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

Data from the Adult Social Care Survey (ASCS) 2023 for Surrey showed 72.39% of people who use services feel safe, which is similar to the England and regional averages of 69.69% and 70.37% respectively. Also 90.53% of people who use services say those services have made them feel safe, which is higher than the England and regional averages of 87.12% and 86.89%. In Surrey 44.72% of independent/local authority staff had completed mental capacity/deprivation of liberty safeguards training and 48.28% had completed safeguarding adults training. Both of which were in line with England and regional averages. Adult Social Care Workforce Estimates (ASC-WE) 2023.

Systems were in place along with processes and practices to ensure people were protected from abuse and neglect. However, it was clear that processes were still to be fully embedded in some areas and this was the feedback we received from both staff and partners. Concerns were raised about whether all staff were suitably skilled and supported to undertake safeguarding duties effectively following some recent changes in processes. Staff acknowledged recent safeguarding changes had not been fully embedded yet, however felt they were well underway.

Safeguarding teams were made up of co-ordinators and social workers who had shared responsibilities and used a screening rota and duty system to answer calls. Assistant team managers screened information, rating it using systems based on level of risk and urgency. Where information came in that was not of a safeguarding nature this was reassigned to the relevant place. Teams felt they knew care providers well and had a good level of understanding how services worked but where they were unsure about something they would check in with managers for clarity.

Oversight of safeguarding practice was provided by senior staff, with regular meetings, audits and discussions taking place for serious and/or complex casework; additional support being available through the Practice Assurance Group. There was a multi-agency approach with safeguarding where different agencies discussed cases. Additionally, as part of the Safeguarding Improvement Group, there was a focus on both safeguarding improvements and learning from instances where things had not gone well. To support both safeguarding practice quality and audit, Safeguarding Case Audit Quality Standards Guidance was in place.

Senior staff told us it was a challenge to get the right mix of staff, particularly for Deprivation of Liberty Safeguards (DoLS) and best interest assessments, which required a specific skill set. There was a national shortage of experienced social workers with the necessary skills for these tasks and this was an area where they recognised the need to be more creative in attracting highly experienced social workers to meet the demand for DoLS assessments.

Comments from partners about safeguarding were particularly polarised, including concerns that some staff may not be qualified as safeguarding officers. There could be inconsistencies in the approaches to safeguarding and they felt some parts of the safeguarding process were not well understood by staff. For example, someone with mental capacity should be asked what they wanted to happen as part of the process and this did not always take place. There could be times when staff took longer to act and investigate safeguarding concerns and it could take months to receive feedback from the safeguarding team. However, outcomes of investigations were generally transparently shared.

Responding to local safeguarding risks and issues

People's experience of safeguarding was positive overall stating the local authority showed an understanding of abuse and neglect and were able to work with agencies to reduce the risks and prevent future risks. For example, one person had developed a pressure ulcer in hospital and the local authority raised a safeguarding concern. The person was involved in the process to their satisfaction, receiving a formal apology from the health trust. However, another person was dissatisfied with the local authority response to some concerns raised feeling that staff had not understood the cultural implications for their family.

The local authority has a Safeguarding Adult Board with an independent chair with a focus to ensure that in Surrey, safeguarding adults arrangements worked effectively. Surrey Safeguarding Adults Board Plan 2023 to 2024 demonstrated the board had identified key safeguarding aims and objectives within Surrey. These were recorded in a strategic plan identifying how these will be achieved, what success will look like and the evidence base required to measure success. A key objective was to disseminate learning from Safeguarding Adult Reviews and other statutory reviews to ensure that learning was embedded across partnerships. Another objective which had been carried forward from the previous year was for real understanding by seldom heard groups of how the Safeguarding Board could support. Also, to ensure the role of unpaid carers and the challenges they faced was recognised, and action taken to prevent unpaid carer breakdown and abuse/neglect. Another key objective was to have a consistent view of gaps in referral processes and put in place effective initiatives to address these. There was evidence of partnership working with police with the referral process and guidance.

Staff told us about partnership working and working with the Safeguarding Adults Board. For example, meetings to support domestic abuse survivors through muti-agency risk assessment conferences. There were 5 prisons in Surrey which brought other safeguarding issues however a large scale piece of work was underway to develop better pathways for prisoners.

