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 were protected from abuse and neglect and the local authority worked very well with its partners and the safeguarding adults board to deliver a coordinated approach to safeguarding adults. This was evidenced by having no delays on standard DoLS and no waiting lists for safeguarding. Although community DoLS had some waiting times they were managed safely. Additional resources had been allocated to safeguarding over the last few years. The Multi Agency Safeguarding Hub (MASH) worked well and there was a dedicated DoLS team. Pathways to Safeguarding, MASH and the local authority's decision-making arrangements were clear from the information provided to us by the local authority. Leaders said the local authority had prioritised safeguarding and the elimination of waiting times. Safeguarding arrangements were well resourced, and staff consistently described the arrangements in place and how to manage complex cases.

Partners said the local authority worked well to safeguard people, and they were accessible, responsive and knowledgeable. The safeguarding adults board (SAB) annual report showed multi-agency work included the NHS, the Metropolitan Police, the national probation service and the VCSE, with agreed priorities for each agency. It set out governance arrangements and relevant performance data including section 42 enquiries. There was also a delivery plan within the five-year strategy which referenced over 40 SAB partnership members. Strong partnership working was evident in the safeguarding adults arrangements involving a regional safeguarding adults board which the SAB chairs attended and collaboration along ICB geography. The pan-London safeguarding policy arrangements worked well, and its policies were amended to the local authority's needs. Safeguarding in transitions was managed through the integrated young peoples team and communication worked well.

Staff consistently described how, both in and out of working hours, contact was made with a person and the duty system worked well in safeguarding people. Partners described support from the local authority in reviewing and shaping their own safeguarding policies. 'Family group conferencing' was referenced by partners, leaders and staff as providing an exemplary approach to safeguarding adults and placing them at the centre of their care. We heard an example where family group conferencing had been used to support homeless people and this was used effectively to safeguard individuals while supporting holistic outcomes for people involving their networks and communities.

The local authority had identified themes and trends in relation to safeguarding adults with a breakdown of the types of abuse which led to referral and provided comparative data across 2022/23 and 2023/24. There was clear evidence of extensive staff safeguarding training with an emphasis on legal updates, including the Mental Capacity Act and Court of Protection, which demonstrated a commitment to safe and effective practice and the involvement of safeguarding leads and regular safeguarding forums. A case file audit had demonstrated to the SAB practice had improved following training and there was an evident learning and quality assurance cycle.

However, ASCS data (2023-2024) showed fewer people (63.93%) who used services felt safe than the national average (71.06%) (negative variation) and fewer people (79.34%) who used services said those services had made them feel safe, then the national average (87.82%)(negative variation). 74.07% of carers felt safe compared to the England average (80.93%) (tending towards negative variation).

Responding to local safeguarding risks and issues

Staff said there was effective learning undertaken following safeguarding adult reviews and we heard about a clear interaction communication and responsibility cascaded to frontline teams. The principal social worker role and their team of lead practitioners supported a quality assurance process and learning from people's deaths. An example of an emerging safeguarding risk involved 'cuckooing' and staff and leaders ensured guidance was then cascaded to teams about this safeguarding issue.

Some concerns were raised from partners in relation to accessibility of mental health and dual diagnosis support between partners in the local authority area. Leaders said the current review into the Section 75 arrangements where mental health social workers were placed within health teams, sought to address this issue. Partners described an extremely positive safeguarding culture and said the local authority worked with them to support people to stay at home and within their existing support networks. We heard about an example where staff supported a partner agency to raise a safeguarding concern - in relation to services provided to a person in a provider setting, which improved the situation and allowed the person to remain at home safely.

We heard examples from staff about supporting people in housing settings with hoarding behaviours. Staff reported an understanding of their levels of hoarding in the local authority area and lessons had been learned from a safeguarding adult review (SAR) case. The local authority provided commissioned support for deep cleaning and staff said they used supportive therapeutic and psychology services, with experience in hoarding, to support individuals in the community. Staff said there was training available to them around hoarding in order to avoid self-neglect. There was a hoarding panel which had an overview of cases and outcomes. Partners said self-neglect was emerging as the largest category of safeguarding challenges and the preventative work on homelessness and issues which came to the high-risk panel meant the local authority understood the safeguarding risks and issues in the area.

A practice lead from the local authority worked with the safeguarding adults board chair to coordinate learning from SARs. Methods included seven-minute briefings, monthly audits of cases and safeguarding adults board cases and quarterly learning sessions. There had been a recent learning event held on both childrens and adults safeguarding reviews which included sub-regional collaboration and learning.

Responding to concerns and undertaking Section 42 enquiries

Partners said they were informed of outcomes of safeguarding concerns in a timely way and kept informed and involved. Because there were no delays in safeguarding cases and partner feedback was positive, the local authority was responsive to safeguarding concerns. The percentage of initial inquiries that moved on to becoming a Section 42 enquiry was between 30% and 33% across each of the last five years (taken from safeguarding adults collection data). There was clear guidance and detailed information on the referral and assessment pathways for safeguarding concerns and Section 42 enquiries. This included details around quality assurance arrangements and safeguarding adults' partnership board and annual general and thematic audits. Newly closed cases had been reviewed weekly and RAG rated, shared with commissioners and used in provider oversight board meetings which supported effective governance and learning from concerns raised. Safeguarding pathways from concerns to Section 42 enquiries fully involved staff and partners and the safeguarding system was clear and well resourced. The MASH had all referrals routed through it. It was a virtual hub, however there were police co-located in the local authority building and a mental health representative who screened cases and gave advice and support. We found MASH worked well, similar to other multidisciplinary or multi agency partnerships in the local authority.

Making safeguarding personal

People's outcomes were very well embedded in safeguarding procedures and practices. 94.12% of individuals lacking capacity were supported by an advocate family or friend with the England average being 83.38% (Safeguarding Adults Collection data 2023-24)(tending towards positive variation). Partners said the local authority was an early adopter of the 'making safeguarding personal' approach and case audits in the SAB had shown it to be evident in practice. Significant safeguarding challenges existed in the local authority area and partners, leaders and staff spoke to us about this in detail. Complexities around mental capacity, homelessness, self-neglect, transitional safeguarding, people with drug and alcohol needs and those leaving care were high within the local authority and there were emerging difficulties around 'cuckooing'. Partners said preventative outreach work took place which was effective and the local authority promoted safeguarding as everybody's business. Family group conferencing received safeguarding referrals from MASH, to be used in a Section 42 enquiry for a person. This approach placed people within their communities and networks at the centre of the safeguarding process and was used effectively to make safeguarding personal.
