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

Safeguarding is the process of ensuring people at risk are not being abused, neglected or exploited. Wiltshire had a Safeguarding Adults Board statutory function that aligned with safeguarding children and community safety partnership (Safeguarding Vulnerable People Partnership). The safeguarding partnership board was attended by the local authority, police, health services and other local organisations, this did not include advocacy or provider services. There was an adult safeguarding subgroup of the board that had a wider membership (Safeguarding Adults System Assurance). The local authority had other groups and forums that supported staff to enhance and share safeguarding adults practice and learning. The safeguarding partnership board heard from staff about current safeguarding practice. However, it was recognised more could be done to ensure people's voices could also be heard at a strategic level. The local authority had also identified the need for independent scrutiny on the safeguarding partnership board to hold them to account on changes needed and was recruiting to this post.

There was a multi-agency safeguarding hub (MASH) during weekdays that included a team of investigating managers, police and a nurse funded by the integrated care board (ICB). We heard examples of joint working with housing, environmental health professionals, ambulance service and community health professionals to reduce risks to adults in Wiltshire. The MASH was described by staff as supportive and flexible. This allowed information, knowledge and expertise to be shared quickly, and initial concerns to be actioned without delay. The MASH was also aligned to the advice and contact team for any extra support around managing risks. There were processes for handing over urgent safeguarding concerns and interventions between the MASH and out of hours team through manager-to-manager telephone calls, backed up by documentation.

Staff had access to training to support them to carry out safeguarding duties. Safeguarding training promotes an understanding of what preventative actions can be taken to reduce risks to adults. It also aids the quality of referrals made and the skills and knowledge required to investigate concerns for people with care and support needs and/or their carers. The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions for people who may lack the mental ability to do so for themselves. 38.70% of the wider social care workforce in Wiltshire had completed Mental Capacity Act and Deprivation of Liberty Safeguards (MCA, DoLS) training and 44.14% had completed safeguarding adults training. This was not statistically different from the England average of 37.48% for MCA, DoLS and 48.81% for Safeguarding adults (Adult Social Care Workforce Estimates, Skills for Care 2022-2023). Internal local authority staff had compulsory training in these areas as well as more training for staff that carried out specific safeguarding duties, for example investigating officer training. Partners could also access training on offer from the local authority to support their staff.

Responding to local safeguarding risks and issues

The local authority reported on safeguarding risks and issues in the area. The most common types of abuse outside of care home settings in Wiltshire were physical, psychological, neglect and acts of omission, and domestic abuse. The safeguarding partnership board had a strategic plan with 3 themes: learning and improvement, supporting a prevention approach and developing leadership and culture. There were 5 areas of practice identified as priorities with one focused on children's safeguarding only, the other 4 priorities had an all age or family approach to safeguarding people in Wiltshire. Domestic abuse was both a theme and a priority in relation to safeguarding adults. Processes were in place and there was evidence of good partnership working where there was domestic abuse. For example, the local authority worked with primary care colleagues to meet and work with the adult at risk in a way and place that was best for the person. This provided a safe place to give advice, support and options to adults at risk to protect their right to live in safety.

The safeguarding partnership board's strategic plan had descriptors to support improvements in practice. Outcome measures were identified or under development. However, there was areas that lacked detail to demonstrate what the local authority was doing to deliver its part of the plan. The local authority was working on improved engagement with the public, people using services, unpaid carers, voluntary sector and providers.

Transitional safeguarding was another priority in the strategic plan. Transitional Safeguarding in Wiltshire was an approach to safeguarding for people aged 16 to 24 years old. Staff and partners told us about pilot and improvement work, this included a multi-agency 'creative solutions' board that focused on preventative work, trauma-informed practice and early intervention to support better outcomes in adulthood. The local authority had identified gaps in support for young adults leaving care who didn't have care needs that met Care Act thresholds but were posing risks to themselves or others. There was ongoing work to address this concern including the development of 'Risk Outside of the home' tool. Staff described how senior leaders ensured a close multi-agency approach and offered solutions around reducing high risks to young adults.

The safeguarding partnership board in Wiltshire had an overview of safeguarding reviews, between 2022 and 2024 there were 3 Safeguarding Adult Reviews (SAR), 1 of which had been completed and 2 of which were underway. They had 5 referrals for SAR that had not met the threshold. There was also 1 LeDeR (Learning from lives and deaths) review, 2 domestic homicide reviews and recommendations about a Child Safeguarding Practice Review. Themes identified from these reviews were: the use of the Mental Capacity Act, working with people that are at risk of self-neglect, management of high risks including escalation, and care being provided by a family member including unpaid carers.

