Our key findings

Overall, the evidence from our programme of inspections points to a sector that is meeting contractual standards. Staff are dedicated and caring, providing appropriate personalised support. The majority of survivors reported feeling safe and satisfied with the support they received. For the most part, their support needs were being met in a safe, discreet environment where their confidentially was respected.

We found appropriate systems for safeguarding and robust recruitment practices. Staff and leaders engaged with the inspection process well and showed a good understanding of the MSVCC. Survivors knew how to report complaints or concerns and most services had systems to gather feedback, although in some cases learning from this could have been improved.

There were some strong areas and examples of good practice including:

- an enthusiastic and caring group of staff who were aware of their roles and responsibilities
- personalised care and support
- working in partnership with services delivered outside of the MSVCC, including local healthcare services and charities, to meet survivors' support needs.

However, there were some clear themes across the service where improvements could be made, including:

- identifying, assessing and responding to risk

- oversight and quality assurance
- support needs and risks relating to dependent children of survivors (the MSVCC provides support tailored to the needs of adult survivors of modern slavery; local authorities are responsible for safeguarding and promoting the welfare of all children in their area, including child survivors of modern slavery)
- the suitability of the safehouse estate, maintenance issues and fire safety
- training and workload for staff
- specific challenges relating to outreach support.

We also collected additional evidence outside of the scope of the MSVCC that sometimes had a negative impact on a survivor's journey through the system and a provider's ability to provide safe and effective support. These issues included:

- the quality of the initial assessment and admission process
- a lack of appropriate support for survivors with more complex and challenging needs
- the impact of delays in the National Reporting Mechanism to identify and support potential and confirmed adult survivors of modern slavery.

Areas of strength and good practice

Dedicated and caring workforce

The real strength of the service is a caring, compassionate and dedicated workforce. Inspectors consistently described staff who really cared about the people they were supporting.

We judged all but one of the locations inspected to be meeting the caring key question in line with our assessment framework. On a daily basis, staff worked with survivors who were recovering from some terrifying experiences, but they did so with resilience, professionalism and, crucially, compassion.

"Staff spoke with warmth about those they supported. They described their favourite part of their job as 'seeing the women empowered' and leaving the safehouse to lead fulfilled lives." (Inspection report)

"Staff took great pride in survivors' progress and spoke warmly about those they supported. One member of staff told us the best bit about their job was engagement with survivors and seeing what they achieved together. They told us survivors were 'at the heart' of what they did. Another told us they loved their work and described having a supportive team. The same staff member described advocating for and supporting survivors as 'a privilege'." (Inspection report)

"I think we've all been surprised by the calibre of staff ... They're very knowledgeable and passionate and driven. They're intelligent people – but they don't stay around for very long." (Interview with inspector)

As suggested in an interview with an inspector, staff turnover in the sector tends to be quite high so there are often vacancies. However, the service attracts applicants of a high quality. One inspector reflected that if there could be a specific formal qualification for these posts, this may help to improve staff retention.

One provider had an arrangement with a local university, which inspectors agreed was good practice and helped to reduce the impact of staffing challenges.

"There was an ongoing recruitment process for project workers and the provider worked with a local university and specialist recruiters to ensure quality candidates. This meant a range of skills and experience across the team, allowing the provider to continue to accept new referrals while maintaining stable staff caseloads." (Inspection report)

Survivors also spoke very highly of their support workers – both directly to inspectors and through the survivor survey. We saw professional and caring interactions between staff and survivors during the inspections. Survivors were generally very positive about the support they received from staff and said that staff listened to their concerns. One survivor told inspectors that the support from staff at the safehouse had "saved their life". Others described staff as "lovely", "kind", "friendly" and "caring". One specialist support worker was described as "working from the heart". Other comments from the survey included:

"I feel staff are very friendly and supportive. I feel like a big family here." (Survivor survey)

"My support worker always has time for me and always helps me in the right direction; I think I'd be quite lost if she wasn't around even for a chat." (Survivor survey)

"When I first came to the house, I was completely broken, angry and lost trust and hope in myself. I am being supported in some areas of my life by the staff and slowly gaining trust and confidence in myself." (Survivor survey)

Some survivors did suggest that they would like staff to spend more time with them and that a change in the support worker could be worrying. A high turnover of support workers could be quite distressing for survivors as they felt they had to keep re-telling their story to different people. Others felt there could be more or better ways to provide feedback and that providers could be more responsive when they did so.

