

Safeguarding Overview and Scrutiny Committee – 15 February 2024

Early Response in Adult Safeguarding

Recommendation

I recommend that the Committee:

- a. Notes the latest position of early adult safeguarding response in Staffordshire.

Local Member Interest:

NA

Report of Councillor Julia Jessel, Cabinet Member for Health & Care

Summary

What is the Overview and Scrutiny Committee being asked to do and why?

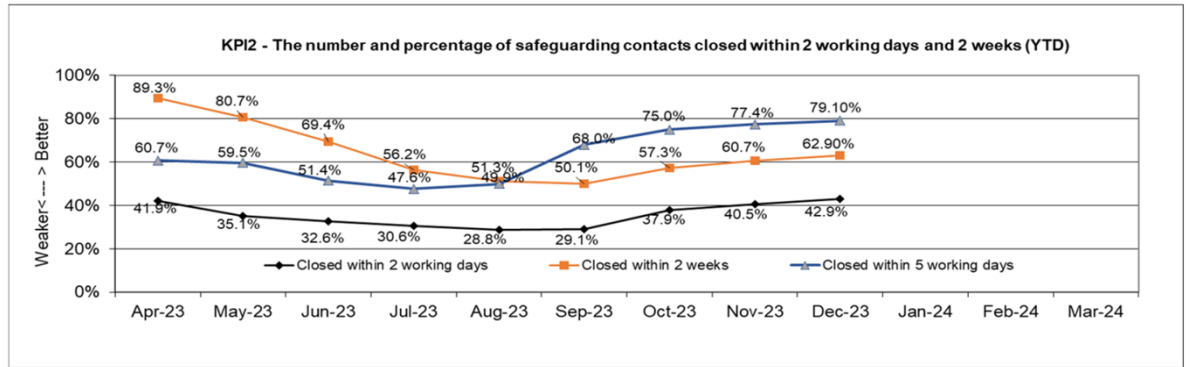
1. Consider the early response given to adult safeguarding concerns and steps being taken to reduce delays and unnecessary referrals.

Report

Background

2. Previously the committee has received updates as to the safeguarding transformation project. The transformation was completed last year, and this report is to highlight the wider work to ensure an early response to safeguarding matters and the actions being taken to reduce risks and ensure that concerns have the right response at the earliest opportunity.
3. Since the close of the transformation project the response from Staffordshire Adult Safeguarding Team (SAST) has improved significantly, meaning that safeguarding concerns are being responded to in a timelier way. In August 2023 safeguarding concerns closed within 5 working days was at 49.9% rising to 79.10% in December 2023 as shown below.

Figure 1a



- The number of concerns waiting has also decreased from approximately **800 in August 2023** to **154 at the start of January 2024**.
- This improvement has enabled wider work within the safeguarding arena to be completed so as to respond more effectively to initial concerns and to work with other agencies to ensure that appropriate concerns are referred into safeguarding.

Work with Providers

- It is acknowledged that most safeguarding concerns are raised by and in relation to provider services, e.g. domiciliary care providers and care homes (up to 48% of all concerns). It is also understood that a high proportion of these concerns are closed at initial decision making as they do not meet the requirement for a safeguarding enquiry.
- In reviewing these concerns it has been established that there are a number that need not to have been referred, usually they are one off isolated incidents, such as medication errors and falls. On speaking with providers, they expressed that they refer in as they feel that they may otherwise be criticised by CQC or our own quality teams.
- We have therefore completed some joint work with Staffordshire County Council quality team in producing several flow charts and fact sheets regarding, including falls and medication errors that have been added to the MIDOS platform and that providers can use to evidence their decision making to CQC.
- Further to this we are completing provider engagement and training sessions to raise awareness of this guidance. To date we have completed 3 sessions with approximately 90 providers having attended. We have further sessions planned and will be using the feedback from the sessions completed to develop the sessions further.

Work with social work teams

10. Social care practitioners will identify low level safeguarding concerns when completing assessment, review and other activities, often these can be dealt with immediately, however it was apparent that practice had developed where social work teams would refer in to SAST as opposed to dealing with the matter.
11. We have developed a process so that low level isolated safeguarding concerns identified by the social work teams are swiftly dealt with through immediate action and where there is no ongoing risk team managers record this directly into the system and close with no ongoing risk. This reduces delay in responding to the risk and also unnecessary bureaucratic processes.
12. Safeguarding training to teams has been refreshed and relaunched, this also covers early response and ensuring in line with the quality assurance framework.

Quality Assurance Framework

13. We have developed a quality assurance framework that sets out the expectations of Staffordshire County Council, social work teams, partner agencies and provider services. This highlights what a good enquiry looks like, the quality standards expected and the audit and assurance process. This will be 'going live' in March 2024 and will be shared with the adult safeguarding board and will be available to providers on the MIDOS platform. We will also share this wider with partners such as West Midlands Ambulance Service and Staffordshire Police.

Upcoming changes

14. Following changes at SAST and also in line with best practice we are in the process of introducing redesigned safeguarding forms to both assist with more accurate data recording but also to ensure enquiries are completed proportionately and in line with the quality assurance framework. These will be going live by March and we have training sessions planned with teams prior to this date.
15. Further to this we have an online portal being developed starting with providers, where they will be able to refer concerns into Staffordshire County Council. By using certain questions their concerns will be directed to the right process, e.g. request for assessment, quality assurance alert or safeguarding. These referrals will still be checked by relevant professionals, however any unnecessary delay will hopefully be mitigated.

16. We are also considering a new MASH arrangement, where we will remain co-located with Staffordshire Children and Families Services but will have separate Police arrangements. This will mean a dedicated and specialist adult safeguarding service from Staffordshire police enabling us to work more effectively to assess risk and respond to adult safeguarding concerns. We will keep the links that we have developed with children's teams and will continue to share the same information sharing system (ISL) and maintain links between the two services.

Link to Strategic Plan

17. Encourage good health wellbeing, resilience and independence

Community Impact

18. NA

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