Safeguarding

Score: 2

2 - Evidence shows some shortfalls

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 indicated that there were challenges in how safe people felt in the borough and work was needed to improve this. 64.33% of people who used services felt safe, which was lower than the England average of 69.69% (Safeguarding Adults Collection, September 2023). Leaders told us that recent resident wide surveys echoed this trend in general concerns about safety, especially at night.

74.85% of people who use services said that those services had made them feel safe and secure, which was significantly lower than the England average of 87.12% England (Safeguarding Adults Collection, September 2023). Leaders told us there was a higher figure in the 2023/24 survey but this had not been published at the time of our assessment.

70.27% of carers felt safe, which was significantly lower than the England average of 80.93% (Survey of Adult Carers in England, June 2024).

The local authority's Advice and Referral Centre (ARC) received all safeguarding enquiries. Contacts were initially triaged to identify level of risk and if there was a need for an immediate safety plan. Where these contacts related to individuals who were already allocated to a locality social worker, these staff investigated any concerns and completed any 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.

Where a contact related to an individual who did not have an allocated social worker, the local authority's safeguarding team investigated any concerns and completed a section 42 enquiry if relevant. The safeguarding team had a duty role to review all contacts made to the service to ensure that they were appropriate, start the process of gathering relevant information and identify any priority and immediate actions. Some staff told us they felt there had sometimes been considerable delays between receipt of the contact in ARC and them being passed on to the safeguarding team. The local authority told us that, on average between August 2023 and July 2024, ARC passed safeguarding concerns on to relevant teams within 24 hours, which was better than the 48-hour timescale outlined in their process. Staff in ARC used a clear risk assessment tool to support consistent decision making. The local authority had changed their processes to move safeguarding screening from the ARC to the safeguarding team, which had reduced delays. The risk rating considerations the local authority provided were clear, though it was less clear how aware staff outside of the ARC - for example social work teams - were of the tool or that it was used consistently. We were told by leaders this was not a concern as the tool was most applicable to the ARC, who were the initial receivers of concerns where immediate actions are required.

Once a safeguarding contact was assessed to have met the threshold for a section 42 safeguarding enquiry, these moved to an 'awaiting worker allocation' list. This was monitored daily, but systems were not in place at the time of our assessment to review and analyse the timeliness of this process and any trends over time. The local authority told us the practice of case noting risk assessments and risk discussions was being developed into a reporting system scheduled for roll out in the autumn as part of the established programme for enhancing analytics.

All section 42 enquiries were allocated to a social worker. Ealing worked within the Pan London Multi-agency safeguarding policy and procedures which sets out the pathways that all agencies followed in Ealing. As part of the section 42 enquiry, the social worker liaised with other organisations as required. Some staff felt that information from partner agencies relating to safeguarding enquiries was not always clear; this had been noted through the Safeguarding Adults Board. For example, specific questions regarding an individual's medical risk had received generic responses from another agency that had delayed progress with enquiries. While some partners described having good partnership working on safeguarding investigations, some staff told us that there was more to do to ensure there was a whole partnership approach and understanding that safeguarding was everyone's business.

Staff who completed safeguarding work were well trained and knowledgeable. Staff in the local authority completed mandatory safeguarding training. Training was also available through the Care Academy to professionals within the sector. 49.58% of staff in the sector in Ealing had completed Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) training, which was better than the England average of 37.48% (Adult Social Care Workforce Estimates, October 2023). 55.40% of sector staff in the borough had completed safeguarding adults training, which was statistically in line with the England average of 48.81% (Adult Social Care Workforce Estimates, October 2023). Where teams had different needs, such as the out of hours team, staff had been able to commission safeguarding adults training specifically for these teams.

Responding to local safeguarding risks and issues

Partners and staff in the area told us that there were rising issues with self-neglect, including hoarding, domestic abuse, and sexual and financial exploitation. There had been a recent rise in suicides in the Polish community. Some actions have been taken regarding these issues, for example, the development of a multi-agency self-neglect toolkit to promote best practice for operational staff. The staff we spoke to were knowledgeable about the emerging risks and demonstrated a nuanced understanding of the ways they would support people in these circumstances.

The local authority ran a 'high-risk' panel which acted as a multi-agency forum to support and advise staff involved in complex cases which helped ensure best practice in supporting people and manage risks in the community. This was seen by partners as effective at supporting people's safety. There were good partnership relationships that linked to the strategic level through the Safeguarding Adults Board.

