Safeguarding

Score: 3

3 - Evidence shows a good standard

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

There were effective systems, processes, practices to make sure people were protected from abuse and neglect. These included person-centred assessment and care planning with people, effective quality assurance and support of registered care providers, whether commissioned by the local authority or not, and robust safeguarding arrangements. Some partners however, said there could be more information around who to contact in the local authority when they have issues or wanted to support people, including for safeguarding.

The local authority had a Safeguarding Adults Board and worked with partners to deliver a co-ordinated approach to safeguarding adults in the area. In addition to the Board, there was a strong multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place so concerns could be raised quickly and investigated without delay. The Board had a clear business plan and produced an annual report.

The Safeguarding Adults Board Chair was from one of the organisations who were represented. This was a rotating position, with the expressed intention it increased commitment to the Board. This arrangement had been approved by the Department of Health and was found to be effective in practice. There was an independent scrutineer who reviewed how well the board was performing. The Safeguarding Board also undertook an audit to determine how well it was functioning. The Chair had received positive feedback the Board had an open and transparent culture.

National data from the ASCS (Oct 2023) showed people who used services in Hillingdon reported similar levels of safety to the England average. 68.79% of people who used services felt safe, and 88.30% of people who use services who said those services made them feel safe. National data relating to carers SACE (Jun 2024) was less positive, showing only 73.21% of carers who felt safe which was lower than the England average of 80.93%.

Staff in the local authority told us they were trained to level 3, which meant they were suitably skilled and supported to undertake safeguarding duties effectively. They received ongoing training, supervision and learning. The national ASC-WE data (Oct 2023) showed 30.79 % of independent or local authority staff had completed MCA DoLS training and 44.15% of independent or local authority staff had completed safeguarding adults training which were both similar to the England average.

Responding to local safeguarding risks and issues

The local authority had a clear understanding of the safeguarding risks and issues in the area. They told us they worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. Senior leaders said that meetings took place between the police, health partners and the local authority to discuss wider issues, which were fed down through organisations, allowing a proactive approach as information was shared earlier.

Staff had a good understanding of the prevalent risks in their local community and spoke of forced marriage, cuckooing, county lines as well as risks associated with hoarding and self-neglect. Staff told us the Safeguarding Board partnered with the NWLA, and resources such as 7-minute briefings, were shared. These briefings contained key information and knowledge derived from recent trends identified in the borough or from case reviews. Bespoke training sessions were occasionally organised, focusing on topics such as honour-based violence, forced marriage, and female genital mutilation (FGM). A partner organisation who was represented on the Safeguarding Partnership Board, supported the local authority in the preparation of a support document on hoarding.

The Safeguarding Adults Board had an infrastructure with representation from all key partners, to ensure lessons were learnt when people had experienced serious abuse or neglect and action was taken, to reduce future risks and drive best practice. There was a Safeguarding Adults Review (SAR) Panel, which looked at cases which had resulted in serious harm or death of a person with care and support needs. The 'Learning from Practice' task and finish group considered these, with the outcomes of a range of other reviews, research and any other significant information. This group reported to a quarterly Learning Development Forum which led on the planning, delivery and quality assurance of training and service development across the Hillingdon Safeguarding Partnership.

Following the 2 SARs in 2022/23, recommendations and action plans to improve practice were developed. These included mental capacity assessment in the context of self-neglect, the importance of professional curiosity, appropriate challenge when what is seen does not match what is said and avoiding "diagnostic overshadowing" whereby practitioners wrongly assume symptoms of physical illness are instead a symptom of mental illness or learning disability. Several resources were developed by the Safeguarding Board to support learning. An audit was used to assess what had supported learning most effectively, and whether practitioners had retained what they learned. The audit however concluded there was little assurance learning from recent SAR's had been embedded into policy, procedure or training among agencies including the local authority. The Safeguarding Adults Board had measures in their Business Plan for 2024-27 which sought to address this concern.

Responding to concerns and undertaking Section 42 enquiries

According to national data in the Safeguarding Adults Collection (SAC) (Sept 2023) 588 enquiries in Hillingdon met the Section 42 (s42) threshold over time (based on 2017-2022) but this average was based on annual figures from 245 in 2017 to 900 in 2020. Figures were significantly higher during the COVID 19 pandemic and have since dropped back to approximately 500 per year. In 2023- 24, 20.5% of 2810 referrals met the threshold for investigations under s42.

The local authority and other system partners were clear about what constituted s42 safeguarding concern and when s42 safeguarding enquiries under the Care Act were required, and this was applied consistently. There was a clear rationale and outcome from initial enquiries, including those which did not progress to a s42 enquiry. A s42 enquiry is the action taken by a local authority in response to a concern a person with care and support needs may be at risk of or experiencing abuse or neglect.

There were multiple channels through which members of the public or professionals could pass on information or raise safeguarding concerns. Some providers told us there had been issues raising safeguarding alerts, which noticeably improved when escalated to senior staff in the local authority. All safeguarding concerns or referrals were passed to the Multi Agency Safeguarding Hub (MASH) service.