In conversations with staff, some commented that they didn't always feel they had as much time to spend with survivors as they would like. Some linked this to increased workload because of staff vacancies or the volume of paperwork. Early in the inspection programme, staff commented that the administrative tasks associated with the MSVCC had an impact on their workload. However, this issue arose less frequently in the later reports, which could be attributed to the requirements of new systems and processes from the introduction of the MSVCC in 2021 becoming more embedded and staff becoming more settled in their roles.

All the providers had a clear set of visions and values that staff understood as well as their role in supporting them. Staff spoke passionately about the work they did and their important role in supporting survivors to go on and live independent lives. The dedication ran throughout the organisations, with most leadership teams comprising people who had spent a significant length of time in the field of modern slavery, and who understood the MSVCC very well and knew what they were doing.

Personalised care and support

Providers supported survivors to access education and become employment-ready through training, information and advice, and volunteering opportunities. Through the survey, survivors identified the implications of not being able to work on their mental health and wellbeing and they sometimes highlighted a lack of activities and things to do. However, inspectors found providers encouraged survivors to establish activities and pastimes in line with their interests and skills, and they worked together with other partners to establish meaningful activities and opportunities.

We saw some good safehouse-based activities that empowered survivors to feel valued and respected as well as have a positive role in their community, shown in the following examples:

- Survivors at several locations were able to grow their own vegetables in allotments and vegetable patches. One location donated excess produce to a local food bank. Another location donated excess vegetables to an organisation that arranged food boxes for people who were in more vulnerable circumstances.
- At one safehouse, survivors had made garden furniture from pallets, which they donated to a local charity.
- One provider was engaged in an 'Art is Freedom' event. Survivors could submit photographs or written work, such as poetry, and these were displayed at an event open to the public in October 2021. Survivors felt their self-esteem and confidence had improved by being able to take part in the programme.

- In one safehouse, survivors received a computer tablet when they moved in, which they could use to access a range of wellbeing activities, join language classes and pursue other interests. As well as providing a tablet for each survivor, staff at another safehouse arranged a package with a mobile phone provider to supply free SIM cards with a large data allowance and unlimited calls for six months (the provision of this equipment was additional to MSVCC requirements).
- One provider had a health and wellbeing team within the organisation that provided a structured programme of activities for survivors using the safehouse and outreach support. Although these activities were not part of the MSVCC, survivors in the safehouses could access the activities programme, which benefited and supported their emotional and physical wellbeing.

There were some good examples of supporting the cultural and religious needs of survivors by telling them where to find local places of worship and culturally appropriate food stores.

"Survivors were signposted to support and community groups according to their needs. The safehouse provided survivors with 'Ramadan packs' containing a prayer mat, skull cap, beads, a Qur'an and information about their local mosque." (Inspection report)

Another survivor described how staff had supported them with their request to attend a local church and found it had really helped their wellbeing.

Being able to cook what they wanted when they wanted was an important aspect of wellbeing and autonomy for survivors, so having plenty of kitchen space that was well equipped was important. In most cases this was available, and they could cook and eat the types of food they wanted. In the one location where there were no self-catering facilities, this had a negative impact on the survivors.

Some safehouses went beyond the requirements of the MSVCC by sourcing charitable food donations and hampers to subsidise benefits and subsistence allowances, including nappies and wipes and other baby supplies.

As required by the MSVCC, support workers assisted survivors with many aspects of their lives – for example, pointing them to healthcare and interpretation services and supporting them to register for and use these services. They also provided advice on how to access counselling and support for their mental health, how to access support with legal and subsistence issues, and provided help when liaising with the authorities.

Inspectors heard how support workers would accompany survivors to appointments or travel with them to the embassy to collect identification documents.