Partners also described the advent of the head of service for safeguarding in the local authority as a positive move. They told us this had resulted in better communication and focus on safety for people following concerns being raised, but where the section 42 safeguarding enquiry threshold had not been met. This included, for example, an increasing focus on preventative safeguarding work by raising awareness of concerns such as cuckooing. This followed an increase in local cases. Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation resulting in them losing control of their property. Partners told us there was a wider discussion needed across Northwest London, including in Ealing, about safeguarding referrals made by the police for people who needed care and support which were not always at the appropriate safeguarding level.

There were 3 Safeguarding Adults Reviews (SARs) in the area in the 2 years preceding our assessment. Key themes included inappropriate staffing levels, lack of use of protective equipment, gaps in recorded information (including safeguarding), lack of oversight of staff and care plans, incomplete health information for people with a learning disability, and self-neglect. Some improvement actions had been implemented, for example, improvements were made in local authority staff supervision in response to SARs which had highlighted staff needed more support to manage complex and difficult situations. Leaders reflected that how learning from children's safeguarding, domestic homicide reviews, and SARs came together was challenging.

Learning from SARs was shared through staff through 'lunch and learn' sessions, seven-minute briefings, and through information published online through the local authority's website. Staff in local authority services described how managers cascaded learning from SARs through team 'huddles'. The multi-agency self-neglect toolkit included learning from SARs to support the reduction of future risks and to drive best practice.

Where the local authority identified areas for improvement outside of the SAR process, action was taken. For example, the local authority told us they had responded to a pattern of safeguarding issues in a commissioned service which had contributed to a decision to decommission the service.

Responding to concerns and undertaking Section 42 enquiries

Some staff felt there was a limited understanding of what constituted a safeguarding concern from partners in the borough, including within local authority services. Staff described safeguarding contacts being made about housing issues, such as mould or bed bugs with no additional concerns regarding abuse or neglect. Safeguarding staff were clear they reviewed all contacts made to their service but contacts that did not relate to safeguarding created additional work and delays.

Over the last few years, the number of safeguarding contacts with the local authority has been increasing. In 2019, the local authority received 890 safeguarding contacts, and 340 of these went on to become section 42 safeguarding enquiries (Safeguarding Adults Collection, September 2023). This was a conversion rate of 38%. In 2022, the local authority received 1925 safeguarding contacts, and 425 of these went on to become section 42 safeguarding enquiries (Safeguarding Adults Collection, September 2023). This was a conversion rate of 22%. The local authority told us the conversion rate for 2023/2024 was also 22% which was the same as the previous year. This meant that in 2019, a higher proportion of the safeguarding contacts made to the local authority met the threshold for a section 42 safeguarding enquiry than in 2022, using comparable data. The local authority told us that staff met monthly with partners regarding inappropriate referrals and that details of these referrals were highlighted to the Safeguarding Adults Board through the 'effectiveness' subgroup. The local authority told us they were not concerned about their concerns to enquiries conversion rate as this was in line with their assurance role where there is perceived risk.

Some staff told us that some partners were unrealistic about the timescales for completion of section 42 enquiries. The local authority's timescale for the completion of a section 42 safeguarding enquiry was 28 days, but some partners expected conclusions the same day. This could be a confusion about the role of the enquiry compared to an immediate safety plan. The local authority had recently appointed a dedicated head of service for safeguarding which expected to be able to understand and challenge any quality concerns and interrogate trends.

The local authority retained the lead role for all section 42 safeguarding enquiries through allocated social workers. Staff engaged partnership colleagues as needed to support the completion of section 42 enquiries. Partners felt this ensured ownership of concerns within provider services, which were well overseen by commissioning colleagues. Health partners told us that they were asked to complete initial enquiries, which would be reviewed by the local authority safeguarding team. Partners felt this was effectively scrutinised, further information was sought, and appropriate strategy meetings were arranged.

Some providers felt they did not always find it easy to get in touch with teams regarding safeguarding concerns and their progress. They described an example of an individual who wanted to return home, but there were concerns about the individual's safety at home. The provider was unable to get information about the progress of the concern and was unclear who could support them within the local authority. Providers felt they were not always told about the outcome of enquiries and often had to chase this. Some providers felt processes had improved in Ealing, particularly in the way providers had been included in developing solutions and learning, rather than feeling blamed.

