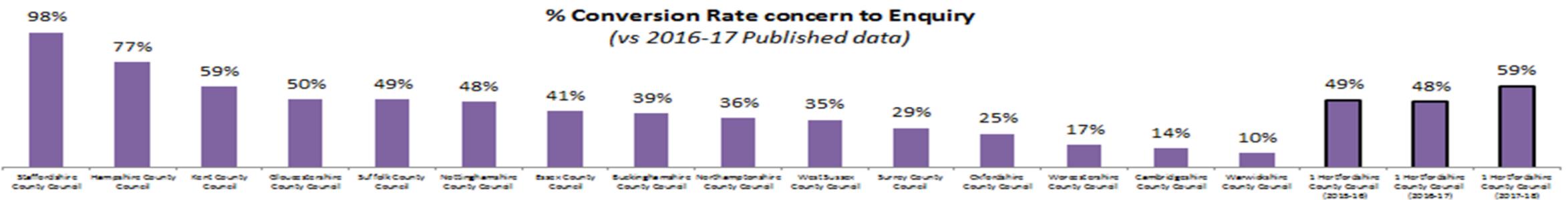
Rate of Concerns Reported per 100k population
(vs 2016-17 Published data)



Rate of Enquiries (S42 & Other) Reported per 100k population
(vs 2016-17 Published data)



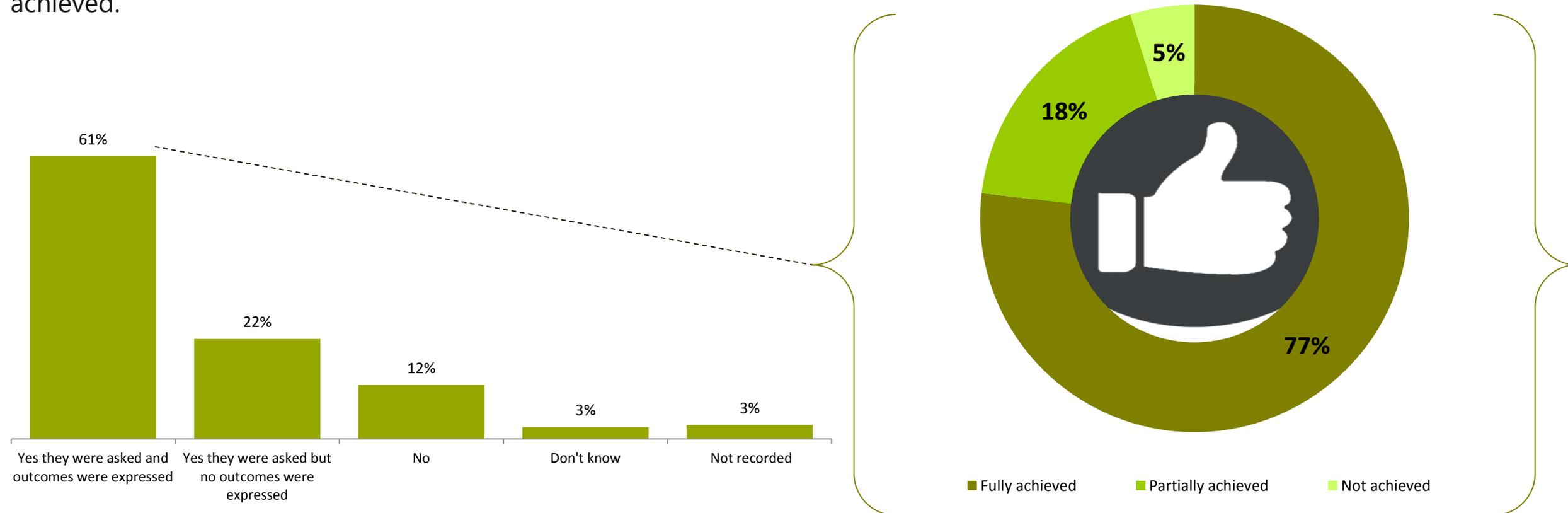
% Conversion Rate concern to Enquiry
(vs 2016-17 Published data)



Making Safeguarding Personal

83% of clients involved in a safeguarding adults enquiry were asked what their desired outcomes were with **15%** either not asked or not recorded. **3%** answered that they "Don't know".

Of the clients who expressed their desired outcomes, **95%** had their outcomes achieved or partially achieved with only **5%** not achieved.



Key Issue

What is an enquiry under the requirements of the Care Act?

S42 ENQUIRIES – IMPACT ON STATUTORY NOTIFICATIONS

Teresa Kippax

National Advisor Safeguarding Children and Adults, Care Quality Commission. Directorate of Primary Medical Services and Integrated Care.