The local authority said there were no safeguarding concerns awaiting initial review as all cases were allocated within 24 hours. The MASH service responded to all enquiries and completed initial enquiries within 24 to 72 hours to establish crucial facts of the concern. They used this to determine the level of safeguarding response required by the local authority or partner organisations. They reviewed whether there was a protection plan in place to keep people safe and reduce future risks, and whether it was adequate. If not, they would take action to ensure the person was safe pending any further investigations. A leader told us that any enquiries which took longer than 50 days were explored, and support provided where necessary to bring to a timely conclusion.

There was no waiting list for s42 enquiries. If a s42 enquiry was necessary, the case went to a MASH s42 officer for review and then to the correct locality or specialist team for the s42 investigation. If there were mental health concerns, a referral would also be made for relevant support. Managers from the MASH team signed off every decision which was made. The MASH team oversaw s42 enquiries, audited them before they were concluded and provided feedback to locality teams. There was a consistency of decision making, and quality assurance through management support, audits and formal supervision. The MASH team told us they tracked concerns and enquiries through monthly meetings, reviewing data outcomes as well as case notes and could view trends.

Safeguarding enquiries were not usually conducted by care providers in Hillingdon but were occasionally delegated to a hospital provider. The local authority retained responsibility for enquiries and the outcome for the person(s) concerned. All enquiries were quality assured by the MASH team, before they were concluded. At the end of each s42 enquiry, the person would receive a closure letter and every person at risk had a conversation with MASH team members. The local authority's information system provided an infrastructure which kept the process open and in the correct stages which could not be signed off until all steps were taken.

Some partners told us they didn't always get feedback following a safeguarding referral, but others noted they attended a safeguarding multi agency risk panel and there was inclusion from VCS organisations into these meetings. They said the relationship with safeguarding was good and they generally received feedback/outcomes from safeguarding referrals, although some noted they might have to chase these.

Deprivation of Liberty Safeguards (DoLS) are when people in care homes and hospitals are deprived of their liberty in a safe and correct way, to receive care and treatment. This is legally authorised under the Mental Capacity Act 2005 and is only done in the person's best interests and when there is no other way to look after them. The local authority provided data which showed they had no waiting lists for Deprivation of Liberty Safeguards for people in residential care. Once identified, cases are allocated for assessment within 5 to 7 working days and sooner where there is an urgent need to complete. Most people whose DoLS authorisations were ending were also reviewed and renewed in a timely manner.

By contrast the local authority had some delays in administering DoL for people living in the community, for example in supported living, where the degree of supervision and living arrangements amounted to a deprivation of liberty. By the end of February 2024 there had been an increase in the numbers of people requiring a Community DoL overall to 302. The local authority told us they have identified distinct workers to focus on Community DoL applications to improve the number being completed and reduce the backlog. Further solutions were being considered to fully resolve the challenges.

Making safeguarding personal

The Safeguarding Board took seriously the importance of Making Safeguarding Personal and undertook a yearlong project to seek the views of people who had been involved with safeguarding, as an adult or a child. As a result, they had produced a video webinar and briefings to educate professionals about what people said was important to experiencing safeguarding in a more personal way. These included good listening, tailoring communication, clarity about the process and relationship and rapport building. Some people were sharing this feedback to address poorer safeguarding experiences in recent years.

Staff told us they were committed to making safeguarding personal and prioritised implementing the least restrictive measures. They facilitated safeguarding meetings in places suitable to the person and where they felt safe, such as local libraries, and routinely asked for the individual to share their desired outcomes from the protection plan. Enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. Once a referral was passed to a team for the s42 enquiry, they developed a strategy within five days, and created a plan for the enquiry officer to follow up on specific actions. They engaged with the adult at risk to obtain consent and progressed to a case conference if necessary. They adhered to established timeframes, with safeguarding processes aimed to be concluded within 50 days.

Most people had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they didn't feel safe, or they had concerns about the safety of other people. We spoke with one family who confirmed this. They were confident they would receive feedback from any safeguarding concern they raised.

People could participate in the safeguarding process as much as they wanted to, and people could get support from an advocate if they wished to do so. National data from the Safeguarding Adults Collection (SAC Sept 2023) showed 96.15% of individuals in Hillingdon who lacked capacity were supported by advocate, family or friend (SAC) which was significantly above the England average of 83.12%.

People were supported to understand their rights, including their human rights and those under the Mental Capacity Act 2005, and the Equality Act 2010, and they were supported to make choices which balanced risks with positive choice and control in their lives. Staff told us if a person lacked capacity, they used advocacy services and might also request an Independent Mental Capacity Advocate (IMCA), particularly if considering changes to a service user's accommodation. We heard staff had a good response from the service providing advocacy in the borough, but it could sometimes take a while for an advocate to be allocated to a case, particularly to access advocates for section 42 safeguarding investigations. This had an impact on the timeliness of completing investigations. Staff told us monthly meetings were held with advocacy providers to discuss capacity and understand any barriers to progression of a case.