The local authority told us in June 2024 that there were 42 section 42 safeguarding enquiries that were awaiting allocation to a social worker, once immediate risk issues had been addressed. People waited 7 weeks from the point of contact for an allocated social worker. This had reduced from 80 in March 2024 and an 8 week wait. Some staff felt that staff shortages had affected people's waiting times. The safeguarding team was a relatively small team covering a large area and a high level of work. Although staff felt the pressure of having a lot to do in a timely way, they felt senior managers were aware and direct line managers were very supportive, aiming to keep caseloads at a consistent level.

Service timescales, in line with the Pan London Multi-agency safeguarding policy and procedures, were 28 days to complete section 42 safeguarding enquiries. Some complex cases could take longer than 28 days to completion, such as hoarding and criminal activities which rely on police investigation or court proceedings. The local authority told us, in the year to date 67.15% of section 42s were completed in 28 days which was an increase from 43.96% in the full year 23/24. 22/23 the number was 51.84%.

The local authority told us there was no Deprivation of Liberty Safeguards (DoLS) waiting list with all requests screened and allocated on the same day to the appropriate professionals. Requests for authorisation extensions were screened and signed off the same day. This was monitored daily, but analysis systems were not in place at the time of our assessment to review information and trends over time. The local authority told us that there were 2061 referrals for DoLS over the last year, made up of 684 referrals and 1377 reviews. The DoLS team received inappropriate referrals, such as people who were intoxicated at hospital and where no capacity assessment had been completed or where DoLS were requested for delayed hospital discharge as people waited for their care package to start. The DoLS team were working with local hospitals to support understanding and monitor cases.

The local authority had recognised they had a lot of data relating to safeguarding activity, but they did not have the tools to analyse the information to understand key themes and trends. This was noted by partners. Without the trend and analysis information, partners found it difficult to understand the context about changes in relation to safeguarding reporting in the community. There had been a noted increase in the number of safeguarding contacts in the recent months prior to our assessment according to partners, but the limited analysis meant it was difficult to have an insight as to why this may have been happening.

The local authority had recently appointed a head of service role to oversee safeguarding and maintain the lead for quality assurance. The interface between this role and the Principal Social Worker (PSW) and how they supported coordinated learning across the service was being developed at the time of our assessment.

Safeguarding information systems supported oversight of the quality assessments, which included reflection on how an individual had engaged in the process. All enquiries were reviewed, and quality checked by a manager, ensuring all identified risks had appropriate protection plans in place, before being closed. Staff described access to team manager reflective sessions around SARs, regular team huddles supporting case discussions, and monthly safeguarding surgeries to share learning and good practice.

Making safeguarding personal

All safeguarding enquiries included specific points and guidance on Making Safeguarding Personal that had to be met. This included clearly evidencing how staff had contacted the individual, gathered their views, identified the outcome they wanted and whether they felt heard. Questionnaires were sent to individuals about Making Safeguarding Personal. The feedback from these was passed to managers and discussed with their teams. The team measured whether outcomes had been met for the individual. Local authority data indicated that 97.5 % of people surveyed had outcomes fully or partially met, though it was not clear when this survey was completed or what period it related to. At times, the professional and individual or family disagreed but the safeguarding team worked with the family to support them to understand the concerns and develop plans with them. Staff reflected that effectively supporting people's diversity of experience in safeguarding took time and involved lots of work.

Some staff couldn't be sure that all partners understood Making Safeguarding Personal. The safeguarding team took the lead in ensuring partner agencies addressed safeguarding enquiries in a timely way and accepted the duty of care for people.

Frontline staff felt they were able to access advocacy support for people in a timely way and work jointly with them if needed throughout the safeguarding and DoLS processes. National data indicated that 72.73% of individuals who lacked capacity were supported by advocate, family or friend, which was lower than the England average of 83.12% (Safeguarding Adults Collection, September 2023). Leaders told us that the figure had improved in the 2023/24 survey, but this had not been published at the time of the assessment. Additionally, the local authority had identified an error in their reporting of this information, that they had only included people with a formal advocate, not an informal advocate. Including informal advocates, the local authority told us that the figure improved to 93%. Further work was underway to improve the accuracy of recording family/friend support to provide a more accurate baseline for future performance monitoring.