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

National data from the Adult Social Care Survey (ASCS) for 2023/24 said 71.46% of people who used services felt safe, which was not statistically different from the England average (71.06%). The same data also showed 91.17% of people who used services said that those services made them feel safe, which was a tending towards a positive statistical variation from the England average (87.82%).

There was a single point of access to ensure clarity across partners and the public about where and how to raise a concern. A safeguarding team progressed referrals and made decisions about when to open an enquiry under section 42 of the Care Act 2014. 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.

The local authority monitored safeguarding performance, with systems informing leaders about volumes of concerns or enquiries, types of abuse or how long enquiries took to conclude. They also used national data to compare performance against other local authorities.

National data *(*Safeguarding Adults data collated and published by NHS England in 2023/24*)* showed the local authority had 531 per 100,000 population for the numbers of safeguarding concerns raised, which was the third lowest of 16 comparable local authorities. The local authority had 137 section 42 enquiries per 100,000 people, which was the second fewest s42 enquiries compared with 16 comparable local authorities. The same national data showed 94% of safeguarding concerns went on to become section 42 enquiries which was consistent with comparable local authorities.

A 2022/23 performance report by the Safeguarding Adults Board (SAB) identified that an enhanced screening process at the point of referral could be screening out referrals that did not require a safeguarding response, and this may account for the lower number of safeguarding concerns than was evident at other local authorities. The local authority's Quality Assurance Board (2023/24 report) had also identified the need to explore and further understand the lower numbers of safeguarding concerns per 100,000 of the population with comparable local authorities.

At the time of our assessment, the local authority had not carried out detailed work to understand the relatively low numbers of safeguarding concerns received and subsequent s42 enquiries undertaken.

Leaders told us they used a recognised national tool for screening safeguarding concerns and they had compared the numbers with other local authorities and were satisfied that safeguarding concerns were being reported and acted upon when required. The local authority's own data showed a gradual increase in both the numbers of safeguarding concerns and section 42 enquiries from 2022/23 to 2023/24, and we heard about work to raise awareness of safeguarding, which could have been behind this increase. They told us they were satisfied reports were acted upon effectively through the introduction of the single point of access and their audit processes. Whilst this showed some assurance, it was limited and we did not see evidence of a robust analysis by the local authority to understand the potential risk that safeguarding concerns were not being effectively reported or that people at risk of or experiencing abuse and neglect were not always being identified.

Local authority data showed safeguarding concerns took between 2 and 4 days to respond to between October 2023 and March 2024 and this had reduced to an average of 2 days between April and June 2024.Staff told us they were able to respond promptly and worked in a risk-based way.

There was a multi-agency Safeguarding Adults Board (SAB) which was independently chaired. The SAB had representatives from across the partnership, including the local authority.

The SAB has a duty to carry out Safeguarding Adult Reviews (SARs) in instances where a person or people have died as a result of abuse or neglect, or where a person or people experience serious abuse or neglect. There had been 8 referrals for SARs made to the SAB for SARs in 2023/24. This represented a relatively low number of SARs undertaken when compared with the rest of the south-west region. Decisions about whether to undertake a SAR are the responsibility of the SAB, however, local authority leaders told us they were assured SARs were being carried out where required. They also told us that referrals were sometimes linked to other reviews, such as domestic homicide reviews or LeDeR (Learning from Lives and Deaths – People with a Learning Disability and Autistic People), which could account for the lower number of specific SARs.

The SAB and the local authority used a thematic document to share learning from SARs and from also from referrals which had not been taken forward as SARs. The document showed there was work undertaken to analyse SAR referrals and learn from cases which were not taken forward as SARs.

