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

National data was lower for Brent with 80.12% of people who use services who feel safe, compared to the England average of 87.12%, although this was much higher than the regional average which was 65.32 % (ASCS, 2023).

Staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively. Safeguarding training was in place for staff, providers and partners. Staff were required to complete mandatory safeguarding training, with social care providers and partners having access to safeguarding awareness training. Providers also received additional training where safeguarding referrals were not being received. Senior leaders told us they recognised the importance of training all staff, identifying challenges and streamlining processes to enable a smoother transition between different stages of the safeguarding process and develop a culture of continuous improvement.

National data shows 37.41% of independent/local authority staff completed Mental Capacity Act 2005 and DoLS (Deprivation of Liberty Safeguards) training, which was in line with the England average of 37.48% and higher than the regional average of 33.82%. In addition, 73.34% of independent/local authority staff completed safeguarding adults training which was significantly higher than both the England and regional averages of 48.81% and 48.20% respectively (Safeguarding Adults Collection, 2022, SAC).

There were effective systems, processes, practices to make sure people were protected from abuse and neglect. Concerns were received by contact centre staff who had received safeguarding training to support them to spot signs of abuse. These were then triaged for the safeguarding team to follow up. Staff told us the morale in the safeguarding team was positive, with a good learning culture although they were currently going through a period of transition from being a generic team to a duty team. Locum staff were supported to be an integral part of the team. Other teams worked in conjunction with the safeguarding team. For example, the transitions team held complex cases which included safeguarding enquiries until these were completed to ensure a smooth transfer into adult's services.

The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area. Leaders had a good oversight of any safeguarding issues to understand any changes or learning. Six monthly meetings were held with senior local authority leaders, the safeguarding board and cabinet members. The Principal Social Worker was responsible for strategic safeguarding, leading on practice and learning alongside OT leaders. They were part of the Safeguarding Adults Board and involved in serious case reviews. The approach for learning from Safeguarding Adults Reviews was still being embedded. Two cases had been reviewed so far and the learning shared with the team involved however new measures had been planned to ensure learning was shared more widely. For example, in staff quarterly meetings, newsletters and 7-minute briefings.

There was a multi-agency safeguarding partnership, however staff felt the roles and responsibilities for identifying and responding to concerns were not always clear and there could be confusion about available resources in the community. For example, difficulties accessing other organisations to carry out risk assessments or have a planning meeting in cases where safeguarding concerns needed further discussion. A high-risk panel had been implemented as a pathway to escalate concerns related to people known to adult social care when the safeguarding threshold was not met. Local health trusts attended the panel to support cases involving people with mental health issues.

The Safeguarding Adults Board was focused on improving partnerships. There was strong partnership working between the statutory groups such as the local authority, the Integrated Care Board and the police. However, they recognised the need for improved engagement with housing, the voluntary and community sector and Healthwatch to better embed people's experience and better measure the progress of their priorities. They were working with other local safeguarding boards to improve processes and had set a strategy with key priorities to improve safeguarding across the borough. The priorities for 2024 included self-neglect, housing needs and substance misuse which were continuing themes, and to strengthen learning from safeguarding adult reviews (SARs).

Feedback from local authority leaders was that the Safeguarding Adults Board maintained strong partnerships with the voluntary sector who were represented at, and active participants in meetings. They were also included within their annual report and involved in other related work with the board.

One newer area of focus was cuckooing where there had been 9 reports of cases received over a 12 month period. Consideration had been given to early identification, involvement of relevant agencies and partnership work was planned with Healthwatch to understand this better.

Partners felt the local authority could get out more into community organisations to explain what safeguarding was and some of this work had started to take place. One partner said they had referred to safeguarding before but had not received feedback.

Responding to local safeguarding risks and issues

Clear safeguarding quality assurance processes were in place to ensure oversight, learning and development. For example, safeguarding cases were included as part of monthly case audits, quarterly audits and other reviews. The operational safeguarding lead told us they were working on actions from the most recent annual review which was completed externally. Random case files audits led to managers reviewing the safeguarding support offered and from this had identified the use of relevant law and policies was not consistently applied in a minority of the cases so continued to be an area of learning for staff.

Gaps had been identified in areas such as coproduction, voluntary and community sector engagement and transitions in Brent's safeguarding approach but they were actively working to address this. Self-neglect had been identified as a recurrent theme and the local authority recognised to address this category of abuse was complex and required a multi-agency approach. Staff had subsequently received specialist training in relation to this and a toolkit had been created to support frontline staff to increase transparency and efficiency in addressing self-neglect cases. This was not coproduced however so needed further input before its full implementation.

