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, and practices to make sure people are protected from abuse and neglect. National data was lower for Westminster with 71.53% of people who use services who say that those services have made them feel safe, compared to the England average of 87.12% (ASCS, 2023). Further data provided by the local authority (but not yet published) suggested this had improved for 2024.

The safeguarding frontline team had a dedicated safeguarding line for internal staff where they provided advice and support to the different teams. Staff told us this central point of contact was well received as they found it positive and had improved morale within the teams, as there had been a specialist team managing the safeguarding process. This service provided the safeguarding team with a better oversight of what was happening across the Borough from the safeguarding point of view. However, one partner told us that it was difficult to gain advice and guidance on safeguarding matters due to difficulties in getting through to the team.

Frontline teams shared the structure and model of the safeguarding team, which changed 3 years ago, had brought improvement which was evidenced in a staff survey conducted by the Safeguarding Team. Teams across the local authority appreciated the accessibility and support of the safeguarding central team and felt their workload was shared. Teams told us that this way of working was still new for some of the teams which has presented some challenges, however coaching was ongoing.

The local authorities Safeguarding Adults Executive Board (SAEB) had a multi-agency partnership made up of senior representatives from a range of organisations, which provided leadership and strategic oversight of adult safeguarding work. They met four times a year and had a range of subgroups ensuring priorities set out in strategic plans were delivered. Local authority leaders had a good oversight of the safeguarding issues. The Annual Community Engagement Development Day was an example of partners and people sharing stories about how their communities had been affected by fear of abuse and the local authority held discussions on how to prevent abuse or harm from happening.

Another positive example of co-production has been the diverse group of Safeguarding Ambassadors. They played a crucial role in ensuring the perspectives of people was heard at both operational and strategic levels. For example, they had raised awareness on hate crime and provided practical advice on being vigilant around the risks of borrowing money from loan sharks.

The Safeguarding Adults Executive Board Strategy 2022-25 had detailed how the local authority work towards achieving ambitions for safeguarding adults. This was through leading and listening, with a key focus on sharing learning to prevent harm and abuse. The local authority's quality and performance teams had developed and delivered best practice learning, through multi-agency training. The team had also used data to better help inform partnership responses to safeguarding referrals.

There was evidence of information sharing arrangements where concerns were raised quickly and investigated. For example, the safeguarding frontline team attended meetings and forums with commissioners and Quality Assurance teams. This approach had ensured the safeguarding team had oversight of what was happening across the Borough, and this supported to improve awareness and response to safeguarding issues. Staff from frontline teams told us that the remodel of the safeguarding service has worked well to allow for interface between the strategic and operational practice. Partners told us safeguarding team had been very responsive with any safeguarding concerns raised.

There was evidence of a strong multi-agency safeguarding partnership, as frontline teams had regular contact with partner agencies and provided them with support, advice and training. Staff shared they had good communication and positive relationships across all teams, particularly the hospital teams in supporting and responding to safeguarding concerns.

Quality Assurance and Market Shaping teams were informed about safeguarding concerns which demonstrated a clear understanding of each stage of the safeguarding process, which worked effectively. Overall, providers feedback was positive around the safeguarding referral process, and they felt they were able to reach out for support and advice on safeguarding matters. This support had improved providers' response to safeguarding issues and the number of referrals that did not meet safeguarding criteria had reduced. Teams shared the providers' feedback regarding the support and advice received from the staff on safeguarding concerns was positive and as a result, the referral process was clearer for partner agencies.

Partners told us the local authority's approach to safeguarding and mental health had been a preventative and reactive approach. Outcomes of safeguarding referrals were always provided, and the teams also reviewed trends and near misses to ensure future learning had been identified.

All staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively. Safeguarding training had been accessible for all staff and partners. Staff were required to complete mandatory safeguarding training.

Responding to local safeguarding risks and issues

The local authority had a clear understanding of the safeguarding risks and issues in the area. For example, the rise in domestic abuse and financial abuse safeguarding concerns against the elderly had been a key focus. The local authority had been collaborating with partners within the safeguarding systems through the Staying Safe Project and the community safety around hate crime.

The local authority's Quality Assurance model for safeguarding had aimed to provide assurance that the safeguarding systems, process and practice worked effectively towards improving outcomes for adults at risk. The model had incorporated analysis of performance data and informal and formal audits, which had supported a culture of continuous learning and improvement. For example, local data identified there had been an increased concern around managing people developing pressure sores and a task and finish group had been set up to help towards improving outcomes for people.

Staff within the safeguarding team had been able to develop their specialist areas of interest and this had resulted in wide-ranging specialism and expertise within the team, which had also benefitted other teams. In addition, the safeguarding team organised monthly open practice forums to share learning. Teams shared they had been aware of safeguarding themes and trends, particularly around the increase in financial abuse.

Senior leaders told us that partnership working around safeguarding was an area of strength for the local authority. For example, the local authority safeguarding leads worked closely with the fire brigade to improve safety around smoking risk.