For people subject to applications under deprivation of liberty safeguards (DoLS), there was work underway to improve systems and respond to risk. There were over 1900 applications in the waiting list by September 2024, which was up from 1765 in March 2024. The oldest DoLS application was submitted over 5 years ago. The local authority was undertaking work to review the list to check applications were still valid and the data was accurate. Two new roles had been appointed to and these staff were focused on carrying out this work. Alongside this there were plans to improve data and oversight of the waiting list. Staff said they triaged cases and responded to higher-priority cases first, for example where a person may be actively seeking to leave a setting or there could be doubts about the person's mental capacity to consent to being there.

Leaders told us there was oversight of risk within the waiting list which team managers and senior leaders regularly reviewed, but leaders acknowledged that the current format presented a risk. The new case management system did not currently have the capacity to hold DoLS information so the team worked from a spreadsheet but there were plans to improve this and migrate DoLS to the new system after our assessment. The local authority had also appointed to roles within their DoLS team to address the waiting list.

Responding to local safeguarding risks and issues

There were systems to monitor the types of abuse and identify impacts on people. Information included analysis of the types of safeguarding concerns and outcomes by ethnicity to consider any equality impacts. However, staff said they did not use data to inform their practice, for example in looking at any themes in the types of abuse or the outcomes of safeguarding for people from any minority groups.

Lessons were learned where people had experienced serious abuse or neglect. Whilst there had been few SARs, the SARs recorded showed a review of what had happened and any learning from the review. Staff described strong partnership working with colleagues from health, housing, the police and fire service. They described how their work was audited but said there was not yet an established system to share learning from these audits to improve their practice. The local authority was in the process of implementing a new system of auditing to improve in this area. Staff said team meetings were used to share learning, and we heard about recent events in specific theme areas so there were opportunities used to share learning.

Responding to concerns and undertaking Section 42 enquiries

There was clarity about what constituted a section 42 enquiry and the local authority monitored this through data. Whilst the numbers of concerns and section 42 enquiries were low compared to peer local authorities, the proportion of concerns which led to section 42 enquiries was 94% which was consistent with peer local authorities in NHS England safeguarding data for 2022/23.

There was a risk-based system to triage concerns received by the safeguarding team. Roles had recently been introduced to respond to lower-level concerns to ensure specialist staff were able to undertake the more complex work. Staff told us there was a waiting list, but the data provided by the local authority did not indicate this. Staff told us they usually responded promptly and within 24 hours for the most urgent cases. Local authority data showed concerns moved from the single point of access team to the safeguarding team in between 2 and 4 days, this had come down to below 2 days by June 2024, but this did not show how promptly cases were picked up or their risk levels once they went to the safeguarding team.

There were quality assurance standards in place and safeguarding audits had recently been reviewed and updated. Staff described having regular audits of their work which they learned from, and leaders told us about plans to improve the frequency and detail of audits to enhance this. New audits had been implemented which looked at areas such as quality of records and consistency of section 42 decisions, to improve the local authority's understanding of quality and provide improved feedback and learning for staff.

Making safeguarding personal

Staff practice put people at the heart of safeguarding but the local authority's systems and processes did not always enable them to measure how they implemented a making safeguarding personal approach. The local authority was in the process of improving their system to better their understanding of people's wishes when it came to safeguarding outcomes. People had good access to advocacy. Safeguarding Adults Collection data (SAC) showed 100% of individuals lacking capacity were supported by advocate, family or friend which was a significant positive statistical variation from the England average (83.38%).

The local authority's quality board regularly reviewed data about people's outcomes after a safeguarding enquiry as well as carrying out 'deep dives' into particular areas to understand people's experiences of safeguarding and highlight learning for staff. We heard examples of good practice from staff, where they worked with partners and other teams to ensure a personalised approach to safeguarding. However, there was not always a clear feedback loop to understand the outcome of safeguarding and the impact on the person. The local authority undertook audits and had recently introduced a new audit tool to improve the feedback loop. Recent audits had identified that whilst records reflected the person had been involved in decision making and their feedback had been recorded, it was not captured in the right place which made it harder to analyse, so the local authority was not able to easily measure the impact of this work.