Although staff worked hard to help survivors to get the support they needed, there were delays across the system that were outside the remit of the MSVCC, particularly access to counselling and mental health support. Some of these delays were attributed to the COVID-19 pandemic. For example, as well as long delays for counselling, survivors reported that the quality of the services was not always very good. In some cases, counselling services were not effective as they were provided remotely. Over a fifth of survivors who responded to our survey expressed low rates of satisfaction with the service they received.

Although many of these issues were not related to the support being provided under the MSVCC, staff often found ways of mitigating these concerns by going beyond contractual requirements and facilitating access, providing support themselves and introducing innovative approaches, which inspectors agreed were good practice.

"There was an issue with my referral to the community mental health team following my discharge from hospital, but the staff were very proactive in following this up and getting an assessment set up. They also walked me to the appointment which was very helpful due to my anxiety" (Survivor survey)

"The [safehouse] staff always listen to me and give me time and emotional support. Everything is excellent... I have access to mental health services and I'm happy with meds." (Survivor survey)

"We have a wellbeing carer who takes us for walks along the beach, at the park, playing outdoor games – this really helps a lot. It does occupy your mind with these lovely surroundings and therefore less stress/depression." (Survivor survey)

The Home Office funds access to private counselling on a case-by-case basis, through the MSVCC when suitable NHS counselling is not available. Case workers knew how to access this and there were many examples of it being used.

Other examples of support over and above contractual requirements included one service actively promoting wellbeing opportunities by enabling female survivors to access a 40-week self-development programme through their tablet; and male survivors who were experiencing mental health issues to access weekly mentoring and coaching support, either face-to-face or online. There was a wellbeing programme every Friday morning for women.

In another example of good practice beyond contractual requirements, a provider proactively addressed the language barrier by enabling psychological counselling through an Albanian charity. This meant that Albanian survivors were able to speak directly to an Albanian counsellor without having to use interpretation services. A survivor told us they found this very helpful and believed the counselling had been successful because of a shared understanding of Albanian culture.

The MSVCC provides access to interpretation services, which providers actively promoted. Telephone interpretation services were readily available and easy to access. However, although some survivors reported a good experience, these were one of the main sources of negative comments in the survivor survey.

Information and signage were available in other languages and pictorial representations were used in communal areas of the accommodation to give guidance in relation to emergency situations such as fire. Interpreters were accessed wherever necessary to aid engagement in assessments and journey plans to ensure survivors' views were appropriately considered.

There was some innovative work in recruiting support workers from diverse backgrounds. One service went beyond MSVCC requirements by ensuring that all the support workers spoke at least two different languages or had experience of living in a country that was not their country of origin. This meant they could relate to the survivors well and that they could communicate in-house directly with people with whom they had built trusting relationships.

Good partnership working

We found that partnership working was a strength among safehouses and outreach support services. As part of the assessment process in this programme, inspectors asked partner agencies for feedback on how they worked with safehouses and outreach support services. While there was limited direct feedback from other agencies, especially statutory bodies, the information we received from partner agencies suggested strong partnership working and services were able to demonstrate some good examples of this to achieve the best outcomes for survivors.

Staff built networks across their local communities. We heard how they worked effectively with a range of other services such as substance misuse and mental health support services as well as local community groups and food banks. The following are some good examples:

- One location had seconded a member of staff to the post of 'Regional Modern Slavery MARAC Coordinator' to work with the police. (A Multi-Agency Risk Assessment Conference (MARAC) is a multi-agency meeting to assess the risks of domestic violence.) The post was jointly funded by the provider and police outside of the MSVCC contract and was the only post of its kind in the area. The worker supported survivors to make statements and 'broke down barriers' where survivors may not trust police officers. They also helped to train officers to identify potential victims and understand how to support them in the best way.
- Records showed staff at one location had made referrals to services such as the Red Cross befriending service, which provides support and companionship for those experiencing loneliness.

- Another location had collaborated with a partner agency and the British Red Cross on the 'Hope for the Future' pilot, with the aim of extending support for survivors once they have exited MSVCC support.
- Providers organised outreach hubs where survivors could meet their support worker and also obtain other professional, multi-agency support, such as the opportunity to see a nurse or job coach.

