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

Senior leaders were jointly responsible for the oversight of processes, systems and practices to safeguard people in Medway from abuse and neglect. Medway local authority operated 3 safeguarding hubs across the 3 locality teams. The safeguarding structure was being redesigned to create 1 safeguarding hub. Oversight for safeguarding had previously been undertaken by an Operational Safeguarding Lead, however the post was removed as part of the new design of the safeguarding hub. The aim was for the hub to be operational from 1 February 2025 under an Operations Manager and Team Manager reporting to the Head of Service for Safeguarding.

The local authority was in the process of recruiting a Safeguarding Development Lead, to further develop safeguarding practice and ensure this was maintained while the restructure consultation was underway.

Following a peer review by the Local Government Association (LGA) in January 2022 the recommendation was made to review the way safeguarding was managed. This was being addressed by the restructuring of the safeguarding hub and we saw other recommendations that had been actioned or in progress with a clear rationale, if the target end date would not be met.

Feedback received across system partners highlighted some had concerns with a lack of engagement with providers in the safeguarding process, including minimal information sharing, no lessons learned, and no outcomes following an enquiry or concern. Partners told us they had to frequently follow up with the safeguarding team to request an update or outcome. There was conflicting information on whether staff provided advice to providers regarding whether a concern should be raised as a safeguarding. Some staff told us they regularly had conversations with providers to advise whether something met the requirement of a section 42 and whether it should be raised as such. A section 42 enquiry is the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect. However, other staff said they did not offer a formal consultation service with providers around safeguarding. A senior leader told us other senior leaders had met with provider representatives to discuss referrals and responses in relation to safeguarding. An outcome from the meeting was for adult social care safeguarding team members to attend a provider forum to run a briefing session on safeguarding processes, including thresholds, and communication. The local authority told us they would continue to work in partnership with providers to develop their understanding of safeguarding thresholds and referrals. Senior leaders would also meet with provider representatives to review the impact and effectiveness of safeguarding processes and systems.

The local authority worked with Kent and Medway Safeguarding Adults Board (KMSAB), the Integrated Care Partnership Kent and Medway System Quality Board, and Medway and Swale Quality and Safety Board. Partners referred to Kent and Medway as working well in partnership and corroboration with shared practice for collecting and sharing safeguarding information such as the Self-Assessment Framework (SAF). The SAF had been developed by the KMSAB Quality Assurance Working Group with the purpose to provide a consistent framework to assess, monitor, and improve safeguarding adults' arrangements.

All agencies represented on the Board were asked to complete an annual SAF comprised of a series of questions to measure progress against key quality standards. There was a multi-agency safeguarding partnership in Medway, and the roles and responsibilities for identifying and responding to concerns were documented. However, the majority of providers raised concerns there was a lack of safeguarding processes. The Medway safeguarding hubs had access to the Multi-Agency Risk Assessment Conference (MARAC) and Integrated Locality Review (ILR) panels, with multi-disciplinary teams, where they were able to discuss cases and request support. National data showed 73.13% of people who used services felt safe, which was in line with the England average of 71.06% (ASCS). In addition, national data showed 85.71% of people who used services felt those services made them feel safe and secure. This was also in line with the England average of 87.82% (ASCS).

Responding to local safeguarding risks and issues

The local authority was an active partner in Safeguarding Adult Reviews (SARs) and other serious incident enquiries; however, learning was not always embedded into systems, processes, and practice. Staff did not identify any relevant themes or trends from recent SARs and were not aware of any changes or improvements in practice. The local authority had introduced mandatory sessions for SARs to discuss the review and mitigating risks going forward. Prior to mandatory sessions being introduced, there were and continued to be other mechanisms in place to share learning from SARS including an Operational Safeguarding Lead meeting with safeguarding staff to share learning and good practice, SARs being discussed in team meetings and shared in the PSW and Safeguarding newsletter. Kent and Medway Safeguarding Adults Board were working with the local authority and multi-disciplinary teams to make improvements to practice and identify further areas for learning. Examples included a change to processes following learning from a SAR to identify people with safeguarding needs moving into Medway from out of area, and work with public health teams to ensure the Kent and Medway Suicide and Self-harm Prevention Strategy 2021-2025 included key findings from a SAR.

