Safeguarding

Score: 2

2 - Evidence shows some shortfalls

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 Care Act 2014 sets out a clear legal framework for how local authorities, and other parts of the system, should protect adults at risk of abuse or neglect. One of the key priorities in Telford and Wrekin's strategic plan (2024-2025) was to 'support people with care and support needs to live a life free from abuse'. Key performance measures identified in the strategic plan included data from ASCS, the percentage of Section 42 safeguarding enquiries undertaken where risks were removed or reduced at closure, and the number of completed DoLs applications. A Section 42 enquiry is the action taken by a local authority in response to concerns a person with care and support needs may be at risk of or experiencing abuse or neglect.

Overall, there were effective systems, processes, and practices to make sure people were protected from abuse, neglect, and exploitation through the TWSP. TWSP coordinated thematic and locality working to ensure effective delivery of joint safety priorities. For example, the Safer Telford and Wrekin strategy identified the 3 localities experiencing the highest harm from crime and antisocial behaviour. Other areas of focus included child exploitation and domestic abuse. TWSP allocated resources to the Building Safer Stronger Communities Board to support community projects and developments in these areas.

The TWSP Board had an independent chair and worked closely with TWIPP and the Health and Wellbeing Board to deliver a coordinated approach to safeguarding adults in the borough. The safeguarding board ensured there was a multi-agency safeguarding partnership, including West Mercia Police, the Shropshire, Telford and Wrekin ICS, and other internal and external local authority partners. Roles and responsibilities for identifying and responding to concerns at a strategic level were clear and information sharing arrangements were in place, so concerns were raised quickly and investigated without delay.

Governance arrangements ensured the TWSP Board had overview and scrutiny of safeguarding sub-groups, including domestic abuse, adult exploitation, the Safeguarding Adults Review (SAR) panel, and the adult review, learning and training sub-group. There were community hub safeguarding drop-in sessions to increase the accessibility of the safeguarding team and plans to add a separate safeguarding lived experience group following feedback. However, people told us coproduction in this area was not as strong as in other Adult Social Care partnership boards.

Senior leaders told us the local authority had identified improving co-production and engagement in safeguarding as a theme in their Safeguarding Strategy, with a member of the Making it Real Board sitting on the SAB as an active member and voice. In addition, the refreshed terms of reference and membership of TWIPP included a member from the Making it Real Board.

National data (ASCS 2023) showed 83.16% of people using services said those services made them feel safe. This was statistically comparable to the average for England (87.12%). Further data provided by the local authority suggested this rate had improved in 2024. National data (SACE 2024) showed 76.92% of unpaid carers said they felt safe, tending towards below the average for England of 80.93%.

Concerns could be sent from any source and were initially received by the frontline, Family Connect team. Concerns were triaged using a safeguarding threshold matrix and care quality concerns thresholds to identify risks of abuse or neglect. These tools were also used to ascertaining whether the person identified as a potential victim was a person who may be made vulnerable. Teams then recorded cases using the local authority's case recording system to ensure security and confidentiality.

Policies allowed for people with concerns which did not meet the threshold for safeguarding to be signposted to information, advice, and other services such as the police or citizens advice bureau. Out of hours concerns indicating risks of abuse or neglect were handled by the emergency duty team who would hold the 'case' and implement any necessary urgent action to keep people safe until they could be passed on to the Family Connect team to help manage risk and prevent potential safeguarding concerns from escalating.

Concerns meeting the criteria for safeguarding were then shared with the frontline safeguarding team who would determine if Section 42 (S42) enquiries were required. There was a dedicated team dealing with safeguarding. If the person at risk or subject to abuse was allocated to a social worker in another team the safeguarding social worker would undertake the S42 enquiry and work in collaboration with the allocated worker.

Frontline teams worked closely with the quality monitoring team when concerns were raised about a provider. The local authority safeguarding team were responsible for oversight of all safeguarding concerns. Where a decision had been made to delegate part or all the investigation to a partner agency, management responsibility remained with the local authority, including decisions on outcomes and actions.