There were clear governance processes for sharing learning and carrying out actions from safeguarding reviews. However, there were gaps in the local authorities plans and overall assurance of how successful learning and practice was embedded and if future risk of reoccurrence to people and unpaid carers had been reduced.

Staff told us with confidence how they internally used data and analysis to monitor trends and how this influenced practice. For example, there had been a recent increase in concerns relating to self-neglect. MASH investigating managers each had lead roles in specialist subjects. One manager led on self-neglect and they had led a safeguarding forum for staff to focus on self-neglect in response to the trends seen in data. Investigating managers took on a lead role to represent the local authority at partnership forums such as MARAC (multi-agency risk assessment conference; a meeting where information is shared on the highest risk domestic abuse cases) and Wiltshire Sexual Exploitation Panel. Staff told us about external workshops to share 7-minute briefings with partners (easy read learning from SARs in 7 minutes), and other topics.

Responding to concerns and undertaking Section 42 enquiries

The safeguarding partnership board website promoted 'if in doubt refer' for professionals making safeguarding referrals in Wiltshire. National data from the Safeguarding Adults Collection (NHS Digital, 2023- 2024) between April 2023 and 2024 showed a conversion rate of 40.08% for safeguarding initial concerns moving to a safeguarding enquiry under section 42 of the Care Act. Section 42 enquiries are 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 number of concerns and enquiries had reduced from the previous year, and was lower than the average number of concerns and enquiries for the local authority over the past five years.

All safeguarding concerns came to the Multi-Agency Safeguarding Hub (MASH), each concern was actioned by an investigating manager. There was support from information officers to gather specific information to aid the triage and decision making. When the threshold for a section 42 safeguarding enquiry was met there were investigating officers in locality teams to progress this. Investigating officers could be occupational therapists, social workers or social care practitioners dependant on who had completed the required training and who was best placed to support the adult at risk. Referrers or providers did not receive formal feedback when the enquiry was closed as there was no formal process to be followed. Staff and partners told us about differing methods to feedback such as over the phone, through email, in a meeting or passing of information to an investigating manager. Staff explained how they did not always inform care providers depending on the nature of the concern raised. Therefore, more could be done to ensure feedback was consistently shared when it was necessary to the ongoing safety of the adult concerned.

There were processes for safeguarding enquiries to be carried out by a care or health provider. A risk tool aligned to best practice and legislation supported staff to consider whether a provider was suitable to carry out the enquiry. When partners did carry out investigations for the local authority there remained oversight of a named investigation manager to lead on meetings, check the quality and outcomes before closing the enquiry. Where there were organisational abuse enquiries to be carried out, senior leaders led on these with managers carrying out the investigating officers' role. This showed the local authority kept responsibility for the enquiry and the outcomes for people to ensure people were protected from abuse and neglect.

Concerns raised in relation to discriminatory abuse were 6 times higher in Wiltshire's care homes than that reported in other settings. 'Provider referral forms' were used where internal staff in the local authority could raise concerns about care providers to the quality team. This meant all organisational quality or safeguarding concerns were reported. However, staff and partners feedback described reporting concerns without informing providers and/or people using services. There was concern any immediate risks to people using services were not addressed at the time by care providers as they were not told. There were low numbers of organisational abuse enquiries completed despite the high numbers of concerns relating to providers as a source of risk. However, there was evidence of the local authority applying statutory guidance to dealing with organisational abuse to improve outcomes for people.

There was mixed feedback from partners about safeguarding advice and guidance. For example, partners described social workers as very knowledgeable and approachable around safeguarding. In contrast, there could be inconsistency over section 42 threshold decisions and feedback about outcomes and learning. While safeguarding is not a substitute for providers' responsibilities to provide safe and high-quality care and support, local authorities must cooperate with partners to protect adults. It is necessary to create strong multi-agency partnerships that provide timely and effective prevention of and responses to abuse or neglect. A threshold matrix for safeguarding enquiries, aimed at improving consistency in section 42 threshold decisions, was pending feedback from care providers at the time of the CQC assessment. However, there was more to be done around developing a positive learning environment across partnerships and at all levels within them, to help breakdown any risk averseness and blame cultures which could negatively impact on adults at risk in Wiltshire.

Deprivation of Liberty Safeguards (DoLS) are legal protections (authorisations) that ensure people who are unable to consent to their care and support arrangements either in hospital or in care homes, are safeguarded. The median number of days people waited for an authorisation was 149 days. The maximum wait had gradually increased over the year to 3195 days and then dropped significantly in March 2024 to 1545 days after focused work on lower risk requests and found many people had a change in situation (data provided by the Local Authority April 2023 to April 2024). In April 2024 the number of DoLS requests waiting was 1729, by September 2024 this had steadily dropped to 1693 requests waiting. The local authority had a separate DoLS team, we heard staffing resource was growing and there was a focus in the team to reduce risks to people by considering less restrictive options. Administrative support monitored the waiting list, and priority was identified through the local authorities' own criteria. Staff told us they had worked hard to make improvements using best practice guidance tools as a guide. Staff felt this had allowed them to be more proportionate and as a result were working with more people.

