Safeguarding

Indicative score:

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

Birmingham was in line with national averages regarding the percentage of carers and people using services who felt safe, and regarding the percentage of people who said the services they used had made them feel safe and secure.

The Adult Social Care vision for Birmingham spoke of a focus on “making safeguarding personal” and that delivery of this strategy required partnership working as standard, as well as an effective safeguarding team with high quality intelligence about safeguarding issues.

According to the Safeguarding Adults Board, in 2021/22, 62.7% of people felt their enquiry had fully achieved what they wanted, 29.1% partially achieved and 8.2% not achieved.

Referrals to the safeguarding team had increased over time, while the average days from concern to decision making was 48 days and to complete an enquiry was 85 days. This meant there had been a build-up of work, without an equal increase in staff capacity, or throughput of referrals.

There was a high number of unallocated Section 42 enquiries that had been triaged and met the threshold for an investigation under Section 42 of the Care Act. In September 2023, almost 250 of these had been waiting between 5 and 6 months.

An earlier improvement plan to work through a large backlog of safeguarding concerns, resulted in the backlog moving from untriaged, to awaiting investigation. For a period, the plan to reduce the backlog led to staff having high caseloads and was not sustainable. It also meant that pressure to progress work risked the quality of work undertaken. We heard feedback from some staff about difficulties in raising concerns about quality or workload, but other staff found management supportive. Changes had subsequently been made to the way this work was being managed to reduce this risk.

Senior leaders told us that they were aware their safeguarding performance was on “an improvement journey” with an ongoing plan to add capacity to the safeguarding team, to address the flow of work. This included a plan in place to eliminate the backlog of Section 42 enquiries by December 2023. Evidence provided by the local authority since the assessment has shown the impact of this plan, bringing forward the expected date of eliminating the backlog of enquiries to November 2023.

The backlog, albeit reducing, presented a risk to people, which needed to be managed.

Senior leaders told us that enquiries held in the queue are reviewed regularly, closely monitored to maintain oversight of prioritisation, and to ensure that where someone was at imminent risk of harm this was allocated for investigation immediately.

The local authority had produced a suite of guidance to inform decision making in different circumstances, a robust governance framework and a corporate safeguarding network with dedicated safeguarding leads from each directorate. This met monthly to share information and support effective safeguarding of children and adults across the local authority. Senior staff were monitoring progress to improving performance and had developed a Safeguarding Improvement Next Steps plan for 2023/24.

There were now robust management processes in place to review caseload management with each team and an individual on an ongoing basis. This management incorporated both the timely completion of cases, and an oversight of the quality of both the assessment and record keeping.

Under Part 1 of the Care Act, the local authority had powers to delegate the investigation of a Section 42 Safeguarding enquiry, to determine what action should be taken and by whom. Senior leaders told us that they had oversight of such delegated investigations, but providers and other partners told us that oversight was inconsistent.

Some providers told us that they found it difficult to work with the safeguarding team, who rejected many concerns that the provider had submitted as not meeting the threshold for a safeguarding enquiry. Ongoing communication was needed so that providers were clear about the threshold for safeguarding referrals. On occasions where referrals were progressed, providers told us they were not always informed of the outcome.

The local authority received 10% more Deprivation of Liberty Safeguards (DoLS) applications than the national average per 100,000 and had processed approximately 9% more than the national average. To mitigate this risk of the backlog of applications awaiting approval, the local authority has used a prioritisation tool, which has indicated that 642 are high priority and of these, 490 had been waiting more than 90 days. This level of backlog was a risk to the rights and protections of those who were being deprived unlawfully pending the authorisation of their DoLS assessment.

The local authority had set clear targets to manage ongoing work and plans were in place to reduce the backlog by adding additional capacity and proportionate methods.