social care
institute for excellence

Learning from safeguarding audits and reviews to increase system capacity

Themes and trends from safeguarding audits

Department of Health & Social Care

Suzanne Cottrell - Safeguarding Audits Manager
Lauren Westerman – Safeguarding Principal Auditor

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Aims and Objectives

The DHSC have funded us to work with organisations sharing our learning and safeguarding best practice to support delivery:

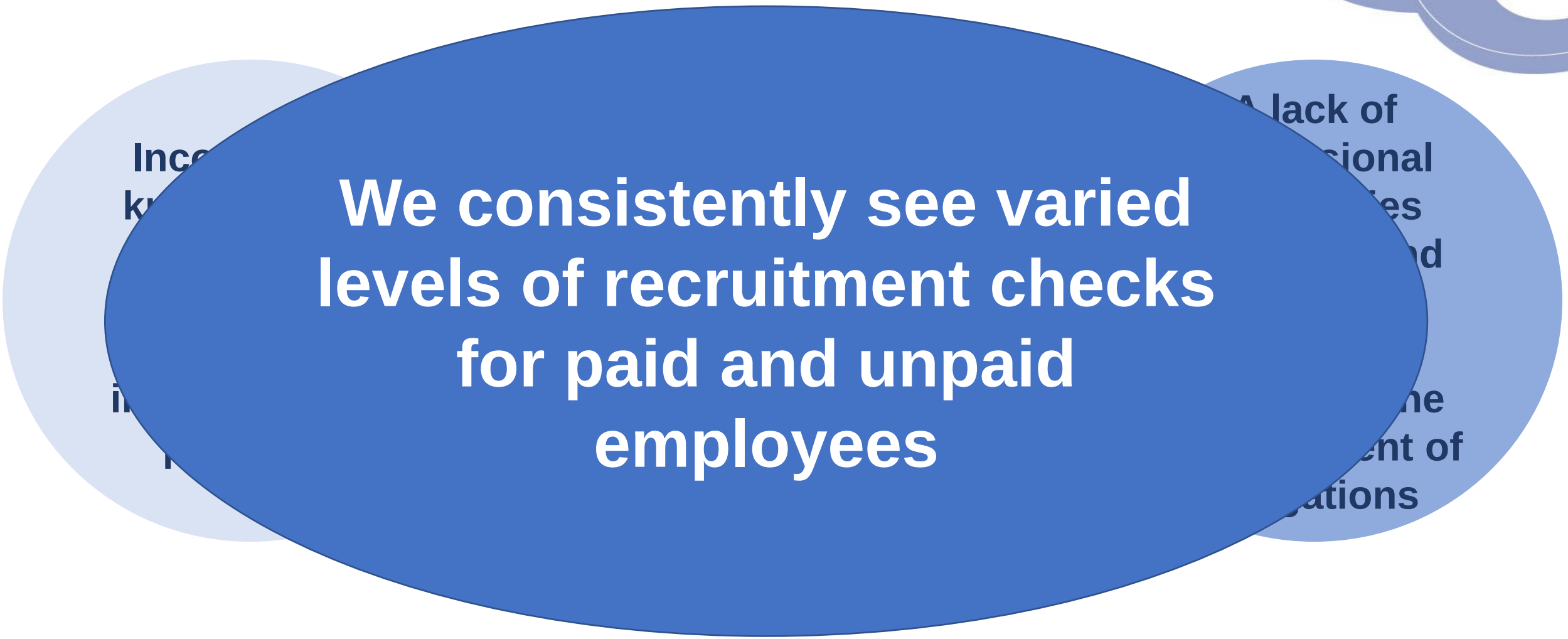
- Consider areas of key safeguarding risk/potentially problematic areas and relate them to their own organisation or sector
- Appreciate the importance of effective safeguarding governance between front line practitioners and recipients of services to senior leaders; and how this can improve safeguarding delivery
- Discuss how culture, leadership and robust systems can enable or inhibit effective safeguarding implementation.
- Understand the interface between key functions across the organisation and its impact upon safeguarding systems.
- How '*the golden thread of safeguarding*' can be supported via effective communication and messaging from senior leaders.

Our methodology

- Our audits cover safeguarding across ***children, young people and adults***
- 2 auditors work with your organisation
- We distinguish between ***unique localised challenges*** in sections of the organisation and ***underlying issues that impact*** across the organisation
- We follow the line of sight of safeguarding through from front line staff to the Trustees and/or Board, looking for the ***'golden thread'*** of safeguarding governance
- **We inform you for a journey of cultural change** wider than what is needed, it is thinking about why it isn't happening despite great policies and procedures – ***'Culture eats strategy for breakfast'*** **– Peter Drucker**
- **We minimise hindsight bias** in understanding decisions, acts or omissions
- **We move beyond findings to think about the wider system** through descriptive and analytic thinking in the writing of the report

"The systems approach explicitly focuses on a deeper understanding of why professionals have acted in the way they have, so that any resulted changes are grounded in practice realities"
Professor Eileen Munro, Review of Child Protection

Safer Recruitment



Induction, Training and Supervision

Overreliance on the knowledge of staff from previous safeguarding training

E-Learning was often found to lack the context and benefits of interactive training

Supervision is occurring but lacks the dedicated time to discuss and reflect on safeguarding practice