A Safeguarding Adults Review is an independent review which takes place to identify lessons when a person had experienced serious abuse or neglect and there are concerns that partner agencies could have worked more effectively to protect them. Actions are recommended to be taken to reduce future risks and drive best practice. The local authority had one published Safeguarding Adults Review in the past 24 months. A learning event was held in June 2023. There were several recommendations and an action plan was developed, with key learning points including improving the skills and knowledge of teams around substance misuse, homelessness and training. Key risks identified were in relation to domestic abuse, self-neglect (hoarding), suicide and cuckooing. Partnership working had taken place around self-neglect to better support people.

Work was undertaken to engage with core leads such as the Police and Integrated Care Boards so risk management processes could be developed. The Safeguarding Adults Board focused on quality assurance. The aim was to see how they could make the process less cumbersome and not just data driven, but also taking learning from safeguarding adult reviews and feedback from people with lived experience.

Interaction with the local authority on a strategic level was reported to be positive by one partner. There had been a settling in period in teams due to leadership changes, but the local authority had looked at priority areas that needed to be attended to, for example there had been a revision of the hoarding protocol. There was an understanding of staffing capacity issues but they felt everyone was committed to work to manage risks.

There was a challenge around processing of community DoLS however a task force had been formed to address this. To support frontline staff further a training model had also been developed to understand tenancy and housing rights including mental capacity. This was reported to be well received by 200 staff and was planned to be rolled out to housing providers.

Staff working in the DoLS team worked together on a rota basis. Where there were more complex DoLS, a robust triage process took place. Examples of more complex DoLS included areas such as objections to care home placements and when covert medicines were being given. Covert medicines were sometimes given to people when they were refusing to take medicine but lacked the mental capacity to make a decision around this. Covert medicine means this is hidden, usually in food. On occasions care homes may provide the incorrect information in DoLS applications, so clearer prompts had been introduced by staff to assist with this. Over the last year staff had introduced checks to ensure conditions of DoLS were being met, introduced a DoLS webinar (where 120 people signed up) and a DoLS forum had been introduced.

In July 2024 the number of DoLS applications awaiting allocation to the appropriate worker to complete assessments had reduced by 3% (84) from the previous month and decreased by 8% since March 2024. In the previous 12 months there has been an average of 445 DoLS applications monthly. Of these, approximately 50% were considered to be 'high priority' applications by the local authority so were prioritised.

The local authority received DoLS requests from across 375 registered care homes in the area. The local authority had sourced additional resources to reduce the numbers of DoLS applications waiting to be processed and these had reduced. The local authority identify their DoLS model was currently being reviewed to ensure continued improvements.

Responding to concerns and undertaking Section 42 enquiries

Data provided by the local authority in July 2024 indicated an overall reduction in the numbers of safeguarding over the last few months. As of the beginning of the month, there were 2,567 open concerns/enquiries on the local authority system which has reduced from a peak of 5,156 in September 2023. The number of section 42 enquiries waiting to be allocated to workers had decreased from 20 in March 2024 to 2 at the start of July 2024.

As of early July 2024, 43% of concerns received in June 2024 became a section 42 enquiry compared to 63% in March 2024. The number of safeguarding concerns received reduced by 26% since the previous month and in the last 12 months, there had been an average of 1,270 concerns received per month.

Work with the Safeguarding Adults Board had introduced new processes which meant section 42 enquiries were sifted out and managed to reduce backlogs. For example, a change was implemented in how incidents were handled and through data cleansing. Several pathways were documented to differentiate between safeguarding concerns and section 42 enquiries.

The Multi-Agency Safeguarding Hub (MASH) for adults was the main referral point for adult safeguarding enquiries, but there were other referral points. If the adult was open or known to another team, the referral was passed onto them via duty, unless there was an immediate risk, then MASH contacted the allocated worker or duty directly. There was a main public and partners referral point for safeguarding concerns and referrals could be made at any time via an online form, a telephone or using a Sign Language Video Relay Service. Section 42 enquiries were managed by a safeguarding duty worker and there was management oversight to support decisions. Some staff acknowledged there had been challenges with safeguarding and a consultancy firm had come in to look at how to make improvements.