Some professionals in partner organisations told inspectors "staff went out of their way" to support survivors, and that staff "went the extra mile" for their clients, sometimes above and beyond MSVCC requirements. For example, when describing the staff of one safehouse provider, partnership organisations told us that the staff had "brilliant knowledge" of local support available and described them as "respectful of partners and other services, and of their remits and expertise". One professional told us they felt lucky to be able to work with them.

We received some excellent feedback from the police, who described how one provider had worked with them on several occasions to support survivors of enforced labour, saying:

"I can only speak on the highest level of praise around the services they provide... for victims that ensures their best possible chance of recovery and reducing the possibilities of the victims being re-victimised." (Feedback from partner)

Areas for improvement

Managing risk

Risk assessments were a common area that needed to improve across all services. Our recommendations highlighted the need to implement effective systems to enable staff to review, assess, record and update risk appropriately and consistently, as well as appropriate governance to identify and mitigate risk. This is an area that influenced our judgements around both the safe and well-led key questions.

Inspectors found that risk assessments were not always reviewed within the timescales set out in the MSVCC. The format providers used for recording was not always clear for identifying risks and sometimes risks were missing from records.

This meant that staff were not always aware of identified risks or how to respond to them, or they didn't have the most up-to-date information to support survivors' needs. There were a few examples that suggested timescales for review were not met because of staffing pressures.

"The assessment, recording and response to risk was disorganised and inconsistent. Risk assessments were not regularly reviewed or updated. Staff did not consistently complete, review or update survivor risk assessments. Records did not show evidence that staff had appropriately considered or implemented mitigating factors. Staff did not complete risk assessments about dependants. This meant that residents were exposed to the risk of harm because staff could not be sure of individual risks and how to respond to them." (Inspection report)

Risks were not always recognised in relation to children, kitchen equipment, safe storage of medicines, and environmental risks such as fire safety. In some cases, risks to staff had not been recognised, for example around lone working.

There were some potentially more serious examples, where risks were not appropriately considered around housing men, women and children together – particularly where survivors had complex needs such as alcohol and substance misuse issues. Some of this arose from a lack of specific placements within the MSVCC and in the community for those with complex needs.

There were a few examples of allegations of abuse and assault where the perpetrator had a criminal history that had not been identified. However, there were examples where providers had shown good awareness of these types of issues and mitigated them well by reviewing accommodation arrangements and going beyond contractual requirements

"Individual risk assessments were completed and reviewed in line with changing needs of survivors living in the safehouses. These were used to inform the nature of support offered for individuals. We saw evidence that where additional risks were identified in relation to volatile or dangerous behaviours in survivors, staff responded quickly to identify alternative, more appropriate, accommodation. This meant that all survivors living in the safehouses were supported to keep safe." (Inspection report)

"The safehouses accommodated male adults only. Staff assessed any potential new admissions, aiming to avoid placing people together where conflict could arise, for example, two people with alcohol misuse issues, or people prone to volatility and violence." (Inspection report)

One provider managed more than one safehouse, and we had made recommendations for one of its locations to improve systems to identify and manage risks. When inspecting another of the same provider's safehouse locations, we saw evidence that it had implemented our recommendations in that location and there was a better system in for identifying and responding to risks. There were some areas of good practice too, for example:

"In response to concerns, the service manager had introduced a new health needs assessment which included for example, mental health needs, an assessment of a survivor's ability to perform activities of daily living and a forensic history. This information was used to identify potential risks." (Inspection report)

However, there was a clear link to oversight as audits were not always carried out, or where they were, they were not always effective in identifying risks. Our recommendations often asked providers to review processes to ensure all risks to survivors were identified and addressed.

Systems for audit and oversight

As well as assessing and managing risks, we identified a lack of clear audit and oversight as a theme across the areas of concern. Training and staff supervision were key areas where oversight needed to improve.

We found some areas where staff needed more enhanced training, as well as some gaps in mandatory training such as health and safety and safeguarding. But the root of the problem was record keeping and oversight.

Providers were not always able to show that their staff had received the required training, or whether it was out-of-date and due for renewal. We made recommendations to implement better oversight mechanisms.

