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

The local authority had a clear and robust approach to safeguarding with a Multi-Agency Safeguarding Hub (MASH) and other reporting networks and metrics to reflect on cases and learning, which had senior leadership oversight. The MASH team consisted of 8 social workers, 4 lead practitioners and a team manager. They worked jointly with the Children's MASH team which included partner agencies such as the police. The MASH operated a duty system for safeguarding referrals which came directly from frontline staff such as social care direct, online enquiries through the local authority website and direct to MASH email inbox.

The local authority worked closely with the local Safeguarding Adults Board (SAB) and partners to deliver a coordinated approach to safeguarding adults in the area. The SAB had made notable progress in recent years, particularly with improving data intelligence and oversight capabilities. Data related to adult safeguarding was analysed quarterly, which enhanced the board's ability to respond to concerns and track performance. This improved data analysis helped the board, and its partners identify areas for improvement and address gaps effectively, whether through partners or collaborative inquiries involving the police.

The SAB had developed a decision support tool to help staff and partners to raise appropriate safeguarding concerns and actively supported enquiries for adults at risk. The SAB met quarterly, and included the local authority, partners and the VCS, to review operational and strategic safeguarding practice issues. Sub-groups were also established which enabled partners to come together to provide a collaborative approach and continuous learning and improvement. For example, a hospital discharge protocol was devised, which set out practice expectations of all staff across hospital and community-based services to work together, to reduce risks and promote safety.

Barnet Safeguarding Adults Board Strategic Plan 2023-2026 detailed the local authority's vision for creating a system approach that embodied the principle that safeguarding was everyone's business, particularly emphasising safeguarding was personal to individual needs, risk and aspirations. Actions were in place to implement the priorities in the SAB Strategic Plan, around reducing the severity and prevalence, delivering a whole system approach and developing a culture where safeguarding is recognised as a shared responsibility.

The local authority professionals and quality performance group met quarterly, where the group focused on the Quality Assurance framework, which was chaired by the ICB's Designated Safeguarding lead. The group reviewed core multi-agency safeguarding data and scrutinised reports from the MASH, and assurance reports. The local authority had implemented safeguarding quality assurance procedures, where there were three monthly audits, after each external audit, findings and any themes emerging were shared with the Principal Social Worker (PSW) and Head of Safeguarding, which were subsequently used to formulate any additional support or training offer to individual staff or teams across adult social care.

The assurance gained from external audits was strengthened by open conversations between the VCS and the MASH team and proactive dialogue with the PSW and the Head of Safeguarding, which allowed for in-depth discussions about case complexities. Partner leaders and health leaders contributed by sharing case examples, which helped to identify additional actions needed, which meant safeguarding efforts were continuously improved and tailored to respond to the needs of people.

Senior leaders told us over the past year there had been a strong emphasis on shared ownership of safeguarding responsibilities across the borough. For example, VCS worked closely with MASH frontline staff to review policies, provide training, and ensured insights from the community were fed back into the board's work.

The CQC regional team told us the safeguarding practices in the local authority were well-regarded, with responsive teams that conducted thorough safeguarding enquiries; safeguarding concerns were effectively managed as the local authority exceled at linking health and social care concerns, which involved partners. There was good communication with Healthwatch and within the Care Quality team, which had enhanced their ability to manage risks and improve care quality. Healthwatch had maintained a good relationship with MASH and was part of the SAB and told us they were confident that the local authority was implementing learning from Safeguarding Adults Reviews (SARs).

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 were raised quickly and investigated without delay.

Within care provider services, safeguarding training for staff was verified during contract compliance visits, and a dedicated team followed up on safeguarding referrals relating to each provider. Quality alerts were used to identify and address emerging issues early, with themes shared with the SAB. Furthermore, regular information sharing meetings were held with commissioning teams, partners, along with engagement with NCL.

People in the area and partner agencies knew how to raise safeguarding concerns with the local authority and this was done easily. For example, partners told us the MASH team was very approachable and responsive to enquiries with most partners highlighting they had received good advice and support from knowledgeable staff.