Staff confirmed where there were safeguarding concerns and the person had died, the case was closed. They said risks to the safety of other people were considered by working with the provider and considering any wider learning. However, feedback from other staff indicated they held concerns that this approach meant risks were not fully considered in these situations and may leave some families feeling the safeguarding concerns had not been fully explored. Feedback from senior staff confirmed that a serious incident policy and approach ensured that immediate risks and lessons learnt were addressed for people, and across the organisation.

A change had taken place from 1 May 2024 in relation to management of low-level safeguarding concerns which meant that these were now referred to the Quality Assurance Team. Staff views on this differed. Some staff expressed real concerns in relation to the recent changes in safeguarding processes. Some staff felt it provided a better overview of care homes and care providers. However, others raised concerns about whether all staff were suitably skilled and supported to manage these. They told us they felt safeguarding concerns were allocated to staff who were not social workers to reduce numbers and they were concerned some were more serious and some staff felt out of their depth. It felt this approach looked at the service process not the safeguard for the individual. Other staff fed back they would like more information in relation to changes made to safeguarding, the processing of low level concerns and clearer guidance around this. Feedback from senior staff confirmed the change made was a roll out of enhancements and further development of a market management and quality assurance approach. Feedback had been sought from staff to understand if they felt supported, communication was clear and had the tools needed to do their jobs.

Partners also told us they felt low-level concerns were not being tracked effectively, and the lack of resources at the MASH contributed to this. They felt a stronger ownership and leadership within the team was needed to address these issues. The new safeguarding system required them as partners to conduct their own assessments and find solutions independently before sharing them with the MASH. They felt there was insufficient oversight from the local authority in relation to safeguarding investigations and the sharing of outcomes. Some felt this increased their workload and reduced effectiveness. Feedback was there was a significant backlog of safeguarding cases, indicating systemic problems with the current process. They did not feel the existing system was functioning effectively, and this backlog highlighted the need for improvements. Senior staff confirmed an effective data led tracking process was in place to ensure oversight of concerns. This was closely monitored and was part of the long standing quality assurance process of care providers.

Partners told us about some inconsistency in the approach to safeguarding and that they felt parts of the safeguarding process were not well understood. They felt there needed to be more training and support for local authority staff in relation to this. For example, there seemed to be some confusion by staff around the threshold for safeguarding referrals made to the local authority by providers. Feedback from some partners was the local authority believed that an adult needed to be known to adult social care already and have care and support needs to warrant a section 42 safeguarding enquiry being opened. Many people who have care and support needs may not have commissioned services already in place and people with care and support needs may not be known to the local authority but still be vulnerable and at risk. An example was given of a person who was experiencing self-neglect and self-harm, however because the person was not known to adult social care and did not have a commissioned care and support service, the case was not investigated. Another example was advice being given to a care provider by a manager at the local authority that only registered managers could make notifications in relation to safeguarding, when this was not the case. Senior staff confirmed work had been done to ensure staff were supported and trained and this included people not being safeguarded where this is not in compliance with safeguarding legislation. Surrey had one of the highest numbers of people in terms of safeguarding concerns so changes were being made to improve this for people and staff.

Making safeguarding personal

National data for Surrey showed 88.21% of individuals lacking capacity were supported by an advocate, family or friend which is similar to the England and regional averages, Safeguarding Adults Collection (SAC) 2023. Staff said they were confident in terms of considering people's mental capacity in terms of safeguarding and considering their human rights. Mental capacity training was mandatory for staff to complete.

Staff considered people's wishes in relation to safeguarding and provided support for them to meet these. People told us they had been involved in safeguarding processes and in the outcomes of these. Some staff felt the recent changes in relation to safeguarding had improved their timeliness and capacity to support people. An example was given of where one person had been living with dementia and the unpaid carer had been struggling to cope. The social worker visited them and identified how they were able to support the unpaid carer better, having more time to complete further visits.

Partners told us about a partnership officer who had been working to better reach seldom heard groups by leading on engagement and understanding. For example, work had taken place to ensure reviewers of safeguarding adult reviews were considering the cultural context of situations.
