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 were built into the end-to-end processes of assessing need, commissioning care, and dealing with episodes where people had faced abuse or neglect. This was reflected in the national data from the Adult Social Care Survey (published October 2022) which showed that 72.69% of people who use services who feel safe and 90.31% of people who use services who say that those services have made them feel safe. According to the Survey of Adult Carers 74.23% carers felt safe.

Operational teams across the adult social care Service manage the end-to-end process of the majority of safeguarding enquiries, including triage. There was a dedicated Safeguarding team, who provided advice and to manage more complex enquiries. They also supported operational teams and organisations who were dealing with other safeguarding issues by producing detailed guidance and organisations, and auditing Safeguarding Enquiries. One provider told us their service was involved in some Safeguarding Plans, they had open channels of communication with the Children's and Adults Safeguarding teams and were very positive about working relationships. Some partners reported they considered the Safeguarding team to be fast responding and open with how they work, including information sharing.

There was independent oversight and auditing of safeguarding activity on a quarterly basis as part of wider quality assurance work. Outcomes of audits are sent to managers and practitioners, who are provided with the opportunity to check and challenge. An action plan was included for areas requiring improvement. The audit tool was aligned to the Internal Audit Framework. This allowed for consistency in relation to judgement and understanding risk.

The Safeguarding team attended Multi Agency Risk Assessment Conference (MARAC) meetings on a daily and monthly basis. This ensured actions happened quickly to manage risk in relation to domestic abuse. The daily meeting comprised of a small group of stakeholders. The monthly meeting had a wider membership and dealt with cases which need more detailed input.

There was a strong multi-agency Safeguarding Partnership, with the roles and responsibilities for identifying and responding to concerns clearly defined. Information sharing arrangements were in place so concerns could be raised quickly and investigated without delay. The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area.

The Executive Director of Children's and Adults Services currently chaired both Adult's and Children's Safeguarding Boards. We noted and they acknowledged the importance of an independent voice to ensure safeguarding was managed effectively and robustly. In recognition of this Hounslow had recently commissioned an external review of the Hounslow Safeguarding Adults Board from an independent consultancy. As this review has not yet occurred, and details of its scope have not been shared, the outcome of this is not yet known. We were advised this was an interim position, pending consideration of whether the Independent Reviewer role being trialled in the Children's Safeguarding Board was effective. The board's Business Plan sought to hold members of the board to account and role definitions and expectations for members were clearly set. There was also an annual challenge event to hold partners to account. These contributed to ensuring that all parties worked together to deliver effective adult safeguarding.

Hounslow had also commissioned Healthwatch to set up a Service User Forum in relation to safeguarding. The aim of this group was to "Ensure that feedback can align and feed into the quality assurance reporting schedule". This was a positive approach to ensuring the voice of people who had lived experience of being affected by safeguarding and the local authority systems which respond to them, was incorporated into assurance and accountability, for the delivery of Hounslow's Section 42 obligations of the Care Act. We were told the group had made some recommendations which had been delivered to the Safeguarding Adults' Board, specifically about public awareness and the timeliness of enquiries.

Fewer staff involved in safeguarding work had completed specialist training to undertake safeguarding duties effectively than was the England average. Hounslow data from Skills for Care Workforce Estimates (October 2023) were 25.00% of independent/LA staff completed MCA DoLS training and 31.58% of independent/LA staff completed Safeguarding Adults training. The risks of this were mitigated at least in part by the development and implementation of "how to" guides from the more experienced and skilled specialist safeguarding team.

Responding to local safeguarding risks and issues

There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring.

In February 2022, an advocate commissioned by Hounslow local authority to work specifically with adult victims, collaborated with Barnardos, Kalayaan, Unseen, The Human Trafficking Foundation, SFIDA and the Metropolitan Police Modern Slavery Team to highlight the issue of Modern Slavery. They created a series of webinars on human trafficking, domestic servitude, labour exploitation, criminal exploitation, child exploitation & sexual exploitation. Since 2022, this advocate has received 11 referrals.

Hounslow told us learning on safeguarding had been prioritised through peer reviews, external challenge, and external and internal case file evaluations. They worked with partners to learn from Safeguarding Adult Reviews, Domestic Homicide Reviews and Learning Disability Mortality Reviews. For example, learning from one Safeguarding Adult Review was used to establish a Complex Cases Group, which is now in place. Another example was learning from a Domestic Homicide Review led to a wider Domestic Abuse Commission in Adult Social Care which has resulted in raised awareness amongst social workers and practitioners. Staff received 7-minute briefings to learn from Safeguarding Adult Reviews, which were also shared at the Provider Forums.

Responding to concerns and undertaking Section 42 enquiries

A Section 42 enquiry is a legal requirement under the Care Act 2014 for local authorities to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. There was clear guidance on what constituted a Section 42 (S42) Safeguarding Concern and when Section 42 Safeguarding Enquiries were required, and this was applied consistently. There were clear rationales and outcomes from initial enquiries, including those which did not progress to a Section 42 enquiry.

According to the Safeguarding Adults Collection (published August 2022) the number of enquiries meeting the S42 safeguarding adults' threshold in Hounslow has declined over time. This was reflected in Hounslow's own data which showed a total of 684 concerns were raised in 2022-23 of which 362 progressed to an enquiry. This meant 53% converted from a concern to a S42 enquiry. The number of concerns resulting in enquiries being made has decreased annually over the last 3 years.