The local authority recognised the risks to people's well-being presented by deprivation of liberty. Residential, nursing, and care home Deprivation of Liberty Safeguards (DoLS) were managed by a small DoLS team, and community DoLS were carried out within locality teams. DoLS applications were not always assessed without delay as the teams were unable to meet demand. The local authority had committed to increasing resources to reduce waiting times. Local authority data showed the number of DoLS referrals awaiting allocation was 364 as of 1 September 2024. To address this, the local authority had employed additional staff who were not yet in post, and they were still actively recruiting. The DoLS team used a RAG rating system to determine weekly allocation priorities, and the waiting list was reviewed monthly. Local authority staff contacted all care homes monthly to enquire if people on the waiting list were still resident with them and still required a DoLS. Any changes or any new restrictions for the person were escalated to senior staff to review. The ADASS Risk Management Tool was reviewed every 3 months.

The local authority reviewed the whole waiting list on a monthly basis. The waiting lists across the safeguarding teams varied in size, and teams supported each other to manage this. Staff gave us examples of working creatively to communicate with people as part of the DoLS process, and shared good practice in section 21A challenges (when a person lacks capacity and is deprived of their liberty under a DoLS authorisation in a care home, have the right to challenge their DoLS and have these arrangements reviewed) as well as returning people home from residential care where this was deemed appropriate.

Responding to concerns and undertaking Section 42 enquiries

There were standards and oversight arrangements in place for responding to information of concern, and for conducting section 42 enquiries. However, an increase in safeguarding referrals, and reduced capacity in the team, meant enquiries were not carried out without delay. The local authority told us the number of safeguarding concerns awaiting initial review was 18 and there were 14 section 42 enquiries awaiting allocation. The median waiting time for review and allocation was 35 days, however some safeguarding concerns requiring section 42 enquiry had waited over a year for allocation. A senior leader told us these cases were actively being worked on. Cases waiting over a year for allocation were enquiries where the local authority had agreed for partner agencies to lead on investigating the safeguarding enquiry. Previously, practice was the enquiry for these cases would not be allocated or opened until the information was received. The local authority reviewed this practice and no longer operated in this way. Currently, enquires being completed by other agencies are being opened and allocated to show accurate performance and to provide a dedicated / allocated worker to track and monitor the progress and keep in contact with individuals.

At the time of our assessment there were 13 enquiries open or allocated, where the concern had been raised in 2023. Some of these remained opened due to external factors for example a police investigation or a person having hospital treatment. Whilst measures had been put in place to address this, vulnerable people may have been waiting long periods to have their safeguarding concerns addressed. People were not always contacted in a timely way following a safeguarding referral, work was ongoing to improve this by senior leaders who were reviewing safeguarding processes.

Action was taken to reduce risks to people whilst they were waiting for enquiries into information of concern and section 42 enquiries to be made. Concerns were raised to senior leaders in October 2023 about the increasing number of concerns and enquiries leading to waiting lists. This was addressed and the numbers had reduced by mid December 2023. In March 2024 an interim backlog team was created to create a backlog hub team to address the number of increasing enquiries. Further staff were transferred to this team which was implemented at the start of May 2024. Cases deemed as backlog were cases prior to 1 April 2024 and all the cases in the back log were RAG rated.

Senior leaders told us oversight of safeguarding had improved with the introduction of the back log hub and a weekly report to senior managers, which detailed caseloads and waiting times. Case audits were conducted on a 3 monthly basis, including dip samples by the safeguarding operational lead to ensure consistency of practice. The themes, learning and good practice was shared with the safeguarding staff and a report collated and shared at the Quality Assurance & Performance Information Board (QAPIB). However, staff could not identify any themes from these audits, or how the learning was used to inform processes and ways of working.

Providers told us frontline staff did not always apply operational standards consistently. Following the local government association peer review, the local authority found they were progressing cases to section 42 when this was not required. The local authority introduced a proportionality 'fact finding 'approach to ensure that decisions were more robust to determine whether cases would be progressed to a to section 42. Or to sign post or refer people to the most appropriate team or partner agency instead.

Making safeguarding personal

Making safeguarding personal was an area highlighted for attention and improvement by staff, senior leaders, and the KMSAB. Staff shared examples of making safeguarding personal and how they prioritised this in practice.

People mainly accessed safeguarding information on the local authority website as well as through safeguarding awareness week and public safeguarding stands. The KMSAB had undertaken work to produce safeguarding information in multiple languages, however accessibility for online content and safeguarding information was otherwise limited. National data showed 86.21% of people lacking capacity were supported by an advocate, family or friend during the safeguarding process. This was in line with England average of 83.38% (Safeguarding Adults Collection).

The local authority and KMSAB had difficulty engaging with the population to collect feedback about their experience with the safeguarding process. This was impeding the making safeguarding personal strategy. KMSAB worked with The Advocacy People to launch a campaign to find people with lived experience of adult safeguarding, however there was no uptake from the community. Senior leaders noted an intention to rethink their strategy around obtaining feedback.