However, partners and staff told us safeguarding policies and procedures were not fully embedded and staff did not always respond quickly enough to concerns. 54% of concerns raised with the local authority were progressed to S42 enquiries (September 2024).

Senior leaders told us the local authority recognised there were areas of development within safeguarding processes, and they were reviewing these for assurances around the application and recording of the threshold for S42 enquiries. As part of their performance reporting approach, they identified details to target and work with providers, referrers, and the care market on key emerging themes. For example, a staff training platform had been created to monitor and improve completion rates.

Responding to local safeguarding risks and issues

There was an understanding of the safeguarding risks and issues across the borough. The local authority insight team produced a safeguarding adult dashboard to give an overview of safeguarding activity. The dashboard contained safeguarding data which covered a breakdown of types of abuse, demographics, outcomes achieved, and identified where risks remained. Senior Leaders used the dashboard to manage workloads, capacity, demand and risk. Staff and leaders told us about emerging themes, including forced marriages, domestic abuse, pressure ulcers, emotional abuse, neglect (including self-neglect), and modern slavery.

In addition to this, the local authority had identified some partner organisations were submitting referrals which did not hold enough data to be easily processed. The TWSP Board collaborated with partners to raise awareness, reduce risks and to prevent abuse and neglect from occurring, and provided toolkits (including '7-minute briefings') for providers and other agencies to use when identifying concerns.

Further partnership working included a focused seminar on pressure ulcers, use of a 'Tricky Friends' animation, new quality framework and standards, a new Domestic Abuse strategy, and a citizen group for those with lived experience of the safeguarding process, to directly feed into the work of the partnership. The TWSP Board had changed the way training was coordinated to allow for a holistic and all-encompassing approach and to ensure learning was brought together across adult and children safeguarding boards. Training included pressure ulcers, the importance of robust recording within casework, SAR awareness, self-neglect, and domestic abuse awareness.

The local authority conducted case reviews, through an adult review learning and training sub-group, to check agreed actions set out in safeguarding plans had been achieved. Where there was ongoing risk of abuse the safeguarding plan could be reviewed within the adult safeguarding framework. Staff and leaders told us processes were in place to ensure lessons were learned when people had experienced serious abuse or neglect.

The TWSP Board had a SAR panel sub-group who were tasked with using learning from case reviews to drive improvements in practice. In 2022 and 2023 Telford & Wrekin Council had not completed any SARs, however the local authority had had 5 SARs in 2024. Partners, staff, and leaders described how learning was shared from SARs nationally, and from neighbouring local authority areas and the ICS, via monthly newsletters, information leaflets, and engagement with regional and national networks. One of the themes from SARs in 2024 had led to an updated strategic SAB priority around self-neglect.

The local authority told us safeguarding concerns in out of borough placements were responded to by the local authority where the concerns were raised (using an out of area protocol), with similar arrangements in place for mental health services and hospitals within the ICS. Partnership working, and quality assurance processes were in place to ensure communication and oversight.

Responding to concerns and undertaking Section 42 enquiries

The local authority set out clear guidance on what constituted an S42 safeguarding concern in their Safeguarding Threshold for Access to Safeguarding Services Matrix (2024). This was under review at the time of the assessment and used in conjunction with the West Midlands multi-agency safeguarding policies and procedures. This process included clear guidance on how to manage cases which did not meet the threshold to progress to an S42 enquiry as well as identifying the standards and quality assurance arrangements in place for completing enquiries.

Safeguarding plans and actions to reduce future risks for individual people were in place and were acted on where outcomes had been identified. Data provided by the local authority showed in a recent survey 96% of people who had identified desired outcomes felt they had been partially or fully achieved through the safeguarding process.

Local authority data showed 450 safeguarding concerns were received in 2022-2023 with 28.8% progressed to an S42 enquiry. In 2023-2024 this increased to 494 concerns received with 47.9% progressing to S42 enquiries. Staff and leaders told us improvements in referral processes and increased staff and provider awareness had contributed to the increase in S42 enquiries in the last 12 months. The introduction of regular drop-in sessions where teams could discuss any case issues or seek advice had supported quality and consistency. This was in response to the local authority recognising their progression rates were significantly lower than neighbouring authorities.