Most safeguarding concerns were triaged in a timely manner. Hounslow provided a data snapshot which showed that 10 safeguarding concerns awaited initial review. There was 1 Section 42 enquiry awaiting allocation, and 107 in progress.

There were clear standards and quality assurance arrangements in place for conducting Section 42 enquiries. When safeguarding enquiries were conducted by another agency, for example, a care or health provider, the local authority retained responsibility for the enquiries and the outcome for the person(s) concerned. These enquiries were overseen by the specialist Safeguarding team, who provided advice and conduct audits of provider investigations.

Hounslow had a small team managing Deprivation of Liberty Safeguarding (DoLS) applications. The team told us they processed almost 700 per year and had strong working relationships with the Locality teams. There were 105 DoLS applications awaiting authorisation or review, the oldest of which was received in July 2023. Of these, 34 were urgent, the oldest of which had been received in September 2023. There was a risk to those people awaiting decisions to be made about deprivations of liberty, but the authority had prioritised those in residential or hospital settings where the highest risk of closed cultures was and had no backlog in those service types. Senior leaders told us they were looking at ways to increase the number of trained Best Interest Assessors in their workforce to improve assessment times.

Hounslow's own data indicated the proportion of DoLs applications completed in 21 days was 29% in 2022-23, compared to a London average of 24% for 2021-22. All referrals were screened, and assessments started as soon as they were received but completion was not as timely as they would like. Frontline staff told us there were sometimes delays in progressing DoLS applications due to external circumstances, such as delays in the court process or in securing an independent mental capacity advocate (IMCA). IMCAs are a specific role to assist in the process where a person does not have a friend or relative with Power of Attorney to support in decision making. The latter would be escalated to commissioning if the existing provider could not provide an advocate in a timely manner, to identify another provider. They were working to make the same improvements in authorisation times for people in community settings.

A key partner spoke of great working relationships with DoLS team. They felt the DoLS team had good processes and systems to manage and maintain flow of applications and assessments.

Safeguarding plans and action plans to reduce future risks for individual people were in place and they were acted on. Some providers told us that they did not hear the outcomes of Safeguarding Enquiries in a timely manner or in some cases at all, but the Safeguarding team was confident relevant agencies were informed of the outcomes of Safeguarding Enquiries when it was necessary to the ongoing safety of the person concerned.

Making safeguarding personal

The Healthwatch Service User Safeguarding Forum had reported prolonged waiting times in relation to Section 42 enquiries being processed. The local authority told us they dealt with most enquiries in a timely manner but there was a short waiting list for some safeguarding investigations, particularly those for people with learning disabilities. These were kept under review until there was capacity to allocate them to someone appropriately skilled in working with a person with learning disabilities to investigate them in a person-centred manner. As an interim measure to ensure people are kept safe, and their individual risks managed pending investigations, protection plans are put in place.

Another reported finding from the Service User Safeguarding Forum was some people did not understand safeguarding or have the information they needed to understand what being safe means to them, how to raise concerns when they don't feel safe, or if they have concerns about the safety of other people. The Safeguarding Adults Board's own performance indicators showed they were receiving a low number of referrals from Black Asian and Minority Ethnic (BME) communities relative to population. This has led to the board prioritising action to increase awareness of safeguarding amongst these communities. Staff told us they had developed user-friendly guides to promote safeguarding awareness for Black Asian and Minority Ethnic communities, which are distributed via the ongoing Gazebo initiative. The Gazebo was an information roadshow taken out into the community.

Staff also noted CarePlace, the online information source, offered 300 different languages to translate details of services on offer, so people could access information in their own language. The Interpretation service operated more online or via telephone, as opposed to in person, which could be a barrier for some people. All safeguarding forms were translated, and they had translators attend meetings as required.

People could participate in the safeguarding process as much as they chose to, and people could get support from an advocate if they wished to do so. Staff told us, the main advocacy organisation commissioned by Hounslow, did not always have capacity to provide advocates upon request, but this had been highlighted and addressed by spot commissioning as required.

We were told the specialist Safeguarding team had reduced in size, and this had added pressure to existing workloads, however, there was recognition gaps in the workforce presented a risk to the local authority's ability to deliver its S42 obligations. There was a detailed risk-based approach to managing the people for whom Safeguarding concerns/ referrals were made. There was management accountability, ownership, and oversight of the management of risk. Safeguarding was an organisational priority and the Service Manager for Safeguarding and DoLS was able to escalate concerns to Senior Leadership and be given proper consideration.

Hounslow told us it identified an above average number of adults at risk lacking capacity (47% against a London average of 31%), and a higher rate of those people received support provided by an advocate, family, or friend (43% against a London average of 8%). The Safeguarding Adults Collection (SAC) found that 87.5% of individuals lacking capacity were supported by an advocate, family member or friend. A recent Quality Assurance audit found the need for Mental Capacity Assessments to take place earlier in the Care Act assessment process to ensure that people had the support they needed to participate fully. The local authority had commissioned external audits of mental capacity assessment work they conducted, as a key element of safeguarding vulnerable people. The tool used was aligned to the Internal Audit Framework. This allowed for consistency in relation to judgement and understanding risk.