Safeguarding

Score: 3

3 - Evidence shows a good standard

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

There were effective systems, processes, practices to make sure people were protected from abuse and neglect. The local authority had a clear pathway for receiving and acting upon safeguarding concerns. National data from the Adult Social Care Survey (ASCS) for 2023/24 said 73.36% of people who used services who felt safe, which was tending towards a positive statistical variation from the England average (71.06%).

Referrals came into Adult Social Care Direct which was a single point of access for the public, which could be accessed by telephone and online. The Safeguarding Triage team, co-located with the police team, ensured concerns shared by partners were routinely and consistently escalated, and people had prompt input from partners to keep them safe. There was also a multi-agency Partnership Integrated Triage Stop (PIT Stop) model which provided a route for police concerns to be triaged and checked, with referrals going to the right place if they were not safeguarding concerns.

The local authority had introduced a dedicated triage function within the safeguarding team in June 2023 in response to an increase in safeguarding concerns seen since 2020. The safeguarding team undertook triage and led on decisions about whether concerns met the threshold for section 42 enquiries. If a person had an allocated worker they usually remained their key point of contact and completed actions relating to enquiries. The safeguarding team supported them by coordinating safeguarding enquiries, planning meetings and implementing protection plans to keep people safe.

The local authority had measured the impact of the safeguarding team on practice and had noted a higher volume of concerns being completed than under the previous model. The local authority told us how between March 2019 and March 2023 they had averaged 1596 concerns completed per year. Since introducing the new processes and team, data showed that from April 2023 to February 2024 the local authority completed 3360 safeguarding concerns. The use of data to inform safeguarding practice was at an earlier stage. Staff and leaders said the new data systems did not yet provide a full overview of safeguarding performance, but we saw how data was used to understand themes, such as changes in volumes.

Local authority data showed a higher volume of concerns went on to become section 42 enquiries than had under the previous model, but this had reduced in January 2024 following introduction of the new IT systems. The local authority had investigated the reason for the reduction in numbers and found it was due to some duplication on the previous system.

Staff spoke positively about the new safeguarding team and model. They told us there was clear understanding of who was accountable, with improved collaboration between colleagues. Staff said this model supported them to maintain objectivity and helped them to effectively challenge other professionals. Staff across teams told us they had benefitted from learning about safeguarding when making referrals, seeking advice or working alongside the safeguarding team on cases. National data from the ASCS said 85.55% of people who used services said those services have made them feel safe, which was not statistically different from the England average (87.12%).

The local authority worked with the Safeguarding Adults Board (SAB) and partners to deliver a coordinated approach to safeguarding adults in the area. The SAB had three subgroups covering safeguarding adult review and complex case referrals, quality and learning, and exploitation. The SAB had been overseeing and contributed to the development of the safeguarding team, we saw evidence of data being shared and leaders described productive challenge. The actions the local authority was taking around prevention aligned with the strategic priorities of the SAB where prevention was a key issue, alongside access to information and advice.

The local authority sent quarterly updates on data to the SAB to draw out any issues or themes. The latest report showed an increase in the number of concerns about neglect or self-neglect and the local authority was looking into the cause for this and any action partners could take to reduce risks in these areas. The SAB followed up on themes and issues, for example we heard how the Safeguarding Adult Review and Complex Case Group (SARCC) subgroup raised the number and quality of referrals which was taken forward by the SAB to share learning with partners and improve volumes and quality of referrals.

Responding to local safeguarding risks and issues

There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. Staff said a current theme was working with people who moved between boroughs, which was a recurring issue because of the geography of the borough they told us about recent work with neighbouring authorities and health partners to keep people safe who moved across local authority areas.

