Safeguarding

Indicative score:

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

There was robust partnership and integrated working across the safeguarding system including police, health, and fire. Partners described positive relationships that were respectful, strong, and open to challenge, to improve understanding and prevent 'group think' and focus on the safest outcome for people. There were strong partnerships with people with lived experience. The Experts Together Partnership were positive about their involvement in co-production with safeguarding.

Section 42 enquiries were dealt with in a timely way with no backlog, so concerns were triaged on the same day. A section 42 enquiry is where the local authority believes that someone is at risk of abuse and therefore a full investigation needs to be carried out. There was a focus on ensuring a personalised approach with the wishes of the person at the heart of the process. The safeguarding team worked well with other teams to ensure an integrated approach both internally as well as with health partners.

There was a comprehensive dashboard with information about safeguarding. Data was used to analyse themes and trends, to target preventative interventions to reduce the number of safeguarding concerns and to raise awareness within communities. There was a risk-based approach to managing safeguarding thresholds and the data dashboard enabled leaders to monitor themes and trends even if concerns did not meet the threshold for a section 42 enquiry. The current approach was introduced following a review of the data, which showed inconsistencies in reporting. As part of the introduction of the new approach, there was awareness raising and development work with providers, voluntary sector partners and communities to enhance understanding of safeguarding, when referrals should be made and how to ensure that all referral forms were completed with the information required by the team. There was also co-production with people with lived experience to make a more accessible version of the safeguarding concern form in an easy read format. Providers and partners gave positive feedback about the changes and felt that the system worked better as a result.

The data dashboard enabled leaders to see increases in the number of referrals as well as gaps in the data to enable targeted approaches. For example, awareness raising was targeted through 'roadshows' at community events in communities where there were less referrals and less knowledge about safeguarding. Training and awareness-raising sessions were held with local voluntary and community groups, to build on the community first approach to wrap around support.

The safeguarding dataset had also highlighted an increase in self-neglect, in line with national trends following the pandemic. As a result, they looked more closely at self -neglect cases and worked across the partnership to develop multi-agency training involving all partners including environmental health and fire. This included a person with lived experience to talk about their experience. This had improved awareness of self-neglect and understanding of what needed to be referred to safeguarding and identification of cases where support can be offered through signposting to other organisations, without the need for safeguarding referral.

Deprivation of Liberty Safeguards were well managed, there was no waiting list and conditions were used effectively to support independence and wellbeing, for example through social connections.

There was a proactive approach to learning from serious abuse or neglect, including oversight of national and regional learning to look at whether it could be used to improve safeguarding locally. Locally, learning from Safeguarding Adult Reviews (SAR) was shared both internally with teams as well as with partners, through training and briefings. In response to one of the SARs, a forensic examination service had been set up as a pilot for adults at risk who may have sustained a non-accidental injury because of physical abuse or neglect. The pilot had been externally evaluated and extended as a result.