Staff were working to address inequalities across protected characteristics in safeguarding referrals. For example, they had reached out to different Asian communities around safeguarding due to low safeguarding referral uptake and they planned to create a coproduction advisory group in relation to this. The Safeguarding Adults Board understood the risks around unequitable safeguarding across different protected characteristics in Brent and recognised this area of work was still under development. They felt people's demographics and experience was a high priority for the local authority and work was ongoing to collate and understand data around equalities so this could be reviewed.

It was recognised improvements could be made in relation to SARs and there was a reoccurrence of themes in relation to timeless of response and communication issues between partners. A feedback loop system was being developed which partners could access to provide feedback better.

Feedback from care providers was positive in that the local authority staff were approachable, skilled and knowledgeable in relation to safeguarding advice and guidance. With 82% reporting safeguarding investigations were carried out in a timely manner. However, there was mixed feedback on shared learning around safeguarding. Some providers said there was a focus on lessons learnt while others said no feedback was shared or sought. This had been raised in a provider meeting already where assurances had been given by the local authority of improvements.

Responding to concerns and undertaking Section 42 enquiries

Figures where safeguarding concerns became enquiries had been reducing. Between April 2023 and Sept 2023 there were 1108 concerns and from this, 224 enquiries (20%). However, the previous year between April 2022 and Sept 2022 there were 939 concerns and 301 enquiries (32%). Although the number of enquires fell in 2023 to 224, this was explained by the changes to the safeguarding function at the front door, where the local authority told us more intensive support was given at the point of abuse being reported. Safeguarding data provided by the local authority showed between February 2023 to January 2024 there had been 2136 safeguarding concerns received and as of end of January 2024 there was a small number awaiting allocation or initial review. Concerns relating to neglect and acts of omission were highest types of risk associated with concluded section 42 enquires.

Concerns that staffing could be an issue in completing safeguarding enquiries had led to a system being adopted to retain oversight of ongoing enquiries. Managers completed weekly situation reports to submit to senior leaders which outlined numbers of enquiries which were ongoing and the reason for any delays.

There were effective processes in place to manage risk around Deprivation of Liberty Safeguards (DoLS) assessments. Senior staff explained they triaged assessments based on risk, dealing with emergencies first and have been able to stay on top of DoLS. Assessments were all allocated when they came in so there was no waiting list then monitored for completion. For DoLS between February 2023 and January 2024 there was 668 referrals and renewals received, and a small number were awaiting allocation at the end of January 2024. An increase in referrals for DoLS had impacted upon the ability of staff to carry out assessments quickly however there was a commitment to ensure the protection and rights of individuals were upheld.

The local authority had identified the challenges for Best Interest Assessors (BIAs) availability. A BIA is a professional who assesses and determines the best interests of individuals who lack the mental capacity to make specific decisions for themselves. Training was offered to post qualification staff, refresher training and an incentive payment to encourage qualified BIAs participation in DoLS assessments on a rota basis, through streamlining processes and using external BIAs if required.

Care providers were contacted by staff to remind them when DoLS renewals were due for people, to ensure lawful deprivation of liberty. In addition, staff supported providers of supported living, shared lives and extra care to have a better understanding of DoLs criteria within community settings.

Safeguarding Workflow Processes detailed the end-to-end process for teams. A, Safeguarding Adults Report in December 2023 set out the key performance indicators for safeguarding adults' activity during 2023/24, identifying areas of improvement and risk mitigation for the next 6 months. As part of assurance and continuous improvement in practice, safeguarding managers audited a random sample of concerns received each month to ensure there was consistency in applying the Care Act definition for a statutory response.

Partners felt the local authority were very good at responding to safeguarding concerns. The council responded to concerns in a timely manner and were positive about supporting people through this. There were clear routes to report safeguarding concerns. Referrals to advocacy services had now positively increased following awareness sessions being held for staff.

Making safeguarding personal

Staff told us there was pride in the person-centred focus on safeguarding, which they felt had been lacking in the past at the local authority. Safeguarding was now more focused on keeping people safe and was less about the investigation process. Recent refresher training on safeguarding had taken place with this message reinforced. Staff were positive about recent safeguarding developments such as the high-risk panel which had been introduced.

Safeguarding processes had improved since adopting an approach where local social work teams completed Section 42 safeguarding enquiries, rather than a central safeguarding team. This approach focused on making safeguarding everybody's business and this was now embedded across teams. Staff told us 'Making Safeguarding Personal' was key and gave examples of how they took time to understand people's views, despite pressure to be process driven at times. Staff were committed to do this well. For example, one person had been admitted to hospital due to self-neglect and had been evicted from their home. Staff identified no-one had really spoken to them about their needs and preferences properly and by doing so they identified suitable alternative accommodation with ongoing support, to help prevent further self-neglect.

Staff had recognised they needed to be better at feeding back safeguarding outcomes to people and following feedback to the Principal Social Worker, their IT systems were adapted so feedback had to be given before staff could move cases on. This was an effective response to an issue, which reflected a listening and improvement culture.