The Safeguarding Adults Review (SAR) Subgroup of the Safeguarding Adults Executive Board (SAEB) managed all SARs. Over the last year the local authority had published a Thematic Review on Fatal Fires. Another SAR included learning around challenges and good practice working with people with complex mental health needs. In both cases the person had died. The second SAR was specifically in relation to another local authority, however due to the Bi-Borough systems approach, lessons were shared across both local authorities and partners to ensure effective complex case management. Frontline teams we spoke with were able to share their assessments had incorporated fire risk questions. This demonstrated the local authority's response to driving best practice from lessons learnt.

Local authority senior leaders told us they had a committed safeguarding team who reported directly into the Learning and Development team to deliver thematic sessions from lessons learnt from the Safeguarding Adults Reviews. Regular learning events had been delivered using the '7-minute learning brief'.

Overall, frontline teams told us they were aware of learning from SAR's and serious incident reviews, which they noted were regularly shared with them. However, staff told us there needed to be more focused work on improving the SAR process. They highlighted there was a need to improve legal literacy, governance and ways of embedding learning. Staff told us they had attended learning events such as lunch and learn with staff to embed learning but felt there was more to do in this space, particularly around the impact on practice following SARs, however noted they didn't always receive training that was directly related to their area of work. The Principal Social Worker had a training needs analysis plan in place which was a tool used to identify training needs for local authority staff.

Partners told us the local authority had been supportive with providing access to relevant safeguarding training from SAR's, which demonstrated the local authorities multiagency approach to learning. Another provider told us the local authority had good oversight of emerging themes and trends in safeguarding referrals as they observed an increase in domestic violence referrals, which they thought might be following the recent outreach work aimed at raising awareness of safeguarding. This demonstrated the local authority's approach to prevention and early intervention.

As part of the Safeguarding Adults Audit Protocol the local authority had a quality assurance framework and safeguarding had an external audit programme. This demonstrated the local authority's approach to meeting their safeguarding duties under the Care Act and provided assurance that there was a good standard of practice.

Responding to concerns and undertaking Section 42 enquiries

In 2022–2023 the local authority received a total of 545 safeguarding concerns, of which 295 cases (or 54%) were assessed as meeting the Section 42 threshold. There was clarity on what constituted a Section 42 safeguarding enquiry and there was a clear rational and outcome from initial enquiries, including those which did not progress to a Section 42 enquiry.

The local authority demonstrated they had a clear process for managing safeguarding concerns. For example, all safeguarding concerns were raised via the Information and Access Team who assigned the concern to the safeguarding team, unless the person had been known to the services already, in which case the relevant operational team would manage this. The local authority had appointed staff with the skills and knowledge in the teams to determine whether the referral constituted a safeguarding concern.

The local authority documents that 52.5% of safeguarding concerns were allocated within 5 days of receipt. All Section 42 enquiries were allocated within 24 hours of receipt. There had been no waiting lists once concerns had been allocated and this has demonstrated good management oversight to risk mitigation during the above stated timescales. The local authority had experienced a 15% increase in the number of DoLS applications in 2022–2023 and had managed to complete assessments without having a waiting list.

The safeguarding teams worked with partners and internal teams to clarify what needed to be included in the Section 42 form, which is a safeguarding investigation form, and developed guidance and implemented a template. This practice had made improvements and feedback had been positive. Partners told us the local authority encouraged a transparent approach to safeguarding issues and supported them with protection plans. Each partner was assigned a safeguarding named person within the local authority to support them with safeguarding queries, which demonstrated a positive relationship-based approach.

The local authority recognised they needed to improve on the feedback they received from people post Section 42 enquiries. Previously they sent out surveys and to increase responses they commenced a new initiative of calling people who had been involved in Section 42 enquiries to ascertain their feedback. This had been a good illustration of co-production work and an opportunity to make necessary improvements where identified.

Making safeguarding personal

Frontline teams told us they had the freedom to be creative in making safeguarding personal as they felt they could take the time to get to know the person and did not feel pressurised with targets or timelines to close cases. One provider shared the local authority had an invested focus on making safeguarding personal. They mentioned there had been a focus on emphasising that safeguarding was 'everyone's business' and increasing knowledge on how to support safeguarding adults in the community and across groups.

Senior leaders mentioned language had been identified as a barrier to accessing safeguarding services. To address this gap the local authority used a multi-agency approach and worked with the Staying Safe Project, Community Catalysts and Community Champions to meet the needs of the community. Partners spoke positively about the Staying Safe Project with the involvement of 13 Black and Minority Ethnic organisations to discuss safeguarding issues. Partners told us local authority teams attended their lunch and learn lessons on Safeguarding. This partnership working supported people to have access to information they needed to understand safeguarding around what being safe meant to them and how to raise concerns when they did not feel safe.

Equality, diversity and cultural competency training was provided to safeguarding practitioners and Safeguarding Ambassadors to ensure that safeguarding practices were culturally inclusive and had been meeting the needs of all people. Staff shared they valued the role of the Safeguarding Ambassadors as they had a positive impact within the different local communities. The Safeguarding Ambassadors represented different seldom heard groups and had close links to the communities.

The Local Account Group (LAG) had been part of the Make Safeguarding Personal agenda. For example, the LAG raised concerns around the increased risks of being scammed. As a result, the local authority and partners had focused their approach on people's experience of feeling safe. Partners told us improvements had been made around the make safeguarding personal agenda in recent years which included the SAEB receiving direct feedback from people involved in safeguarding investigations to better understand their experiences and identify any potential learning.

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