Safeguarding

Score: 2

2 - Evidence shows some shortfalls

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

All staff had access to and used the safeguarding risk threshold tool developed through the Safeguarding Adults Board. This supported staff to understand safeguarding risks and how concerns would be dealt with. There was clarity on what constituted a section 42 enquiry, and this was applied consistently and supported by 'risk factor' training. 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. Approximately 2 in 5 safeguarding concerns raised with the local authority between April 2022 and March 2023 became section 42 enquiries. Some staff told us that they thought the risk factor tool worked well but needed further development, for example to support people with concerns about hoarding. Self-neglect and hoarding were recognised as growing areas of need within the county. The local authority was working with the Safeguarding Adults Board to develop the tool further to account for this at the time of our assessment.

National data showed that people felt safe. 91.15% of people who used services said those services made them feel safe, which was better than the 85.63% England average (Adult Social Care Survey, published October 2023). 89.24% of carers felt safe, which was significantly better than the 80.51% England average (Survey of Adult Carers in England, published June 2022).

Guidance for internal local authority services was clear, in terms of both individual safeguarding concerns and concerns about organisations. The recording information system used by the local authority supported this process and allowed for follow up on progress as needed. Concerns linked to providers were able to be supported through the Practice Improvement Team. These establishment concerns included significant level of concerns about a provider, where several concerns had been identified over time, and the risk to people using the service. This team connected with commissioning staff to support quality improvement and provided a robust response to potential organisational abuse situations.

Some staff described a two-tier system, where some people received a high standard of safeguarding enquiry, and others didn't due to the range of staff skills and experience. Not all staff were confident in each other's skills to complete safeguarding enquiries. This applied across the sector. National data indicated that skills were in line with England averages. Skills for Care estimated 40.34% of staff within the area completed Mental Capacity Act Deprivation of Liberty Safeguards training, and 55.98% of this group completed safeguarding adults training (information published October 2023). Staff felt they had access to appropriate reflective supervision and support.

Relationships between partners were a strength of the area. This was seen at strategic levels and operationally. For example, police met with safeguarding and commissioning every 3 months to share intelligence, themes, and any practice issues. Quality assurance boards linked into the Care Academy to support training development and delivery. The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area. Some staff did identify that shared access to systems would help to improve people's experience of safeguarding.

Responding to local safeguarding risks and issues

The local authority worked well with the Safeguarding Adults Board. There was clear strategic alignment and prioritisation of significant safeguarding activity for the county at an executive level. Chief Officers of partnership organisations met regularly to share information, aiming to ensure learning was shared across organisations in the system. The Safeguarding Adults Board maintained a clear focus on actions and outcomes following serious incidents.

There was a clear understanding of the safeguarding risks and issues in the area. The local authority was part of the Chief Officer safeguarding group including the Chief of Police, Integrated Care Board representatives, representatives from health trusts, and the children and young people's director. The group was an opportunity for Chief Officers to have challenging conversations about issues such as how changes to 'right care, right person' would be implemented. This reduced risks and improved people's experience of crisis responses.

The local authority area recognised rising numbers of people affected by self-neglect and hoarding in both safeguarding enquiries and Safeguarding Adults Reviews. There was partnership across different activities to ensure a robust set of actions to reduce this identified need. The Breakthrough service was developed to support people who were hoarding. A working group was set up to respond to a Safeguarding Adult Review involving an individual's death linked to their home environment. An analysis of the use of advocacy for mental capacity linked to self-neglect took place to ensure this was being used appropriately. Resources developed through the Safeguarding Adults Partnership were shared with staff around mental capacity to support their practice. Lessons were learned when people had experienced serious abuse or neglect and action was taken to reduce future risks and drive best practice.

