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

The local authority did not consistently have robust systems and processes in place to protect people from abuse and neglect. There was a process in place for receiving and processing safeguarding referrals and the managers provided oversight and decision making in relation to risk. Leaders told us staff had access to the duty chair if needed and cover arrangements for managers would be made if the manager was not available. However, staff told us there was not a clear process if the safeguarding managers were off work and staff would often self-allocate work with a lack of decision-making oversight. This increased the risk of people at high risk of abuse and harm being left at risk for a significant amount of time. Staff told us that they had a 4-day timescale to review safeguarding referrals however, due to demand this was no longer achievable. Leaders told us that staff used a RAG rating tool for safeguarding referrals to monitor risk and that data regarding safeguarding timescales was regularly monitored. Data provided by the local authority showed the expected timescale of 4 days for a safeguarding referral was not always achievable.

The local authority recognised safeguarding, the Mental Capacity Act (MCA) 2005 and Deprivation of liberty safeguards (DoLS) training for staff was an area they needed to improve. Despite this the Adult Social Care Survey data told us that 73.65% of people who used services felt safe, this was tending towards a positive variation compared to the England average of 69.69%, and 93.41% of people who used services said that those services had made them feel safe this was a positive variation compared to the England average of 87.12%. 79.66% of carers felt safe which was similar to the England average of 80.93%. Leaders and staff advised their access to training had improved since moving to the local authority and leaders told us how staff approached them for knowledge and advice.

Staff told us there were safeguarding themes emerging with an increase in domestic violence, self-neglect and cuckooing. Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation resulting in them losing control of their property. However, staff told us that there was a lack of focus on specialist concerns and staff did not feel knowledgeable enough to deal with such complex cases. Staff told us leaders had started to provide training around this and had received seminars on self-neglect to inform practice. The self-neglect policy was currently under review.

Feedback regarding outcomes of safeguarding concerns varied. Some providers told us communication following a safeguarding referral was poor. Partners told us they would not hear an outcome unless they chased safeguarding for an outcome and others told us communication was good, and they received outcomes in a timely manner. Staff confirmed whilst it was best practice to share the outcomes this was not always possible.

Responding to local safeguarding risks and issues

The way the local authority identified safeguarding risk was not consistent. Staff told us that quality assurance through audits had taken place in the past, however, this was not consistent, and staff did not know when the last audits took place and had not received any feedback from audits to improve practice. Records reviewed showed the last safeguarding quality assurance audit was carried out in May 2024, following the transfer. Leaders told us a second audit was due to be carried out at the time of the assessment. Audits were completed on cases that did and did not meet the threshold for a section 42 enquiry.

The safeguarding team managers monitored risk and RAG rated concerns, these concerns would then be passed on to one of the 6 safeguarding chairs who monitor allocation through a duty system which was then allocated to social workers. Staff told us whilst they understood risk and would escalate any risk to their manager there was not a clear process for recording risk. Staff told us if managers were off, the team would allocate work to themselves, this meant at times there was limited oversight and increased risk.

Between May 2022 and April 2024, the B&NES Community Safety and Safeguarding Partnership (BCSSP) received 6 cases for consideration of a Safeguarding Adults Review (SAR), 4 of which met the statutory criteria. As per the Safeguarding Adults Board SAR protocol, all organisations known to be involved with the individuals were notified. The cases were reviewed at the Practice Review Group and learning was identified for all cases, whether they met the threshold for SAR or not. Actions were identified to implement recommendations and learning. BCSSP identified areas of good practice in addition to identifying where improvements were needed in the future. One of the methods they used to implement learning from cases was the creation of 7-minute briefings, which provided key learning to aid practitioners' future practice. The BCSSP implemented an action plan to review the recommendations taken from the Practice Review Group, which included cases that required a Safeguarding Adults Review.

Responding to concerns and undertaking Section 42 enquiries

Some providers told us there was a lack of clarity regarding what constituted a safeguarding concern and when S42 safeguarding enquiries were required. The local authority told us advice and guidance for providers around what constituted a safeguarding was provided on their website and safeguarding portal and was accessible to all providers.

Providers told us they could wait around 6 months to hear whether a concern had progressed to a S42 enquiry. Partners also told us they often had to chase the safeguarding team for outcomes of concerns. Safeguarding Data Return provided by the local authority stated 973 S42 enquiries were received during 2023/24, all of which were immediately reviewed, risk rated and allocated to a Safeguarding Adult Manager, however, it did not evidence when these were allocated to workers to carry out the S42 enquiry. The local authority provided data following our onsite visit which showed just over half of the enquiry decisions were made and allocated within the local authorities' 4 days' timescale. Leaders told us enquiries were RAG rated and allocated based on risk. Staff told us vacancies in the team impacted on their ability to carry out their workload. Leaders told us recruitment across adult social care was ongoing.

Safeguarding Data Return provided by the local authority showed 1147 Deprivation of Liberty Safeguards (DoLS) applications were received during 2023/24. At the time of reviewing the information, 621 referrals were waiting, the longest wait was 2472 days, and the median wait was 307 days. All new referrals were triaged according to the Association of Directors of Adult Social Services prioritisation tool and all referrals awaiting allocation were monitored to ensure their priority status remained unchanged.

Making safeguarding personal

The local authority had identified a need to improve the recording of safeguarding with a focus on making safeguarding personal (MSP). Feedback from people involved in safeguarding was mixed, one person told us they felt respected and informed about the whole process and was given choice, whilst another person told us they had raised concerns and were unclear whether any action had been taken.

Staff told us advocacy support was readily available when needed to support people to have their voices heard. Partners told us they had good communication with the safeguarding team and were involved in assessments, reviews and kept up to date on outcomes of safeguarding enquiries.

Safeguarding adults' collection data told us that 88.37% of individuals lacking capacity were supported by an advocate, family, or friend this was in line with the England average of 83.12%.