There was more to be done for people living in the community unable to consent to their care and support arrangements such that may constitute a deprivation of their liberty, having these arrangements legally authorised; for example for people living in independent housing. A recent review identified staff needed more training to recognise where such authorisations may be needed. Training was carried out to improve confidence and knowledge and as a result there was an increase in referrals for authorisations but improved triage and oversite of the extra waiting list. Senior leaders were committed to address the risks, and there was monitoring through governance and performance frameworks which was maintaining the position of the waiting list. However, it was highlighted the list wasn't coming down fast enough, this meant there remained risks to people being deprived of their liberty without authorisation.

There were quality monitoring arrangements for safeguarding enquiries which included when enquiries were delegated to health or care providers. Staff described an open culture of learning and good management support. We heard about regular risk meetings which also covered out of county placements with managers from safeguarding and contracts teams, and partners such as Care Quality Commission (CQC) and the Integrated Care Board (ICB). The local authority used data and analysis for monitoring and informing safeguarding adults' performance and improvement. There were internal and external audits covering multi-agency triage and peer casework. The audits included speaking to people who used services to understand their experience. Audit outcomes were reviewed at a quarterly assurance meeting to identify gaps in knowledge and arrange for training and development of staff. According to local authority data there were no waits for safeguarding concerns requiring initial threshold decision-making between January 2024 and April 2024 except for 1 referral with a 1 day wait. Partners did not receive regular or direct information about the timeliness of safeguarding enquiries or if there were any themes around delays to complete enquiries and plans. However, issues could be escalated to the safeguarding partnership board (of which there was none at the time of CQC assessment), and the business unit of the board monitored the themes of safeguarding outcomes through information received from sub boards.

Making safeguarding personal

Making safeguarding personal is an approach to safeguarding to keep the wishes and best interests of the adult at risk at the centre of the safeguarding enquiry and any plans to reduce future risks to them. The principle is to support and empower a person to make choices about how they want to live their own life, seeking to improve quality of life, wellbeing and safety. We heard how processes and practices supported this approach in Wiltshire.

Where possible, staff who knew the adult at risk best would carry out an enquiry. This reduced the amount of times people needed to share their experiences and promoted an approach to align actions with the care and support needs they had. Staff worked together to identify desired outcomes of the adult at risk. We heard how this was not a 'tick box exercise' and there was continuous learning and improvements to ensure the person's views, wishes, feelings and beliefs were central to the safeguarding processes.

The local authority had a leaflet and video to raise awareness and understanding of safeguarding using simple terminology. Staff could access translation or interpreter support for people once they had been referred to the MASH, to support the person's desired outcomes to remain central when carrying out an enquiry with them. However the local authority could not demonstrate how it was assured information and advice to support prevention and ensure appropriate reporting safeguarding concerns. For example, people from a black, Asian or other people from ethnic minority groups background were underrepresented in safeguarding referral data. The local authority could not show through data or feedback how effective and far-reaching the information they provided about safeguarding was to ensure people from a black, Asian or other people from ethnic minority backgrounds were fairly accessing safeguarding information and advice to reduce potential risks to them.

A subgroup of the safeguarding partnership board used audits to monitor the compliance of recording people's desired outcomes, the quality of plans to ensure safeguarding responses were appropriate, and the principle of 'making safeguarding personal' was embedded. Although we heard about how peoples feedback was sourced, there was no clear place for people's voice to be recorded in the audits and any impact of people's protected characteristics was not considered in audit. Staff were completing cultural competency training. However, at the time of CQC's assessment, learning and improvement around people's experiences in safeguarding work remained limited.

Staff told us they considered advocacy support for people at the point of agreeing risks that met thresholds for section 42 enquiries. If the adult at risk didn't have a family or friend to support them, and they lacked mental capacity around the concerns then referrals were made for independent advocacy support. Advocacy support prioritised safeguarding referrals depending on the level of risk. 100% of people that lacked mental capacity around their safeguarding concerns were supported by an advocate, family or friend in Wiltshire. This was a significant positive statistical difference from the England average of 83.38% (Safeguarding Adults Collection, NHS Digital 2023-2024). Staff described advocacy arrangements as effective through joined up working. This showed there was a focus on the person to understand their rights, including their human rights, their 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.

There was an ethos of there always being room for improvement. Staff and partners told us there was ongoing support for quality and consistency of social work practice in fulfilling its' safeguarding responsibilities, and proactively hearing peoples' voice rather than only through complaints and case reviews.
