Safeguarding in a Pandemic: learning from lived experience.

Isle of Wight Safeguarding Adults Board

An executive summary of the IOWSAB Covid 19 Review to learn from the lived experience of those with care and support needs during the peak of the pandemic.

Context and background

In Autumn 2021, the IOW Safeguarding Adults Board (SAB) established a task and finish review to understand more about the broader impact of the Covid-19 pandemic on adults with care and support needs who may be less likely to be seeking or finding easy access to services. The review was undertaken when the impact of Covid 19 and the resulting lockdowns and restrictions on services was very present. The work was intended to focus on the less obvious, 'hidden' aspects of the impact of the pandemic, that is the challenges which were not disease related, such as access to services, impact on carers (paid, unpaid and family carers) and whether those most at risk but not currently in contact with services could be reached through other means, such as the voluntary sector.

Process

The SAB Safeguarding Adults Review (SAR) group led a multi-agency task and finish group who identified the methodology to be used and how best to obtain the views of people with lived experience.

The review included 13 anonymised case studies provided by a range of agencies, an anonymous staff survey where health and social care workers could share their views and experiences, plus qualitative feedback from agencies about how their service coped with challenges associated with Covid. It was agreed that a broad range of health and social care agencies would be approached across the multiagency partnership and asked to provide case studies of examples of people who may be experiencing challenges associated with changes in services or other indirect impacts of the pandemic. They were also asked to share any verbal feedback on behalf of people being cared for, their carers, from staff within their agency or based on their own lived experiences. In order to understand paid staff experience specifically, a staff survey was also shared across the system asking staff a series of questions, for which they were also given the opportunity to share additional information and examples using free text. This survey was anonymised to promote full disclosure. Comments from working group discussions were also captured and included in the analysis.

The case studies, surveys and other qualitative feedback were individually analysed by the task and finish group

The review findings were then presented to the IOWSAB for discussion and response.

Findings

The task and finish review identified a number of areas of concern and difficulty for people with care and support needs, their carers and professionals too, across many service user and provider settings.

However, it is important to note that many of the problems experienced were relating to changes in health and social care models due to national guidance that not all professionals and care givers were happy with or wished to sustain. The sector also experienced challenges with recruitment and retention, something that continues now and has an impact on both staff and those receiving care and support. For those members of staff either joining or changing roles in health and social care, the restrictions of the pandemic meant limited access to training and shadowing, sometimes leaving them feeling unprepared and unsupported.

The rapidly changing legislation and guidance meant there were significant challenges for people living with, and providing care for, those with learning disabilities, dementia, enduring mental ill health and adults at risk. Some of these groups also found complying with social distancing difficult, and were confused about providing support, visiting arrangements or carrying our social activities. However, support provided by the Local Authority (LA) and the Clinical Commissioning Group (CCG) in keeping up to date and understanding the legislation and guidance was highly valued.

A key area identified was adults refusing care and adults experiencing self-neglect. In some of the cases, adults at risk experienced preventable harm following refusal of care. There is also a question around whether fluctuating capacity and lack of executive capacity was sufficiently understood when people are experiencing self-neglect and refusing care. The review highlighted the challenges faced by the local authority when identifying individuals eligible for care and support packages, but who were refusing due to having to make a financial contribution.

Family dynamics and the importance of understanding them emerged as a common feature across several cases. In some instances, care was delegated to family members, with assessments carried out virtually, which in some cases led to avoidable safeguarding concerns, especially around tissue viability. There was potential risk where assumptions were made in relation to family dynamics and their scope to provide care which were incorrect.

A significant hidden impact as a result of Covid was the increased stress on unpaid carers, families and friends. This army of unpaid carers found themselves having to lose or accept a reduction in services, needing to familiarise themselves with national guidance and to cope with the anxiety and stress about their need to provide care. There were some examples relating to carers who appeared not to be offered a carers assessment, or for whom a single telephone call resulted in acceptance that support was not needed or wanted, despite

intelligence suggesting otherwise. Throughout the Covid pandemic some carers were fearful of any potential suggestion of residential care for the person they were caring for and may have minimised the impact of caring upon them to avoid this. It is important to note that caring for the carers is just as much everyone's business as safeguarding the person with need for care and support.

Although the review highlighted some areas where there were safeguarding concerns, it is also important to recognise that the health and social care sector were subject to fluctuating laws and restrictions imposed, eased and re-imposed by the government, which made reflection and learning challenging. However, there were many examples of good practice throughout the sector too.

What became evident was just how willing the health and social care partnership, its agencies, providers and individual teams were to work in close partnership with each other; with relationships being enhanced and becoming more robust and collegiate in nature. This is an impact of the epidemic which the partnership is committed to maintaining.

IOWSAB Partnership Response

The review findings gave valuable insights to the partners, both in terms of planning for any future pandemics but also for changes which could be made to improve accessibility, support and services in any event.

The findings were taken back into individual agencies and their responses brought to a dedicated Board meeting to share learning across the partnership, a process which also informed priorities in our IOWSAB business plan.

We owe huge gratitude to all of those people with lived experience who contributed to this review: those with care and support needs, carers, front line workers and managers, who were so generous in sharing their time and experience with us.

Our thoughts and sincere condolences remain with all of those people who lost friends, colleagues and loved ones during the pandemic.

Teresa Bell

Independent Chair IOWSAB

July 2023

Resources

There are a range of useful resources appropriate to the issues raised here on the Safeguarding Adults Board website: Information for Professionals - Isle of Wight Safeguarding Adults Board (IOWSAB)

Here are some key resources:

4LSAB-Guidance-on-Responding-to-Self-Neglect-and-Persistent-Welfare-Concerns Download

4LSAB-self-neglect-learning-briefing Download

One-Minute-Guide-to-Self-Neglect Download

One Minute Guide on Managing Difficult Conversations Download

One-Minute-Guide-to-Principles-of-Engagement Download

4LSAB Safeguarding Concerns Guidance (Oct 2020)

4LSAB Multi-Agency Protocol for Pressure Ulcers and Adult Safeguarding (Oct 2020)

4LSAB Multi-Agency Protocol for Falls and Adult Safeguarding (Oct 2020)

IOW-SAB-Multi-Agency-Protocol-for-Medicines-Incidents-and-adult-safeguarding-November-2018-1 Download

4LSAB-MARM-Multi-Agency-Risk-Management-Framework-June-2020 Download

TBA

Response from partner agencies to the review findings

TBA

Good practice examples

TBA

Next steps – partnership actions