"Staff induction packs contained details of mandatory training which staff were expected to complete upon appointment. This included health and safety, basic first aid, vicarious trauma and safeguarding training. However, we heard that not all staff had received an induction, and we were unable to ascertain uptake of training for staff as no local oversight or monitoring systems were in place, and no central recording system existed." (Inspection report)

In a few services, staff had no access to regular structured supervision or one-to-one support meetings, or these had lapsed. The lack of effective oversight of staff training and supervision arrangements meant staff were not fully supported to acquire and maintain the skills and knowledge required for their roles.

Providers submitted a range of monthly audits to the prime contractor on their progress against key and other performance indicators as identified in the MSVCC. However, some service-specific audits and quality assurance processes were still in development or not yet embedded. There were cases where inspectors identified issues that the provider had not previously identified through audit processes, suggesting they were not effective and more robust oversight was required.

One inspector reflected that the reason for the lack of audit and oversight was the lack of regulation in the sector and not fully understanding what good systems look like. On raising this with providers, most understood why things needed to improve and acted to implement better systems.

But there were also elements of good practice in this area, with one provider setting up a 'CQC tracking system' to monitor, review and plan actions in response to areas recognised as requiring further work.

Another provider understood the importance of monitoring and assessing the impact of their service on outcomes for survivors. Senior leaders were creating a 'client outcomes model' to drive service development and improvement, though this still needed to be embedded.

Safety and suitability of services for children

The MSVCC provides support tailored to the needs of adult survivors of modern slavery. Local authorities are responsible for safeguarding and promoting the welfare of all children in their area, including child survivors of modern slavery. Where adult survivors enter support with their children, the support provided should take their needs into account and make sure they are safe.

During our programme of inspections, approximately 35 safehouses were accommodating children and families, with approximately 80 children. Similarly, most outreach services supported survivors with children (over 1,400 when we inspected). Where survivors were in safehouse accommodation, providers were clear that the provision was for the adult survivor, and that survivors held parental responsibility for their children. However, sometimes services did not fully consider the needs of the children or identify and mitigate any risks they may face.

The following case example outlines the basic considerations one service took when housing women and their children and demonstrates some safe practices.

There were up-to-date policies for safeguarding adults and children. Staff demonstrated an understanding of their roles and responsibilities in all aspects of safeguarding and of their duties to protect and safeguard children. Relevant training was provided.

The provider was developing a 'care of dependants in service' policy and procedure, which set out its roles, duties and responsibilities when a survivor entered the service while pregnant, or with children in their care. The provider considered when a child needed specialist support, for example making referrals to local authority children's services. Initial risk assessments included recording any potential risks regarding children. Potential risks to both parents and children were shared with the whole staff team in daily handovers.

A full environment risk assessment had identified areas that could present risks to children living there and the provider had taken actions to ensure their safety. For example, the provider had fitted custom-made stair gates to internal and external areas, double handrails on staircases and waist-high fencing around all identified falls hazard areas. Children had no access to the rear garden area due to its unsuitable landscaping design. The provider had therefore developed an enclosed garden area to the front of the property where children could play safely when accompanied by their parents. Parents were also encouraged to use the beach and local parks for outdoor access.

Children's needs were considered, and plans were put in place to meet them. For example, parents were supported to access school placements, and support from midwifery and health visitor services.

However, such good practice was not the case for all services. Some services only provided training in adult safeguarding for their staff, even though the MSVCC required this training to include working with children and adults with specific needs or who are at risk. This meant staff were not always confident in dealing with potential safeguarding concerns relating to children. Although the MSVCC does not require providers to directly support dependent children, we were concerned that risk assessments didn't always identify potential risks to children. There were examples of cleaning products left unsecured, no stairgates or window restrictors, no radiator covers, an easily accessible boiler cupboard and, in one example, a blind cord that presented a clear ligature risk. None of the accommodation was purpose-built for the MSVCC and often presented challenges for the survivors who lived there.

Although this was an area of concern, we saw some good examples of support that often went beyond contractual requirements. For example, families were supported to get school places and advised how to get access to health visitors and midwives. There were some strong examples of partnership working with safeguarding teams or perinatal mental health services. Some had close links with charities and secured donations of toys, clothes and baby equipment, and helped families to get school uniforms.