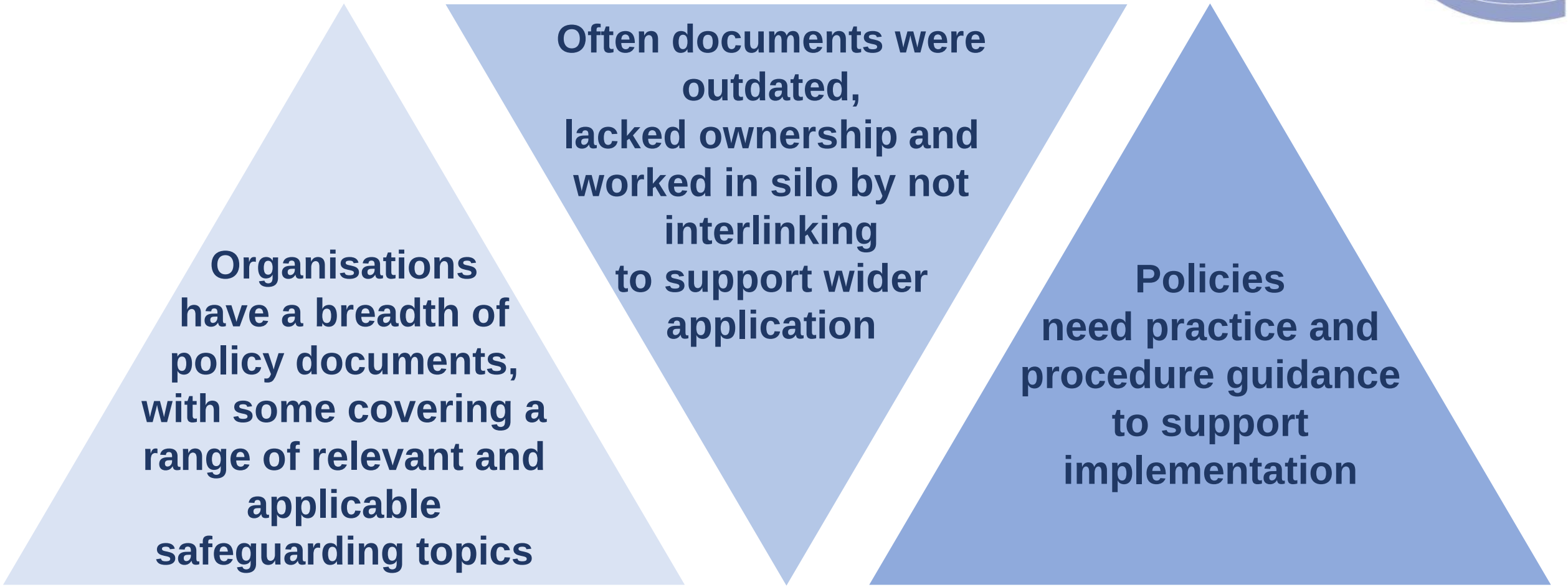
Safer Working Practices/Activities

Most people were keen to do safeguarding well but a lack of training, policies and procedures that were poorly communicated and/or did not work well together, alongside a lack of it being championed from the very top sometimes impacted upon this.

Many safeguarding touch points were not known by those other than front line practitioners, resulting in missed opportunities to mitigate them.

It was often difficult to see how the voice of those receiving services were included in shaping them and how they would feel safe. It was also found that there were poor escalation procedures and limitations of safeguarding services in out of hours provision.

Policies, Procedures and Guidance



Casework

Development needed to support knowledge of recognising, responding, reporting and referring

Internal safeguarding thresholds resulting in being risk averse or holding risk which is felt to be that of a statutory service

Poor legal literacy in areas such as the Mental Capacity Act and Data Protection and information sharing

Significant gaps in record keeping and record management

Complaints and Whistleblowing

Policies and procedures lack stages and time frames. They provided little guidance on ongoing communications with those raising concerns nor possible limitations on providing feedback of actions taken

Organisations often have a whistleblowing policy, but limited or inadequate complaints policy and it was rare that trends was extrapolated from either

Many staff and service users described raising complaints or whistleblowing but felt nothing had been done in response, or felt as they'd received no feedback this discouraged them from reporting again

Strategic and Operational Leadership and Management

It was found that strategic oversight of safeguarding required significant development and the board lacked safeguarding knowledge or data to make informed decisions regarding safeguarding

The safeguarding line of sight from trustees through to service users was frequently unclear and across services work and learning was siloed

It was unclear who had named safeguarding roles, resulting in an overreliance on operational staff and Safeguarding Leads

Designated Safeguarding Lead (DSL)

The DSL role is well liked and appreciated by frontline staff

DSLs were cited having both an operational and strategic role

DSLs often lacked the training and capacity to fully fulfil their role

Quality Assurance

Safeguarding data from case work and wider themes and trends are often not collated

Quality assurance processes and systems in place often do not dedicate time to safeguarding and is often missing from the risk register

Serious incident investigations are lacking a systems approach, impacting the ability to use the findings to inform wider learning

Governance

Information governance was an area requiring significant development in many organisations

Safeguarding risks were frequently not given the same priority in terms of their identification and mitigation as other risk areas such as health and safety, financial, reputational and EDI

The audits found that in the vast majority of cases it was difficult to see how any operational or strategic decision making was informed by the collection and sharing of quantitative and qualitative information

Culture

Safeguarding was described as a priority, but this often conflicted with what was seen in practice

There is a cultural theme of organisations either holding unnecessary risk, being risk averse or being unaware of their safeguarding vulnerabilities

It was often felt that safeguarding sits at an operational level and is not owned or embedded at a strategic level

We want to hear from you….

1. How often do you collate safeguarding information from your front-line practitioners?

2. How is your safeguarding strategy informed by frontline practitioners?

3. How are you collating feedback from your recipients of services on if they feel safe and what makes them feel safe?

4. How are you sharing learning on safeguarding across your service areas?

Thank you!

SCIE Team
Suzanne Cottrell and Lauren Westerman

Department of Health & Social Care

[Safeguarding consultancy, reviews and audits | SCIE]

Suzanne.Cottrell@scie.org.uk
Lauren.Westerman@scie.org.uk