S42 enquiries – impact on statutory notifications



Teresa Kippax, National Advisor Safeguarding
28 & 29 November 2018

Current status



Safeguarding notifications

CQC receive on average 70000 per year



Majority from Adult Social Care providers

What happens with them?

CQC Improvements



Robustness of information

Guidance

New forms

Consistent messaging.

NEWCASTLE CITY COUNCIL APPROACH TO MAKING SECTION 42 DECISIONS; RATIONALE, IMPACT, OUTCOMES AND ALTERNATIVE ROUTES OF ENQUIRY.

James Steward

Service Development Lead, Safeguarding Adults Unit,
Newcastle City Council.

Newcastle City Council approach to making Section 42 decisions;

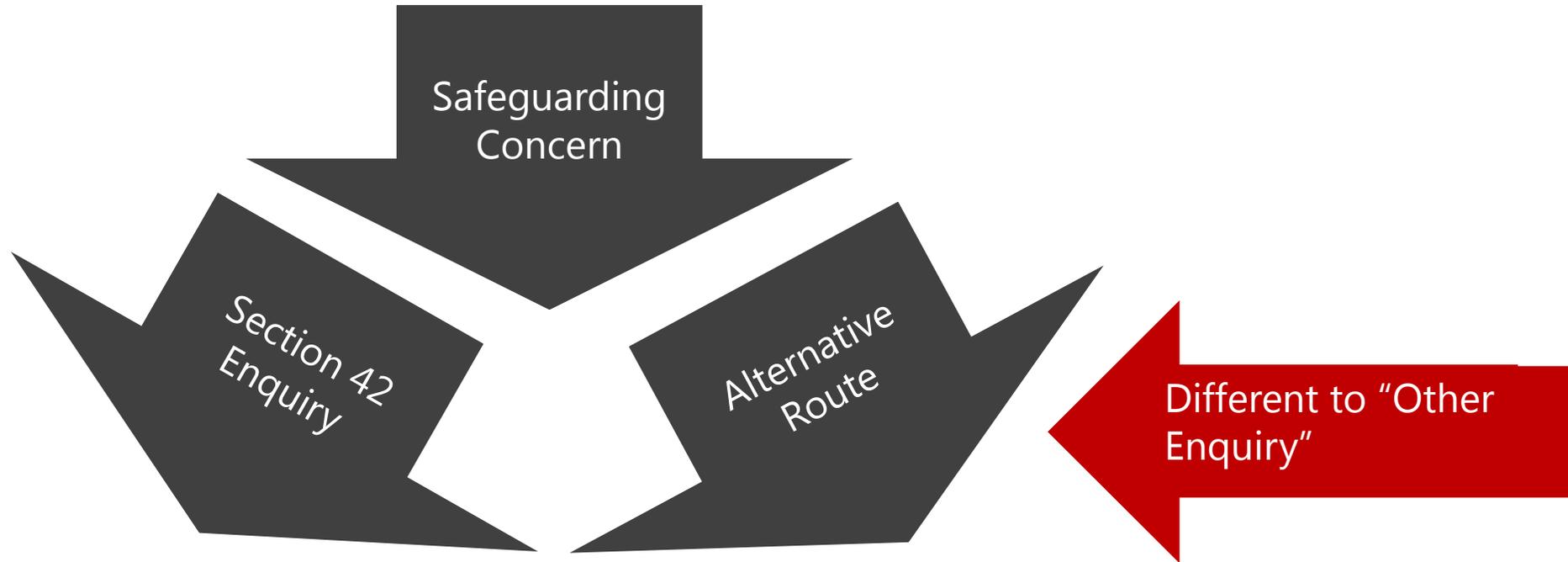
rationale, impact, outcomes and alternative routes of enquiry.



Our Approach

- All concerns raised where (on initial information) adult is an adult at risk and there is a risk of abuse or neglect are considered as Section 42 Enquiries
- Regardless of threshold of harm or length of enquiry
- General Welfare Concerns
- Other Concerns are enquiries where there is a risk of abuse but the adult at risk criteria has not been met.

Section 42 Enquiries



Rationale

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.

Care Act Statutory Guidance.

What is a Section 42 Enquiry

prior to initiating a formal enquiry under section 42

What does this mean?

Section 42

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Outcomes

- Variation of thresholds
- The only consistent point to start counting is at the beginning
- Making Safeguarding Personal Embedded across a 5 Stage process
- Desired outcomes measured at each stage





Refreshments



INITIAL THOUGHTS FROM THE DAY ABOUT IMPACT OF DECISIONS ON PEOPLE

Esi Hardy

Managing Director, Celebrating Disability.

Group discussions

Your table has a facilitator to guide you through the questions.



Moving forward and LGA workplans for 2019

Jane Lawson

Adviser, CHIP, Local Government Association / ADASS.