Others had strong community links that saw the children invited to join Easter egg hunts or training at a local football club. One location received free tickets to the zoo.

In another example of going beyond contractual requirements to support the needs of survivors, one provider had hired a children and family development worker and another had a creche facility.

Accommodation and facilities

Maintenance

Safehouse standards are set out within Schedule 2.3 of the MSVCC and inspectors took these specific standards into account during their inspections.

None of the safehouse estate is built specifically for use under the MSVCC and much of it is owned by private landlords and used by the safehouse providers in a variety of different lease arrangements. This was a factor in the suitability of some of the accommodation and occasionally affected the speed at which problems could be rectified. Inspectors found concerns around:

- general maintenance
- fire safety
- accessibility
- suitability for children
- compatibility with the terms of MSVCC.

Safehouses tended to be comfortable, homely places in a reasonable state of repair. However, inspectors did make several recommendations about maintenance issues relating to their general upkeep.

"We identified a small number of maintenance issues across the properties. We shared our findings with the provider who said that they would take action to address these.

- We found missing locks to 2 toilet doors and a shower room/toilet room. This compromised people's privacy and dignity.
- A lock was missing from an electrical cupboard. In one of the bathrooms, we observed a broken shower door and were told there were plans to replace this. A cover for the shower drain was missing and the extractor fan was not working, which was a concern as there was no window in the bathroom.
- A fire door which was located directly opposite a bedroom slammed shut each time it was used. We asked the provider to consider taking advice from the local fire service as to whether a soft closure could be fitted." (Inspection report)

If the safehouse provider owned the building, issues tended to be rectified promptly, but often they relied on a landlord. This could have implications for people's privacy and dignity. Gardens were often not well-maintained, meaning survivors and their families did not always use this valuable outside space.

Examples of shortfalls in fire safety included a broken fire alarm, lack of fire drills, poor fire door compliance, and fire blankets and furniture that were old and not fire retardant. There were also risks that hadn't been considered, for example appliances in bedrooms and evacuation plans. Sometimes these issues had been picked up by a fire inspection but had yet to be addressed, and the delay in taking action was a concern. As with maintenance, although this was sometimes attributed to the providers' reliance on landlords, safety concerns should still be a high priority for providers. We advised providers to take these delays seriously and take action to address all fire risks promptly. Where we identified and reported standards of accommodation that needed to be rectified, the Home Office took action under its agreed contractual performance management process with the MSVCC Prime Contractor.

Accessibility

The MSVCC required providers to meet the needs of disabled survivors when identified. However, very few safehouses were accessible for survivors who had a disability, especially wheelchair users. This again related to the estate not being purpose-built to accommodate survivors under the MSVCC, so for example even if there was a downstairs bedroom, the doorways may not have been wide enough to allow wheelchair access. Under the MSVCC, staff were required to provide support rather than personal care, so were not necessarily alert to people's needs and how to mitigate risks. For example, one service accommodated a person with a significant risk of falls but the environment still had risks that the provider hadn't identified including rugs on the floor, trailing wires, furniture in the way of walk routes, and cluttered landings.

We found examples of good use of aids and adaptations. For example, one location fitted a bathroom with a flashing light and provided pillows that would vibrate if there was a fire alarm to alert survivors who were hard of hearing. One survivor with a physical disability told us they were "amazed" at the equipment the safehouse had provided to support his needs.

As highlighted in the issues with accommodating children, some facilities also presented challenges for child safety and suitability for young families. Older properties or those with many floors held inherent risks and challenges that weren't always well recognised. Some services had age restrictions for children, for example they could only accommodate mothers with babies up to 12 months old, where the allocated room may be small but manageable for a mother and baby. However, delays in accessing accommodation outside of the MSVCC saw examples where the child grew older and the room and facilities became unsuitable and inappropriate. This affected the wellbeing of the mother and increased risks to the child.

There were also some issues with building compliance with the terms of the MSVCC. For example, the contract has specifications around the ratio of kitchens or bathrooms to the number of survivors, which were not always met. The Home Office assured CQC that it was made aware of any exceptions to the contract on a case-by-case basis.

