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

People felt as safe in Derbyshire as the national average. 70.7% of people that used services in Derbyshire felt safe, compared to a national average of 69.69% and the percentage of people who said those services made them feel safe, was 89.35% compared to a national average of 87.12% (ASCS). 79.55% of carers felt safe compared to a national average of 80.51%.

We heard the Derbyshire safeguarding adults board (DSAB) met quarterly with the Derbyshire District Council's safeguarding leads group, which worked well with positive relationships between professionals. DSAB had three priorities: making safeguarding personal; prevention and quality assurance. The board had seven subgroups and working groups. Vulnerable adult risk management (VARM) was a process that managed risk for adults deemed to have capacity, but who were at risk of serious harm. There was both a VARM subgroup and a financial abuse working group. Subgroup membership was shared out across the partnership and provided accountability across the system. Engagement from the local authority with the board was good, there was a clear commitment and positive relationships from the local authority working with the DSAB. Although consideration of meeting jointly across Derby City and Derbyshire had not progressed longer-term, they did have a joint annual meeting, shared strategic plans and developed joint resources. A decision was made to revert to separate Board meetings at the beginning of 24/25 but with the first meeting of the year being held as a joint Board/ development session. The Joint Core Business sub-group meetings continued to take place quarterly. Leaders told us this was the most effective approach to allow City and County Board business to remain aligned, where possible, via the annual joint development session and joint quarterly meetings but also allowed sufficient time to cover separate business and apply local scrutiny and challenge at the three separate SAB meetings.

The skills for care workforce data estimated the percentage of local authority and independent sector staff who had completed mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training, was 39.31% with a national average of 37.48%. The percentage of staff who had completed safeguarding adults training was 51.75% with a national average of 48.81%. These compare favourably to the national average but remain a low number. Overall Safeguarding training was positive in Derbyshire, staff were passionate and creative in implementing local training and competency sessions within teams. However, some staff reported mental capacity training was not always available and at times the process was confusing. Safeguarding training could therefore be better coordinated and improved to provide staff with the appropriate level of training in areas such as mental capacity act training.

Responding to local safeguarding risks and issues

Staff had local ways of working and supported each other to respond to safeguarding risks. The need to protect people from self-neglect had been recognised as a significant challenge for professionals and as a result Derbyshire Safeguarding Adults Board (DSAB) had created a self-neglect toolkit. Transformation was clearly ongoing in Derbyshire, there were positive actions to improve information sharing and working with the police to make the VARM and safeguarding processes more explicit, improving the shared care record was also intended for development. Some animation work was created following a Safeguarding Adults Review (SAR) which was an effort to communicate learning in a new way. A specific subgroup focused on pulling out learning themes from SARs which was supporting staff to practise differently. However, it was too early to see what impact it had on adults at risk.

DSAB was well attended by partner agencies with good levels of buy-in and challenge. Demand for safeguarding was high, we were told there were many repeat referrals due to poor quality referrals and lack of knowledge from referrers. We were told action was underway with partners to aim to improve the quality of referrals, with local triage systems and staff speaking with referrers to support understanding. There had been a thematic learning action plan with action points around section 42 performance and learning required around mental capacity, best interests, Learning from Lives and Deaths (LeDeR) reports and from ombudsman complaints, and the safeguarding electronic form had recently been developed and was close to being launched.

Staff reported an increased focus on safeguarding and increased support around safeguarding over recent years. Safeguarding was a priority in frontline teams although there were different levels of confidence and consistency.

Responding to concerns and undertaking Section 42 enquiries

The proportion of safeguarding concerns meeting the threshold for a section 42 enquiry had remained stable over a three-year period, at around 40%. Safeguarding referrals had increased annually by around 15% to 20% and resources had not increased to meet demand. Over the preceding three months, data showed there had been 574 safeguarding referrals on average per month, with 191 becoming section 42 enquiries, which was a 33% conversion rate. The median wait time for safeguarding concerns for those on a waiting list, was 7 days and the maximum wait time was 34 days. A section 42 median waiting time (for allocation) was 4 days, with a maximum waiting time of 19 days. Improvements to processes meant safeguarding concerns were more consistently logged.

Deprivation of Liberty Safeguards (DoLS) applications received over the past 12 months had a median waiting time for allocation of 152 days and a maximum waiting time allocation of 364 days. Historic DoLS applications significantly exceed these waiting times and cause the median waiting time for all DoLS to be allocated, to 327 days. The risk of impacts from delays in completion of DoLS, was included on the adult social care risk register. There was a triage and Red, Amber, Green (RAG) rating system in place, to ensure risk was managed while waiting. There was a consistent county-wide approach to DoLS triage and all referrals were triaged via the duty system, led by qualified best interest assessors. In order to develop a future workforce, the local authority had sponsored 6 social workers to train as best interest assessors in 2023 to 2024 and a further 6 in 2024 to 2025.

There were mixed reports around safeguarding practises and reporting of outcomes, however. We heard the duty system meant accessing a social worker for enquiries, could be more time-consuming and difficult. The outcomes of safeguarding enquiries were not routinely received by providers, and they described 'chasing' outcomes. We heard reference to local approaches by local team practitioners which sometimes led to an inconsistent approach across the county.

Making safeguarding personal

The electronic system used for logging safeguarding alerts was recently updated, included mandatory questions around making safeguarding personal and when advocacy had been used to support people. Safeguarding Adults Collection (SAC) data showed only 14.38% of people who lacked capacity were supported by advocates, family or friends compared to a national average of 83.12% (2022-2023). This was supported by staff, we heard it was not always possible to secure independent advocacy in a timely manner, or sometimes at all for new referrals. More recent data from the local authority showed improved performance. This does not change the scores for this quality statement'.

Staff consistently referred to adults at risk with compassion and with reference to their personal views and wishes. They described significant recent improvements and describe the plans for incorporating feedback from adults with lived experience, carers and colleagues, to enhance performance outcomes and well-being.

The local authority stated 57% of people had been asked about their safeguarding outcomes in the year 23/24 which had been an improvement on the previous year. Making safeguarding personal had been prioritised for service improvement by the local authority.
