# 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 transformed its safeguarding referral pathway following the introduction of its localities model. A central safeguarding team screened and triaged referrals based on eligibility and urgency. As pathways were still developing, referrals reached the local authority via different routes, including directly to the safeguarding team, through the first response team, and through the locality front door team. There were target timescales for dealing with safeguarding referrals. For example, it was expected referrals were screened or triaged within 24 hours and cases were allocated to staff members by a manager within 48 hours. Data provided by the local authority in June 2024 stated the median processing time for a safeguarding concern was 13 days from start to finish.

While there were processes to support staff to raise safeguarding concerns, these were not always followed. For example, a person was recorded to have raised an allegation of abuse in their assessment, but this had not been formally raised as a safeguarding concern. Despite this, risk to the person was mitigated immediately and a personalised approach was taken to support them to stay safe. The local authority acknowledged this reporting error but told us staff were now supported with training and workshops to ensure understanding of processes. Staff also told us the safeguarding systems and processes were person-centred and reflected peoples' wishes to support them to remain safe.

The local authority worked closely with the Safeguarding Adults Board (SAB) which met quarterly. For example, the SAB Quality Assurance Subgroup reviewed the local authorities processes around managing provider failure and service interruptions and refreshed their Joint Section 42 (s.42) Enquiry Framework. We heard the local authority's data team shared safeguarding data with the HSAB when requested, including information relating to timeliness of actioning safeguarding concerns.

The local authority acknowledged the importance of joint training and multi-agency collaboration to ensure the safe sharing of confidential information relating to vulnerable children, families, and adults. For example, there was a clear procedure for triaging urgent police referrals and the actions leading to a protection measure being implemented. The local authority used a regional multi-agency adult safeguarding to support their procedures.

The local authority monitored their safeguarding processes and strived to improve them where possible. Following an internal audit of safeguarding processes, the organisation had made several operational changes, for example, to how staff recorded people's information. They continued to monitor the consistency of this documentation. Other areas of action included the need for more proactive planning and professional meetings so clear actions could be agreed within set timeframes with responsible parties outlined. This included care providers and other agencies such as housing.

Safeguarding concerns which did not meet the statutory referral criteria were processed in appropriate ways which informed internal colleagues and community health partners of the risks to people. This approach helped identify the support people needed and prevented an escalation of needs.

The Safeguarding Adults Board told us that the local authority made use of Safeguarding data themes and trends to better understand risks to people. This enabled shared learning and drove improvement.

68.12% of people who used services felt safe in Haringey, which was in line with the national average of 71.06% (ASCS 2023-2024). 81.16% of people said the services they used made them feel safe and secure which was tending towards negative variation from the national average of 87.82% (ASCS 2023-2024). 78.35% of carers felt safe which was in line with the national average of 80.93% (Survey of Adults Carers in England 2023-2024).

## Responding to local safeguarding risks and issues

There was a clear understanding of local safeguarding risks and issues. A senior leader told us there was a focus on homelessness and transitional safeguarding. For example, they told us there were risks for young people who did not meet statutory criteria for support, but work was being undertaken to safeguard young people. A Transitions Board supported processes to support the young people. The SAB chair told us there had been successes in transitional safeguarding and stronger partnership working had supported young people to the right outcomes.

SAB structures supported the reduction of risk and prevention of abuse and neglect. Sub-groups were structured around key risk areas and supported improvement. For example, there was also a sub-group which was focused on prevention and engagement to gather people's voice around key issues.

There had been 2 commissioned SARs since 2023. These reviews identified a range of recommendations and learning for the local authority and relevant partners. SARs included action plans with relevant recommendations, actions required, set timescales and lead officers identified. This supported implementation of improvements and partners being held to account by the SAB. For example, a recommendation had identified improvements to the Mental Capacity Practitioner Manual for adult social care staff. This had been actioned accordingly and was marked as completed.

Local authority staff were supported to access training and learning from SARs. A staff team told us issues and learning from SARs gave them an opportunity to reflect on and discuss practice, including at safeguarding learning forums.

Partners were supported to improve practices to keep people safe following SARs. For example, following a concern raised in a SAR around pressure ulcers, providers told us they had been supported to access training around pressure ulcers which enabled them to keep people safe. However, care providers were not always supported to learn from safeguarding investigations. While some providers told us the local authority shared learning with them, others told us this was inconsistent or did not happen.

There was a multi-agency information sharing agreement which supported local agencies to share information appropriately and quickly. For example, there was a system in place for the police to share safeguarding concerns, where they were rated on urgency. This supported the safeguarding team to triage referrals and plan appropriate responses.

Effective processes were in place to respond to Deprivation of Liberty Safeguards (DoLS) referrals. The majority of DoLS applications were outsourced. However, an internal DoLS team monitored the progress of applications and provided supervisory approval of applications, while supporting external partners such as care homes to navigate the process. There was a clear process in place for triaging DoLS applications and the Chair of the SAB was assured the local authority was actioning DoLS assessments effectively.