One person told us they felt very unsafe and scared where they were previously living as they had experienced abuse. They told us the local authority helped them move to a place where they felt very safe and supported. The person was jointly supported by the housing team to find an appropriate place to stay which demonstrated an integrated approach where roles, responsibilities and pathways within the local authority for responding to concerns were clear and they were used consistently. This example showed the local authority was focused on delivering effective systems, processes and practices to safeguard people from abuse and neglect.

National data showed 89.21% of people who used services in Barnet reported that those services had made them feel safe, this is comparable to the England average of 87.82% (ASCS, 2024). The data was also comparable for unpaid carers in Barnet, with 78.88% of carers who felt safe, compared to the England average of 80.93% (SACE, 2024).

Frontline staff described good relationships with external agencies and told us there was good interagency working to safeguard people. Staff gave an example of working with advocacy services to ensure capacity was considered in a safeguarding case and worked with a VCS partner to raise awareness of safeguarding issues and processes required. Staff told us their relationship extended to internal teams, where they reported excellent working relationships and often invited them to team meetings to update staff on their roles within the local authority.

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 the SAB and safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. The local authority was an active partner in SARs and other serious incident enquiries, and undertook appropriate action to embed learning into systems, processes and practice. The local authority had published two thematic SARs in 2023, which both related to homelessness, subsequently the primary focus had been on how partners had taken forward the learning from the SARs to improve outcomes for people experiencing multiple exclusion homelessness. This showed that lessons were learned when people had experienced serious abuse or neglect, and actions were taken to reduce future risks and drive best practice.

Senior leaders told us across partner organisations there were ongoing efforts to address priorities following the SARs and work was very much still in progress due to the complexities. However, there was strong evidence of improvements in practice. For example, there was close partnership working with the fire service to improve the number of home fire safety assessments being conducted in response to concerns.

Following the SARs there was a range of recommendations, where one was to review the current system for triaging and prioritising high-risk Deprivation of Liberty (DoLs) assessments and expediting authorisations to seek assurance that people at high risk were safeguarded appropriately and lawfully. The local authority recognised the risks to people's well-being presented by DoLs applications, as they were assessed with long delays, which impacted on people's liberty. Due to the high numbers of DoLs a dedicated team was established, which supported to ensure people were allocated according to risk and the team regularly re-prioritised. There were three lead practitioners, all qualified Best Interest Assessors (BIAs). The local authority told us they had 327 DoLs assessments waiting, with a median time of 40 and maximum time of 250 days. The Community DoLs were managed by the case holding teams with no waiting list. To address waiting times, the council had allocated additional budget for DoLs assessment work. For 2024/25, they recruited 2 new internal full-time BIA social work posts which they hoped would help boost productivity and reduce the waiting list.

Learning from SARs was integrated into staff training, and it was evident that this had led to improvements in safeguarding practice. There had also been a review of the current system for case closures and transfers between teams to ensure responsibilities were clear at handover points and to minimise the risk that concerns were not lost, and appropriate and timely action was taken to safeguard vulnerable adults at risk.

Frontline staff told us they were aware of learning which came from SARs and told us themes focused on the need for increased multi-agency working with external partners. However, staff described some challenges for example around police welfare checks due to national changes and they worked hard to address any barriers, through inviting partners to speak at team meetings and events to build understanding and trust.

Staff had completed a homelessness strategic needs assessment and a review of the referral pathway for people with co-occurring mental health and alcohol and drug use, to ensure dual diagnosis services were made available to those who needed them. People who posed a risk of violence to others connected with these needs, were prioritised for access to services. A Homelessness and Rough Sleeping Strategy 2023-2028 further outlined the local authority's plans for supporting rough sleeping in the borough.

The SAB also recognised the need to improve engagement with people who used services, therefore in early September 2023, SAB met with a group that worked with rough sleepers, which lead to a focus group with people to assess if the SAB's efforts were making a difference and what else was needed. SAB worked on themes related to people with learning disabilities and hoarding, which had led to significant developments, especially about how the SAB responded to these issues.