Partners spoke positively about the sharing of learning between agencies and stakeholders. We heard about work with health partners to improve their understanding of safeguarding and when to refer. Provider partners gave positive feedback on the input from the local authority's safeguarding team and how accessible they were when seeking advice or proactively sharing learning with partners.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. The SAB carried out Safeguarding Adult Reviews (SARs) in instances where a person or people die as a result of abuse or neglect, or where a person or people experience serious abuse or neglect. There was a clear process where staff, people or partners could make a referral for a case to be considered as a SAR. The SAB then considered if each referral met the criteria to be a SAR. Local authority data showed in the 12 months to March 2024 there were 6 referrals, and none had met the threshold for a SAR. There was a discretionary SAR commissioned for a case that didn't meet the criteria but there had been learning for partners.

Responding to concerns and undertaking Section 42 enquiries

There was clarity on what constitutes a Section 42 safeguarding concern and when Section 42 safeguarding enquiries are required, and this was applied consistently. There was a clear rationale and outcome from initial enquiries, including those which did not progress to a Section 42 enquiry.

Local authority data showed that in the year to March 2024 16.8% of concerns went on to section 42 enquiry. This was significantly lower than in 2022/23 when 32.3% of concerns went on to section 42 enquiry. The local authority had carried out detailed analysis and found there had been spikes in referrals between 2020 and 2022 and the introduction of the new IT system in 2024 had reduced some duplication and made data more accurate. Data was being shared with the SAB and scrutinised and there had been no evidence the drop meant safeguarding was not being acted upon when required. However, this was an ongoing area of focus at the time of our assessment.

The local authority had recently introduced a new system which meant some data about safeguarding performance was not yet easy to interrogate. Leaders told us they had plans to use the new system to understand performance in more detail, but at the time of assessment there was a lack of data around how long concerns took to be responded to or how quickly enquiries concluded. Feedback from staff and partners showed there was not a known issue with timeliness of safeguarding and despite reporting systems not capturing this it was monitored closely at team manager level. Staff described being able to triage and respond to cases promptly but did say they were noticing an increase in the volumes of concerns coming through to the safeguarding team. Local authority data enabled leaders to monitor themes such as the volumes of concerns or the proportions of section 42 enquiries.

There were systems in place to monitor the quality of safeguarding work. Leaders carried out audits and some staff described receiving feedback in supervision to inform their practice. We also heard about learning sessions based on the themes from auditing of safeguarding, such as a recent case which prompted some learning around the Mental Capacity Act and how it was applied in safeguarding.

There was not a waiting list for DoLS applications from care homes or hospitals. Where applications were made to deprive people of their liberty through a Deprivation of Liberty Safeguards (DoLS) referral, these were acted upon promptly and in a risk-based way. At the time of assessment, applications from care homes or hospitals to put restrictions in place were usually responded to within 7 days. The local authority had sustained this level of performance since DoLS were introduced and we heard how they directed resource to respond to increase in demand following an increase in applications in response to the Cheshire West judgement in 2015.

Staff described a thorough assessment of these applications, which checked restrictions were proportionate and ensured people were not subject to any unlawful restrictions or abuse. Staff described a risk-based approach and robust assessments of applications, which ensured people were kept safe and their rights were protected.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. Whilst local authority data did not capture how timely responses were, staff and partners feedback said interventions were timely and person-centred.

The local authority had been undertaking work to improve how staff recorded information about what was important to people in safeguarding cases. The new IT system included prompts for staff to ensure people's wishes were captured, but the most recent SAB report identified this had not always recorded correctly. The local authority was undertaking work to improve how staff recorded information about what was important to people in safeguarding cases and learning had been shared with staff.

Staff told us how they often received feedback and learning from the safeguarding team around Making Safeguarding Personal, including what information to record in referrals to ensure the wishes of people were clear throughout the process. Staff told us about examples of personalised responses to safeguarding, including positive risk-taking and people attending safeguarding meetings alongside professionals.

People could participate in the safeguarding process as much as they wanted to, and people could get support from an advocate if they wished to do so. People were supported to understand their rights, including their human rights, rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices that balanced risks with positive choice and control in their lives. Staff described good access to advocacy. National data from the SAC said 92.59% of individuals who lacked capacity were supported by an advocate, family or friend, which was a tending towards a positive statistical variation from the England average (83.38%).