The median processing time for DoLS applications was 14 days, with a maximum processing time 50 days. There was no DoLS waiting list and the majority of DoLS referrals were outsourced.

## Responding to concerns and undertaking Section 42 enquiries

Partners told us they did not always receive updates, outcomes and responses when making safeguarding referrals. This included both care providers and partners from the VCSE sector. Some partners told us they had raised concerns to the local authority about this but had not observed any improvement. However, another partner told us they had built a positive relationship with the local authority around safeguarding, and they felt able to challenge the local authority where necessary.

An internal audit completed by the local authority identified 71% of referrers were informed of the outcome of s.42 enquiries. The local authority felt this proportion demonstrated good practice around communication as it was not always appropriate or possible to respond to referrals. However, feedback we received indicated communication around safeguarding remained an issue.

Staff told us they worked with partners to safeguard people. For example, residential care homes were asked to complete investigations and take steps to safeguard people where appropriate following referrals. Staff told us they challenged partners where protection plans did not mitigate risk to people. The local authority retained oversight of this process. This supported people to be protected from the risk of abuse or neglect.

Local authority data showed, as of June 2024, the median processing time of a safeguarding concern was 13 days, the longest processing time was 302 days. The median processing time of a s.42 enquiry was 21 days, with the longest processing time 51 days. There was no waiting list for concerns or s.42 enquiries.

Partners gave us mixed responses on the timeliness of responses to referrals. Some partners felt concerns were dealt with quickly, whereas others did not.

The local authority had created a multi-agency s.42 enquiry framework and guidance, which was to be used by all staff managing or undertaking a Statutory Safeguarding Adult Enquiry under Section 42 of the Care Act 2014. The guidance included a process flowchart showing the different stages of the process including alternative responses if s.42 safeguarding enquiry criteria had not been met. The guidance emphasised the importance of involving the person at risk of abuse or neglect from the beginning and gaining their views on what they would like as the outcome. There was clarity on what constituted a s.42 safeguarding concern and when s.42 safeguarding enquiries were required, and 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 also used London ADASS (Association of Directors of Adult Social Services) s.42 guidance to support consistent decision making. Support was available to staff to undertake their safeguarding duties effectively and this was reflected in national data. 69.31% of independent/ local authority staff had completed safeguarding adults training, which was significantly better than the England average of 48.70% (ASC-WE 2023-2024). Partners also gave mixed responses about the knowledge of staff around safeguarding with some partners feeling staff were knowledgeable but others not.

## Making safeguarding personal

Staff told us they contacted people, or their representative, once safeguarding concerns were received to gather more information and check their desired outcomes. A frontline team told us some people found it important for a face-to-face approach and in line with learning from SARs, this approach was adopted where possible. The team gave an example where an appointment had been made with a person at risk at a place where they felt safe to speak with staff about safeguarding concerns. However, a person's relative told us neither they, nor their loved one, was contacted by the local authority following raising an allegation of abuse. While feedback from people was limited, a partner also told us people were not always kept up to date on ongoing investigations or outcomes.

Systems supported a making safeguarding personal (MSP) approach. For example, referrals which met s.42 criteria, had clear processes in place regarding the division of responsibility for further enquiry. Where there was an allocated staff member who already worked with the individual, further enquiries would be allocated to this staff member. This supported continuity and support from a staff member the person knew. However, if there was not an allocated staff member, the person was safeguarded by the central safeguarding team.

Staff we spoke with demonstrated a strong understanding of a personalised approach to safeguarding and this was reflected in examples they gave. For example, a frontline team told us about concerns raised about an individual with care and support needs. The referral was due to concerns about neglect and the caregivers' approach to supporting the person. A staff member visited the person and took the time to build rapport, understand their needs and recognise there were no concerns around neglect and supported them to remain where they chose to be.

Staff told us people's rights were respected and staff followed relevant legislation such as the Mental Capacity Act 2005 and the Equality Act (2010) to support people to make choices that balanced risks with positive choice and control in their lives. For example, a frontline team told us how they supported a person at risk to make their own choices following a mental capacity assessment which showed them to have capacity to make their own decisions.

Staff understood the need for advocacy and upholding the rights of those they supported However, staff told us statutory advocacy was not always readily accessible and it took up to 6 weeks to get an advocate for people. National data showed 14.29% of individuals lacking capacity were supported by advocate, family or friend which was significantly lower than the England national average of 83.38% (Safeguarding Adults Collection 2023-2024). It was not clear if this again was due to a recording issue within the local authority's safeguarding systems.

The local authority's data showed, in 2022-2023, the proportion of people asked about their desired outcomes from safeguarding enquiries was 86% which was 4% less than their target of 90%. They also found 94% of people's outcomes met or partially met. The local authority told us the most recent data indicated 95% of people felt they had their outcomes met or partial met, which was a positive performance indicator.

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