Responding to concerns and undertaking Section 42 enquiries

A Section 42 (s.42) enquiry refers to the action taken by a local authority, in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect. There were clear standards and quality assurance arrangements in place for conducting a s.42 enquiry. There was clarity on what constituted a s.42 safeguarding concern and when s.42 safeguarding enquiries were required, this was applied consistently. There was a clear rationale and outcome from initial enquiries, including those which did not progress to a s.42 enquiry.

Between April 2022 and March 2023, the local authority received 1665 adult safeguarding concerns, which led to 507 safeguarding enquiries. There was an increase in the following year April 2023 to March 2024, of 1718 adult safeguarding concerns, which lead to 793 adult safeguarding enquiries. Despite this increase the local authority informed us they had no safeguarding concerns or s42 enquiries waiting, this demonstrated MASH was effective as all concerns were allocated to social workers responsively, to ensure risks were assessed and safeguarding plans were actioned.

All enquires were recorded under a risk category, together with the location of the safeguard, outcomes and actions taken to ensure a clear oversight of the safeguards in process. The data suggested that when other boroughs placed residents in Barnet care settings, there was a 2.1 chance of seeing a safeguarding concern particularly for those residents with a learning disability. Work was being done to refine the analysis, as this had an impact on increased safeguarding referrals undertaken by Barnet practitioners, which may lead to work that could be undertaken by other boroughs.

The local authority had received 8 whistleblowing referrals between April 2023 and August 2024. These were all anonymous and related to the quality of care in care homes. The care quality and provider safeguarding teams worked together to investigate the concerns. From September 2023 to August 2024 the team received 25 safeguarding concerns in relation to one care provider. This care provider was subjected to CQC's Provider Concerns process, and new placements had been suspended. The provider safeguarding team continued to undertake the safeguarding enquiries in relation to this care provider, whereby 7 had been completed and 18 were still in progress.

Care providers told us the provider-led enquiries for safeguarding concerns enabled them to have a more holistic approach, where they consulted with social workers to complete s.42 enquiries, which made the process quicker as they were able to share the contributing factors. This meant the timescales for cases to be closed had improved. This example showed the local authority still retained responsibility for the enquiries and the outcome for the person concerned even when safeguarding enquiries were conducted by another care provider agency.

Feedback from VCS organisations indicated there was improved engagement with the MASH, and there was confidence in escalating concerns to them, and inter-agency collaboration was robust. However, there was an ongoing issue was the timeliness of responses, as some concerns took longer than the target 3 days, sometimes 4, with data showing a need for further improvement in timeliness of response.

Relevant agencies were informed ofthe outcomes of safeguarding enquiries when it was necessary to the ongoing safety of the person concerned. Partners told us the learning was shared with them from safeguarding investigations however outcomes were not always communicated promptly and sometimes they had to be chased. One partner told us the local authority had not responded quickly enough to a safeguarding alert they had considered to be urgent; the provider told us they had provided emergency support to keep the person safe whilst waiting for the local authority to respond. The local authority had showed learning from partner's feedback and had rolled out a programme of training to help them better understand what should be raised under the safeguarding process, and a reminder to staff they needed to provide feedback to the referrer.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively, keeping the wishes and best interests of the person concerned at the centre. A local authority senior leader told us measures were being taken to make safeguarding more personal. Feedback from external audits indicated improvements were required, particularly in recording practices. The local authority regularly received updates from these audits, which were being used to inform planning for the following year.

Staff were enthusiastic about their role in safeguarding people and gave strong examples of making safeguarding personal and taking a holistic approach to protecting vulnerable people. People had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they did not feel safe. When people had concerns about the safety of other people, they could raise this through the local authority's website, Social Care Direct via the telephone or supported through partner organisations.

People could participate in the safeguarding process as much as they wanted to, and they could get support from an advocate if they wished. Frontline staff told us they focused on making safeguarding personal using advocacy services and kept the person informed when seeking specialist support from MASH. This approach evidenced best practice and supported making safeguarding personal, where people were assisted to understand their rights, including their Human rights, rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010. People were supported to make choices that balanced risks with positive choices and control in their lives.

National data showed a positive variation, where 94.00% of people lacking capacity were supported by an advocate, family or friend in Barnet, compared to the England average of 83.38% (Safeguarding Adults Collection, 2024, SAC).