Safeguarding

Score 3

3 - Evidence shows a good standard

What people expect

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

There were effective systems and processes in place to provide protection for people from abuse and to investigate safeguarding concerns that were raised. The local authority had reviewed the way they were dealing with safeguarding referrals a few years ago. They had implemented a revised centralised structure which all staff told us worked very effectively and which improved oversight.

There was clear partnership working with other organisations, such as the health trusts, police and care providers. Partners told us the systems in place were clear and there was effective oversight by the local authority of the progress and outcomes of investigations. There were information sharing arrangements in place to ensure this did not delay investigations.

The local authority worked in partnership with the Safeguarding Adults Board and other partners to identify the key safeguarding themes and risks in the area with plans in place to address these.

National data showed that 69.95% of people who used services felt safe which is in line with the England average (ASCS). In addition, the data shows that 88.42% of people who use services felt that those services made them feel safe, this is also in line with the England average (ASCS). The percentage of carers who felt safe was 82.20% which also showed no statistical variation with the England average (SACE).

Care providers were very positive about the knowledge of the safeguarding team and felt that they were well trained.

Responding to local safeguarding risks and issues

Lessons were learned when people had experienced serious abuse or neglect and action was taken to reduce future risks and drive best practice. Themes and trends were also identified through reviews of safeguarding enquiries. Frontline staff confirmed to us that learning was shared in a variety of ways, including bulletin updates and lunch time learning sessions.

There was a clear understanding of the safeguarding risks in the local area with plans in place to address them and share the learning across the local authority and partner organisations. For example, following the outcome of a Safeguarding Adults Review the increasing risks of 'cuckooing' were identified and improvements for organisations identified. Cuckooing is where people take over the home of a vulnerable person with the purpose of exploitation. This led to a specific pathway for concerns about cuckooing and changes to recording of these. Information is being developed for the public and professionals with an awareness campaign planned. The risks to people associated with being homeless and the contributing issues was an area where a thematic review was carried out following homelessness identified as an issue in three recent Safeguarding Adults Reviews. Recommendations from the thematic review were shared with all relevant partners, including the local authority.

The Principal Social Worker sits on one of the subgroups of the Safeguarding Adults Board in relation to Safeguarding Adults Reviews. This enabled them to identify any practice improvements which were directly reported to the local authority's practice governance board for oversight of learning to be shared across the local authority.

Providers of registered adult social care services were positive about whether learning was shared with them following safeguarding investigations with 63% of respondents saying that this 'always' took place.

Responding to concerns and undertaking Section 42 enquiries

All safeguarding concerns and referrals went to the safeguarding team where they were triaged and then decisions made about whether the eligibility for a Section 42 investigation was met. A Section 42 enquiry is a legal requirement under the Care Act 2014 for local authorities to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect.

All Section 42 enquiries were passed to the locality teams to progress them with oversight from the safeguarding team practitioner. Staff said that the advantage of working in this way was that often the person was already known to one of the frontline teams and therefore it was more appropriate for someone they knew to carry out the investigation. Concerns were also passed to the frontline staff teams. All of the frontline staff we spoke with, including those in teams other than the locality teams had a good understanding of the safeguarding procedures and their roles and responsibilities within these.

Where safeguarding referrals related to someone using an adult social care service from a regulated provider the providers might be asked to investigate the referral. This decision was based on a risk assessment and where it did take place the safeguarding team retained oversight of the investigation.

The safeguarding team triaged all safeguarding referrals with good oversight from the safeguarding team manager which ensured that there was consistency with regard to the triage process and identifying those which met the threshold for an enquiry. The safeguarding team retained oversight and quality assurance responsibilities for the Section 42 enquiries and identified themes and trends from the outcomes.

There had recently been challenges in recruiting to the safeguarding team although action taken to address this had been successful with new appointments having been made. In the time in between this the local authority had employed agency staff on a consistent basis to manage the risks of staff vacancies.

The number of safeguarding referrals received by the local authority had been increasing and the number of Section 42 enquiries has also continued to increase. For example, in 2021/2022 the percentage of referrals that went on to be triaged to meet the threshold for an enquiry was 44%, in 2022/2023 it was 47% and so far for this year (2023/2024) up to the month end of February 2024 it was 55%.

This had presented increased pressure on the safeguarding teams as well as the locality teams. The most recent data provided by the local authority (March 2024) showed that there were 46 concerns awaiting review and triage to assess whether they met the threshold for investigation. The local authority's timescale for triage was 24 hours and the average for doing this was 7 hours with the maximum wait 8 days. There were 33 referrals that had met the threshold for an enquiry which were waiting to be allocated within a frontline team and 958 active investigations taking place.

The safeguarding manager had good oversight of the situation regarding waiting lists and there was a risk management process in place to ensure that allocation waiting lists were monitored daily and anywhere the risk had increased was treated as priority.

One of the issues the local authority had identified as causing delays in safeguarding referrals being dealt with was those where information was missing. They had developed a new portal for professionals to use which prompted the person completing it for the necessary information for the referral to be triaged more promptly.

The frontline staff we spoke with said that providing feedback to the referrer was an important part of their processes. However, not all providers and partners felt that they did always receive an update about safeguarding referrals that they had made.

The local authority had a very high number of Deprivation of Liberty Safeguard applications waiting to be reviewed. Again, they had taken a risk-based approach to this to ensure that regular monitoring of the waiting list took place to ensure that where risk changed all urgent applications were prioritised. Additional training had been provided to frontline staff to increase the number of staff who could complete the application approval process.

Making safeguarding personal

Following a review of a complaint the local authority had received they had produced a factsheet for people involved in safeguarding investigations which explained the process and timescales involved. The aim was to improve people's understanding and also to manage expectations. The learning about the need to inform people from the beginning about the predicted timescales was shared with staff to ensure the person affected and other relevant people had that information and that they were then kept informed of any changes to this.

People who had been involved in a safeguarding investigation told us that they felt very involved in the process and that staff had been very helpful in explaining the process to them at all stages. They felt their views and wishes had been considered.

National data shows that 90.52% of people lacking capacity were supported by an advocate, family or friend during the safeguarding process. This is significantly above the England average of 83.12% (SAC)

As a way of identifying strengths and areas for improvement in terms of making safeguarding personal the local authority and the Safeguarding Adults Board have recently commissioned a piece of work to involve people who have been through the safeguarding process to obtain their views about the process. It is intended that the outcomes and any recommendations will be shared and influence future strategies.
