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 had effective systems and processes to protect people from abuse and neglect. The local authority had set up a safeguarding hub to deal with all referrals and concerns and decide about whether to proceed to an enquiry. Cases would then be allocated to the community and front door teams to undertake enquiries.

The safeguarding hub had been set up in response to issues identified in a local authority analysis of safeguarding referrals. The analysis identified delays in processing referrals, inconsistencies in what was progressed as a safeguarding and extended time taken to complete enquiries. Staff and leaders spoke positively about the impact the safeguarding hub had on practice and data showed it was effective in improving performance and consistency. Staff also shared there were pressures in areas such as mental health, where they received a higher number of referrals. The local authority had systems to monitor and audit safeguarding systems, and there were leaders who were accountable for processes and practices.

The local authority recognised safeguarding training for staff was an area they needed to improve. Leaders and staff described improved access to safeguarding training more recently but that difficulty recruiting and retaining staff will have impacted on training data. We heard how the local authority was working on their training offer as part of the transformation. The ongoing impact of training will take time to embed and demonstrate value, but we did hear about ongoing training and learning from safeguarding that was disseminated to staff in response to themes, as well as more formal training for staff.

There was a multi-agency safeguarding partnership board in place, but this iteration of the board had only been set up recently. The complex make-up of the Berkshire geography and the ICS had presented challenges in governance and transparency, and the structure of the partnership board had changed to address this. We heard how the terms of reference and makeup of the boards were agreed recently and the partnership board had published a safeguarding partnership board strategy in April 2024. There were strategic priorities in areas such as domestic violence, early intervention, sexual abuse, and governance. Task and finish groups had been set up in areas such as self-neglect, early intervention, and adult exploitation. We heard how this had led to new tools and systems being implemented, such as the development of a self-neglect toolkit for staff. These groups were still at an early stage and would take time to become fully embedded and influence practice across the partnership. Despite this being new, we heard positive feedback from partners and staff who told us the good joint working around in place prior to the new makeup of the board and been strengthened by the changes.

There were systems in place to provide external scrutiny to the safeguarding partnership board. The partnership board was co-chaired by the Director of Adult Social Services and the Director of Children's Services. The local authority had identified the need for scrutiny in the absence of an independent chair so had commissioned an organisation to provide quality assurance and scrutiny of the board and their work. Staff and leaders spoke positively about this, and we heard from leaders there were plans to recruit to a role to provide governance support to the board to provide better access to data and information for the scrutiny company.

The local authority told us they were particularly proud of the Adult Social Care Survey (ASCS) safeguarding data which showed 92.13% of people who use services said those services had made them feel safe. This was significantly higher than the England average of 87.12%. In the SACE 80.65% of carers said they felt safe which was in line with the England average of 80.93%.

Responding to local safeguarding risks and issues

There had not been any recent safeguarding adult reviews (SARs), but partners, staff and leaders described how learning was shared from SARs in neighbouring local authority areas and integrated care systems (ICSs). We saw examples of learning being shared in areas such as bed rails, restraint, and self-neglect, where there had been learning or themes identified. Staff and leaders told us learning from safeguarding enquiries which did not meet the threshold for SARs were shared with staff to improve operational practice. These 'learning briefs' were signed off by senior leaders before being shared with staff through staff forums and reflective supervisions. Learning was also shared from external partners including other local authorities, health partners, and related forums.

Partners described how the partnership board was a good forum for sharing learning and best practice on themes which had come up locally and regionally. We saw evidence of work with health partners around ambulance referrals for safeguarding in response to high volumes of concerns. Staff told us about work undertaken to educate partners on safeguarding, and a process to conduct welfare checks where a referral was made that did not meet the threshold for safeguarding enquiries but could mean a person required support to keep themselves safe.

The local authority recognised a need to be proactive in identifying and disseminating learning from SARs and had introduced a rapid review process. This was a newly structured, multi-agency decision-making process, for deciding when a case had reached the threshold for a SAR. Staff and leaders told us the rapid review process was set up to provide a more structured, clearer joint working process with partner agencies & to give health partners a clear information governance process. This had improved information sharing and supported clear decision making when reviewing SAR thresholds.

The partnership board looked at data and themes across the patch and monitored for any risks for particular groups or minority communities. Staff and leaders told us about emerging themes from seldom heard groups included forced marriages, incidents of financial abuse, and self-neglect risks for people living with mental health issues and autistic people. The safeguarding partnership board were working with partners to raise awareness and provide toolkits for providers and other agencies to use when identifying concerns.

Responding to concerns and undertaking Section 42 enquiries

Staff and teams worked effectively with providers and partners to keep people safe and there had been recent improvements to performance following introduction of the safeguarding hub. However, local authority data showed performance was not yet where they wanted it to be.

The safeguarding hub provided a central point for all safeguarding referrals. The team reviewed referrals and spoke to the public, providers, and partners to gather information and decide whether to proceed to an enquiry under section 42 of the Care Act 2014. Section 42 relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect.

The local authority took immediate action where necessary to refer to other agencies, such as the police, or to put measures in place to ensure people were kept safe. Providers spoke positively about the safeguarding hub, saying they always had a prompt response and were able to receive feedback or advice in response to concerns raised. Staff and leaders said the hub provided consistency in section 42 decisions and data showed they had reduced the time taken to allocate safeguarding.

Section 42 enquiries were allocated to the community teams if the person was already known to them. The waiting lists for allocations were minimal, with data showing there was usually only 1 or 2 cases awaiting allocation at any given time. Staff said waiting lists for safeguarding case allocation were lower than they had been previously but did say at times there could be delays in allocating cases to the community teams. Staff told us the introduction of the safeguarding hub had helped with caseloads, as well as allocation and consistency in decision-making.

Local authority data showed 69% of enquiries were completed within the local authority's expected timescales in July to December 2023 after the hub was set up, compared to 45.9% in the period January to June 2023 under the previous system. This data and staff feedback about waiting lists showed an improvement but also demonstrated further work will be required to embed the new system and improve safeguarding performance further.

Staff and leaders told us safeguarding processes were quality assured through audits of practice and reviews of enquiries every two months. Managers of individual teams were responsible for authorising case outcomes before going to senior leaders for scrutiny and oversight. Learning from enquiries, including themes and trends were then shared with staff via learning focus newsletters, training, and workshops.

The local authority had identified a need to improve waiting times for review of deprivation of liberty safeguards (DoLS) applications. Staff told us there were 397 cases awaiting allocation at the time of the assessment, which was a reduction from up to 800 cases. Staff and leaders described how they prioritised cases so they were triaged, and urgent cases could be assessed quickly.

The local authority told us staff retention was impacting on DoLS waiting lists and all the best interest assessors who reviewed these applications were recruited by an external company. Staff and leaders said the plans to move Care Act functions in-house were intended to improve recruitment and retention of staff, which would improve waiting lists, as well as to improve consistency and oversight around DoLS. We heard from staff, providers and partners about effective communication and support for providers around DoLS.

Making safeguarding personal

The local authority had identified a need to be more proactive and structured in seeking feedback from people to implement 'making safeguarding personal' (MSP). They had introduced systems to routinely ask the person raising the concern about what was important to them, but shortfalls in staffing of Best Interest Assessors and some limitations on the use of advocacy meant there was a risk people would not always be properly informed about their human rights and their rights under the Mental Capacity Act 2005.

There were sometimes barriers to accessing advocacy. The availability of advocacy support could be limited, and staff described how it was prioritised for higher-risk cases. This meant there was a risk people may not have their voices heard in cases which were not deemed to be higher-risk because they did not have the same access to advocacy services.