There is no requirement for TSA as the Prime Contractor to visit properties and to assess their suitability against the MSVCC. It is not clear whether specific issues in relation to accessibility and suitability for children have been directly considered.

Challenges for outreach support

As well as providing safehouses, the MSVCC provides outreach support to survivors living in the community. This was a generally good and caring service, but there were some particular issues for outreach support workers including:

- staffing and the large size of caseloads

- the remote nature of the service, with the challenge of spread and travel across a geographical area
- access to and quality of accommodation
- the varying level of survivors' needs and requirements that were not considered when allocating support.

Some providers had several staff vacancies, and although providers had plans to tackle a high workload, the plans still needed to be embedded. This meant that some support workers felt they weren't able to give individual survivors the time and support they needed. In one case, the provider continued to accept new referrals even though there were not enough case workers. This meant many survivors did not have an allocated support worker.

"The provider had 146 survivors across their outreach services without an allocated support worker at the time of our inspection. A RAG rating tool [to rate each risk according to level of severity] was used to assess risk before being allocated. The provider managed these survivors on an unallocated list, with those rated as red prioritised for a support worker. While awaiting allocation to a support worker, survivors received regular basic welfare calls from another staff member. However, we weren't assured that the immediate needs of those on the waiting list were being met." (Inspection report)

In this case, 4 survivors without an allocated worker were rated as red and 1 as amber. As new survivors were being accepted all the time, anyone risk assessed as green was unlikely ever to get a support worker. The system meant that any deterioration in their wellbeing was also unlikely to be identified. The report for this provider described how this represented a risk of harm.

"Where risks had been identified and recorded, we found there was not always an effective risk management plan in place. For example, one survivor who had expressed suicidal ideation had no formal risk management plan and was advised to contact the GP and provided with the telephone number for the Samaritans. Another was being housed in a hotel and due to leave two days later but there was no recorded contact or move-on plan in place. This meant that these survivors were at increased risk of harm." (Inspection report)

Recognising risk and possible deterioration in survivor's wellbeing was a concern more generally, because of the remote nature of the provision. During the COVID-19 pandemic, contact with support workers had often been reduced to telephone contact to maintain the safety of survivors and staff. However, support workers expressed concern that this put survivors at risk of isolation and made communication and engagement more difficult. Survivors reported they missed the face-to-face contact. Towards the end of our inspection programme, this picture was improving with providers slowly increasing their face-to-face contact, though this was not universal. One survivor commented of their outreach provider:

"I had a good support from them. Just lately is not the same. Maybe because of coronavirus everything has changed." (Survivor survey)

Support workers often agreed to meet survivors in public settings to ensure their safety when lone working, although this sometimes presented challenges such as holding difficult and personal conversations privately and supporting with paperwork and contacting other agencies on the survivor's behalf. Inspectors felt this also made it harder to identify risk. For example, having access to someone's home may help to assess if they are potentially suffering from depression, as their self-care may be slipping, or if they don't have enough food, or their accommodation is sub-standard. Home visits could be arranged, but this was on a risk-assessed basis and the challenge was in identifying that risk.

But we did see some good practice in this area that was above the contractual requirements. One provider had set up office hubs for their outreach teams across each outreach area, where survivors could meet with their support worker. They were in shared spaces with other agencies, so the survivor also had the opportunity to see for example a nurse or access job coaching, in a confidential space.

Accommodation issues were a common complaint of survivors receiving outreach support, who often resided in accommodation provided outside of the MSVCC. However, staff often liaised with landlords and housing providers on behalf of survivors to raise and speed up repairs, or escalate when there were serious safety or suitability concerns. For example, inspectors spoke to one survivor with a child who had no access to hot water in the bathroom area of the accommodation. The outreach provider was already aware of this situation and committed to following this up again on behalf of the survivor. Support staff told us this aspect of their work was extremely frustrating and the impact of the pandemic meant that attempts to rehouse survivors or get issues addressed could be protracted.