Leaders described a learning culture, with summits to review the actions and learning from recent Safeguarding Adults Reviews. 'Toxic Cultures' training had been identified as a local priority and a training course had been developed attended by staff across local authority, independent and voluntary and charity sector organisations. Frontline staff could not always describe learning from serious incidents or Safeguarding Adults Reviews, outside of where they had been specifically involved in an enquiry or investigation.

Responding to concerns and undertaking Section 42 enquiries

The Social Care Direct team initially triaged all safeguarding contacts and assigned them to relevant teams. This resulted in minimal waiting times for initial reviews or awaiting allocation to staff. Data quality was monitored well through their case management system which had an impact on timeliness of completion of section 42 enquiries. We heard from senior leaders that safeguarding enquiries were not always dealt with in a timely way following allocation and these had 'stacked up'. Audit activity had identified this issue and better recording and practice had improved this situation.

Some staff and organisations felt the safeguarding concerns system needed to improve as it was difficult to raise concerns for some. Some delays at Social Care Direct had been noted, though progress had been made at the time of our assessment to improve this. Some staff told us that there were delays especially when awaiting support or information from the police. Relevant agencies were not always informed of the outcomes of safeguarding enquiries. The local authority was working on improving this with people who use services. Training was available to staff across the local authority and partner agencies to support them to raise concerns effectively.

In local authority cases, the appropriate team was allocated. Sufficiently complex concerns were managed through the Adult Protection Team. These allocations accounted for approximately 10% of all enquiries between April 2022 and March 2023. This team were approached by people working in the sector regularly for advice. We heard examples of complex safeguarding issues that required careful and diligent management to reach resolutions that were person-centred and positive for the individual concerned. The team often had to describe their roles because Adult Protection was not always a well understood or modern term to describe their function. Feedback from some staff was that this team felt stretched, and this had caused delays and backlogs.

Timeliness of completion of section 42 enquiries was improving in the local authority following targeted work. The local authority's data indicated that approximately 90% of enquiries were completed within their 91-day timescale in April and May 2024, compared to 77% between April 2022 and March 2023. Recording practices and appropriate completion of mental capacity assessments had contributed to this improvement. This was led by the Principal Social Worker in conjunction with appropriate managers. National data indicated that the number of safeguarding concerns and subsequent section 42 enquiries was higher between April 2022 and March 2023 than in the previous 2 years, which could impact on how busy it felt to staff. Many staff we spoke to recognised increasing complexity of needs at the point of contact.

When safeguarding enquiries were conducted by another agency, for example a care or health provider, it was not clear how the local authority assured the robustness or quality of planning or outcomes for the person involved in line with their Care Act duties. The Practice Improvement Team were able to support care providers, though did not support enquiries about individuals. For internal local authority teams, operational managers signed off all enquiries. However, mechanisms that enabled the local authority to decide on the actions to be taken and by whom were not evident on enquiries completed by all partner agencies. A process was in place when safeguarding enquiries involved other local authorities or where an individual's care and support was funded through certain joint health arrangements.

Completion of Deprivation of Liberty Safeguards (DoLS) was improving. Data provided by the local authority indicated that they had greatly reduced their DoLS waiting list over the previous 18 months. They said that they were now very close to achieving their monthly completion target. The local authority was defining how they maintained this at the time of our assessment.

Making safeguarding personal

Staff gave examples of when safeguarding enquiries were carried out sensitively and focused on the wishes and best interest of a person. Some staff told us that making safeguarding personal wasn't something they were sure everyone in the sector or all internal teams understood and could apply to enquiries for individuals.

Advocates were not always referred to and involved at the right time with safeguarding concerns, with some instances of referrals taking place after the enquiry was concluded. This aligns with national data where 32.64% of individuals lacking capacity were supported by an advocate, family, or a friend, which was much lower than the England average of 83.12% (Safeguarding Adults Collection, published September 2023). This was a feature of recent Safeguarding Adult Reviews. The local authority was aware and further training, including on recording advocacy, was ongoing. They had also recognised capacity issues in their advocacy contract and were working to resolve this.
