

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. National data from the Adult Social Care Survey 2023-2024 showed 70.14% of people who use services felt safe. This was similar the England average 71.06%. 84.89% of people who use services said that those services made them feel safe and secure. This was also similar to the England average 87.82%.

All safeguarding referrals came through the Access Team (the Integrated Front Door). The Access team is a multidisciplinary team of both health and social care colleagues and had a senior social worker to support with safeguarding concerns and decision making. All safeguarding concerns that were received by the Access team were screened on the same day and sent to the appropriate team. For example, if the person had an allocated worker, that concern would be sent to that worker/team. If the person was not open to adult social care this would then be referred to the First Point of Contact Team.

If a safeguarding concern progressed to a section 42 enquiry this would be carried out by the Complex Needs Team or Mental Health team if receiving support from the Mental Health services. A section 42 enquiry is 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.

Staff felt supported with safeguarding decisions and had the correct knowledge and skills to carry out their work in relation to safeguarding.

There was a multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place so that concerns were raised quickly and investigated without delay. The local authority had a section 75 agreement with the North London NHS Foundation Trust (NLFT) for the delivery of social care mental health services, including safeguarding enquiries. Adult Social Care staff were seconded to the Trust, and the local authority's safeguarding responsibilities were delegated to the Trust through the agreement. The section 75 agreement provides an established framework for the delivery of safeguarding duties from the Care Act 2014. Leaders and team managers had regular oversight of data in relation to safeguarding including safeguarding carried out under the section 75 agreement.

The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area.

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 safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. Staff had identified an increased risk of cuckooing in Islington. 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. The practice often involves exploiting individuals who are more vulnerable or isolated. The property may then be used for criminal activity, including drug dealing, sexual crimes and storing weapons. Examples were shared of how the local authority worked with the hospital discharge team, police and housing partners to ensure people were safe and protected from further abuse.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. Data provided by the local authority showed that there had been no Safeguarding Adults Reviews (SARs) carried out 2023-2024 however learning from SARs in neighbouring local authorities was shared from neighbouring through the Safeguarding Adults Board (SAB). Key learning from SARs was shared with staff.

Responding to concerns and undertaking Section 42 enquiries

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. The local authority took immediate action where it needed to refer to other agencies, such as the police, or to put measures in place to make sure people were safe.

Providers spoke positively about safeguarding support from the local authority. Providers felt able to contact the local authority for advice and guidance on safeguarding concerns and felt the local authority supported them without blame to reduce risk for people.

Data provided by the local authority showed there were 1681 safeguarding concerns raised in 2024-2025 up to the point of our assessment. Of those 1681 concerns 253 had progressed to an enquiry, this meant the overall conversion rate was 15%. Leaders identified that an inconsistency in recording of a safeguarding enquiry meant recording was not always accurate. This was resolved by implementing a new safeguarding form on the adult social care recording system ensuring practitioners appropriately and consistently completed the relevant parts of the form. This form was due to be rolled out February 2025 and had not yet been implemented at the time of our assessment.

Data provided by the local authority showed as of 25 January 2025 there were 23 open safeguarding concerns 21 (91%) had been open for 0-5 days, 2 (9%) had been open for longer than 5 days reasons for this were due to individual needs and not allocation delays. The maximum time a person waited to have a concern considered was 7 days. The Pan-London safeguarding target was 5 days, this meant 91% of cases were closed or progressed to a s.42 enquiry within the target timescales. There were clear standards and quality assurance arrangements in place for conducting Section 42 enquiries.

The local authority told us there were currently no waiting lists for Deprivation of Liberty Safeguards (DoLs). A DoLs is when people in care homes and hospitals are deprived of their liberty in a safe and correct way, to receive care and treatment. This is legally authorised under the Mental Capacity Act 2005 and is only done in the person's best interests and when there is no other way to look after them.

Relevant agencies were informed of the outcomes of safeguarding enquiries when it was necessary to the ongoing safety of the person concerned. Providers were kept informed regarding the outcome of section 42 enquiries and supported to make any improvements to practice reducing risk.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. Examples of how the process was person centred and gave the person the chance to make an informed choice was shared.

People could participate in the safeguarding process as much as they wanted to, and people could get support from an advocate if they wished to do so. People were supported to understand their rights, including their human rights, rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and were supported to make choices that balanced risks with positive choice and control in their lives.

National data from the Safeguarding Adults Collection showed 87.50% of individuals who lacked capacity were supported by an advocate, family, or friend. This was the same as the England average 83.38%.

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