National Referral Mechanism and the wider survivor journey

Our assessment framework for this programme looked at the quality and effectiveness of the safehouse and outreach support part of the survivor journey through the MSVCC. However, through engagement with providers and survivors, inspectors saw the impact of some other elements of the National Referral Mechanism (NRM) on the safehouse environment.

Initial risk assessment and referral process

The MSVCC requires service providers to make quick decisions when accepting new referrals into their services and placing them into accommodation. However, providers told us that they sometimes lacked detail or crucial information about risks associated with some survivors. The implication of this was that providers may not have been able to offer the best support, or the survivor's admission introduced risks for other survivors or support workers at the service. But once at this stage, providers reported it was very hard to find an alternative and more suitable placement for that person.

There were also examples where risks hadn't been identified clearly enough, for example alcohol and substance misuse or complex needs for which the service was not set up to support. In one example, a survivor had a criminal history unknown to the service, which made the placement with women and children unsuitable, and another example concerned a survivor who exhibited quite serious stalking behaviour. There were also allegations of assault against female survivors and a member of staff, which again arose from missing information on admission.

Out-of-hours and night-time admissions were also a concern. Most providers had a night-time concierge or an out-of-hours rota for this. However, the usual daytime measures, for example having 2 staff members for check-in, were not always followed. This left potentially risky situations where survivors were travelling sometimes long distances across the country after experiencing traumatic circumstances to an unknown location to a lone employee who held limited information about the survivor.

"We were told that the night concierge from the homeless hostel would complete a 'basic move in' with survivors who arrived out of hours. The basic move in included showing a survivor to their room and providing a key card to access the safehouse. Interpreters were not used, and risk assessments were not completed until the following morning. Staff from the homeless service were not trained in line with the MSVCC, including safeguarding, the National Referral Mechanism and data protection." (Inspection report)

Most services didn't provide 24-hour support as this was not required under the MSVCC. Survivors were given emergency contact numbers in case there was a problem and there were on-call rotas, but there were ineffective procedures for out-of-hours admissions and training for night staff. Feedback from our survivor survey also resulted in some comments around the availability of staff at night and that a "24-hour service would be better", suggesting survivors may have experienced a need for this.

Support for survivors with more complex and challenging needs

Inspectors also raised concerns about people who presented with more challenging and complex needs. Survivors had often endured very traumatic experiences and may have needed support for their mental health. There was some acknowledgement among providers of the need for better access to secure services for those who are in more vulnerable circumstances, where they can be effectively supported with staff experienced in trauma-informed care – for example, people with mental health and substance misuse issues.

We saw a male-only service that accommodated survivors with complex needs which, although delivered outside of the MSVCC, was notable. The house was staffed 24 hours a day and was funded independently by the provider. The provider told us this enabled them to support some of the most vulnerable survivors of modern slavery who would not ordinarily receive the support they needed.

Delays receiving Conclusive Grounds Decisions

We reported increasingly on survivors who had been living in safehouse accommodation for very long periods, sometimes years, while they waited for a Conclusive Grounds decision from the relevant Competent Authority at the Home Office or other decisions about their status. This was also shown in the survivor survey, where 68% of the respondents had been supported by the service for more than 6 months. Survivors frequently told us this affected their ability to plan their lives and was having a negative impact on their health and wellbeing. One inspector wrote:

"Most survivors had lived at the safehouse for over 2 years and told us they felt unable to move forward with their lives because they were waiting for a final decision [about their status]. They told us how these delays had significantly impacted on their emotional and physical wellbeing, and in some cases had re-traumatised them. We shared these concerns with the provider, who responded by speaking and offering further support to the survivors." (Inspection report)

Respondents to the survivor survey also told us:

"The support is very good and support workers are very helpful but waiting for decision more than 2 years for me it's frustrating, my mental health is not good." (Survivor survey)

"I need to work and live my life, to be independent and not always asking other people to help my life." (Survivor survey)

Positively, safehouse staff worked hard to help survivors navigate the delays they experienced and kept them well supported while they waited.

There was some reflection on the suitability of the safehouses estate where families stayed over long periods. For example, some safehouse accommodation placed an age limit of up to 12 months old for the children accommodated, but inspectors found examples where the children were now older but still remained in the accommodation.