Senior leaders told us relevant agencies were kept informed of the outcomes of safeguarding enquiries when it was necessary to the ongoing safety of the person concerned. Staff told us there were clear communication pathways for the safeguarding concerns, and there was open communication and updates as cases progressed. However, partners we spoke to said this was not always the case, giving examples of requesting updates on multiple occasions before receiving a response on case progression and outcomes. The local authority had recently introduced a new feedback process to address these inconsistencies, but this process needed time to embed fully to show improved outcomes for people.

The local authority had also identified a need to improve waiting times for reviews of DoLs applications. Data provided by the local authority showed there were 319 DoLs (with a maximum waiting time of 26 months) and 105 CoPs awaiting assessment in 2022-2023; updated data provided for 2023-2024 showed the waiting times for DoLs had improved, with 233 cases waiting for assessment and a maximum waiting time of 15 months. The number of DoLs referrals received in 2023-2024 was 1,003. CoP means court of protection and is required legal process for all community DoLs.

Partners confirmed there were delays with DoLS applications, explaining the local authority was using a prioritisation tool (provided by ADASS) to respond to higher risk cases but lower-level assessments were often waiting for many months. Partners had similar concerns around CoP assessments, citing inconsistencies in understanding of MCA 2005 assessments and a lack of understanding of the application process. For example, partners told us of occasions where people's rights were inappropriately restricted due to a lack of understanding of the MCA Act 2005 by the frontline social work teams.

Whilst the local authority had policies and procedures about upholding people's rights and making sure people's needs were respected and met, these were not fully understood or consistently followed. Feedback from people, staff, and partners consistently identified concerns with DoLs applications. They gave examples of some frontline staff's understanding of people's rights under the MCA Act 2005 impacting on people's independence, and identified frontline staff did not always involve people fully in investigations.

The local authority told us awareness sessions had been organised, with a refreshed legal gateway panel for more complex cases, improved tracking systems on the case management system, staff drop-in sessions, and the inclusion of DoLs in monthly safeguarding data. Senior leaders told us this had improved staff competencies and reduced waiting times. There were also competency-based training programmes in place to increase the number of Best Interest Assessors (BIAs). BIAs are social workers who have undertaken a further qualification of Best Interest Assessor who assess and determine the best interests of individuals who lack the mental capacity to make specific decisions for themselves.

Staff and leaders told us safeguarding processes were quality assured through audits of practice. Learning from enquiries, including themes and trends were shared with staff via reflective staff forums and training. This included LeDeR learning.

Making safeguarding personal

Staff and leaders told us safeguarding enquiries were conducted sensitively, keeping the wishes and best interests of the person concerned at the centre. People confirmed they had the information they needed to understand safeguarding, what being safe meant for them, and how to raise concerns when they did not feel safe or had concerns about the safety of other people. However, not everyone felt included in the safeguarding process when they raised concerns.

National data from the Safeguarding Adult's Collection showed the number of people lacking capacity who were supported by an advocate, family member, or friend was above the average for England in 2023 (100% compared to 83.12%). However, due to the poor uptake of MCA 2005 staff training across Adult Social Care in the borough it is unclear people's capacity was always assessed correctly. National data shared by the Adult Social Care Workforce Estimates (2023) showed 20.48% of the local Adult Social Care workforce had completed MCA and DoLs training, compared to 37.48% nationally.

Overall, people were supported to understand their rights, including their human rights, rights under the MCA 2005 and their rights under the Equality Act 2010. They were supported to make choices which balanced risks with positive choice and control in their lives. However, feedback from people and partner organisations showed frontline teams were inconsistent in their approach and understanding of people's rights, leading to confusion and an increased risk of restrictive practices being agreed. Providers gave us examples of challenging restrictions within DoLs and CoP's where they felt the local authority had not taken decisions fully in the person's best interest, including least restrictive practices.