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

There were effective systems, processes and practices to make sure people were protected from abuse and neglect with 76.88% of people who use services saying that those services had made them feel safe, which is higher than the England average of 71.06% (Adult Social Care Survey).

All safeguarding concerns went into the local authority via the Central Advice and Duty Team (CADT), which were then directed to the Multi Agency Safeguarding Hub (MASH) team. Daily screening of all referrals took place in order to identify any referrals requiring an immediate response. In the event there was an extraordinary number of concerns, there was an agreement in place for locality teams' duty to assist. There was an expectation that MASH completed all concerns within a five-day period from the date received, with staff using a risk prioritisation tool. Staff deployed a threshold matrix in decision making for determining when a concern should be converted to Section 42 enquiries, with consistent managerial oversight.

Although not co-located with partners, the MASH team described positive and accessible working relationships with partners allowing concerns to be investigated without delay. People told us that they had felt supported throughout safeguarding processes and were happy with the outcomes they received. Staff told us that having read-only access to health colleagues IT systems was of benefit.

MASH told us they had an experienced, consistent team with all staff involved in safeguarding work being suitably skilled and supported to undertake their duties effectively. All staff interviewed as part of the assessment were qualified social workers. 55.93% of independent and local authority staff had completed safeguarding training, which was higher than the England average of 48.70% (Adult Social Care Workforce Estimates (ASCWE)).

Partners and providers told us that the process in making a safeguarding referral was straight forward and quick, however some partners told us they received feedback after making a referral and some not. Providers in particular reported not hearing back about safeguarding concerns and having to follow up with the local authority to get feedback relating to any action and outcomes. The Wirral Safeguarding Adults Partnership Board (WSAPB) had raised this issue with the local authority for them to address. Since the assessment, the local authority informed CQC that they had implemented a specialist safeguarding officer attending the provider forum due to this concern being raised, who acted as a contact should providers require further information.

The local authority worked with the WSAPB to deliver a coordinated approach to safeguarding adults in the area. We were told that the WSAPB was well attended, however there had been concerns raised about representation from housing which had been fed back to leaders of the local authority to address.

An adult review group had taken place in May 2024 to assess how the local authority could strengthen embedding of learning taken from safeguarding adult reviews (SARs). WSAPB told us they had strengthened their processes in terms of commissioning SARs and completing them in a timelier manner. The WSAPB had secured links with neighbouring authorities which had enabled learning from local and regional research and practice.

There was a multi-agency risk assessment conference (MARAC) forum in situ at the local authority. Following a recent peer review highlighting the importance of sharing information, a staff member from the Professional Standards Team attended the MARAC and now leads on sharing information and learning across the local authority.

Responding to local safeguarding risks and issues

There is understanding of safeguarding risks and issues in the area. Wirral Safeguarding Adults Partnership Board was re-established in July 2021, following the disbandment of the Merseyside Safeguarding Adults Board which ran for 4 years. The move back to WSAPB was due to a drive to represent more local issues, rather than those of the wider region. We were told that due to moving back to WSAPB, resources had diminished, leaving a team of three workers supporting the board. A recent peer review had recommended WSAPB builds leadership capacity to complete the required work. At the time of assessment, no additional resources had been provided which is the responsibility of the local authority.

The WSAPB told us that the local authority safeguarding data is not easily accessible and understandable. They told us that they have asked for analysis of themes, types of abuse, and outcomes of safeguarding activity so they had good oversight, however they had not been provided this. They had access to the authority's data system however, they wanted information to be presented to them rather than having to drill through data themselves. Leaders were aware that data was not always accurate or easy to interpret and this was a priority to address.

The WSAPB annual report highlighted self-neglect and acts of omission being the most commonly recorded types of abuse in the area. Staff and members of the WSAPB told us that hoarding is a growing concern locally. In response to this, a Wirral Hoarding Improvement Project (WHIP) was recently commissioned by the WSAPB due to increasing concerns around hoarding and the complexity of these cases. The project had brought partners together, as well as people who exhibited hoarding behaviours to discuss how their needs are currently supported and met and how this could be improved.

The average waiting time for a deprivation of liberty safeguards (DoLs) assessment from initial request to assessment start date was 74.63 days, leaving people with unauthorised restrictions for long periods of time. We were told of vacancies in the DoLS team; however, these posts were not being advertised at the point of assessment. 'High levels of DoLS referrals' were included in the local authority's risk register, with 901 cases awaiting assessment as of April 2024. Red, amber, green (RAG) rating of assessments was used when allocating, although we were not told of plans to address the backlog. Following the assessment, the local authority told CQC that they had recruited agency workers to fill vacant posts and offered overtime to tackle the backlog.

We were told about the increase of safeguarding referrals relating to people not having access to mental health beds when having been assessed as requiring detention under the Mental Health Act 1983. Members of the WSAPB felt that this issue could have been brought to the board sooner than it was by health partners due to the serious nature of the risks presented. Staff reported that there had been negative impacts on people's wellbeing which could have been attributable to not having had access to a MH bed, however at the time of assessment no reviews of these cases had been carried out. All new referrals relating to this issue are monitored by the board.

In the 24 months preceding assessment, the WSAPB had received and signed off two SARs. There was recognition from the board that a significant amount of time had passed since the person's death and subsequent publication of one of the reports related to the SAR, and local authority leaders recognised that further progress was needed to connect the WSAPB and the outcomes and learning from SARs and other reviews to their operational practice. 7-minute briefings had been established to share learning from SARs, and staff forums were utilised for reflective practice. Lessons learned from the published SARs included missed opportunities for multi-agency approaches to safeguarding and a need for a better coordinated approach to planning transitions in care. Following the assessment, the local authority told us that they had set up a governance group to ensure that learning is received by relevant agencies to gain assurance around improved practice.

Responding to concerns and undertaking Section 42 enquiries

The local authority had a system in place to address safeguarding enquiries that met the section 42 threshold. Due to concerns about consistency in decision making in safeguarding processes, the local authority had moved to a model of having a MASH team. The MASH team screened all safeguarding referrals and completed Section 42 (S42) enquiries. The locality teams as well as learning disability and mental health teams also completed enquiries where cases were open to their team or workers.

The local authority had seen a drop in safeguarding referrals and conversions to S42 enquiries from 2019 to 2022, however, there was an increase in the past 12 months. In 2022, 3960 Safeguarding concerns were received, with 655 meeting the threshold for a S42 safeguarding enquiry (17%). In 2023, 4771 concerns were received with 824 meeting the threshold for S42 enquiry, matching the conversion rate of the year prior (17%). Staff utilised a threshold matrix in decision making for conversion to S42 enquires, with the conversion rate stable this indicated the tool is consistently used.

The local authority and partners in Wirral NHS Trust measured the number of S42 enquiries open over 28 days. Cases that exceeded 28 days required a dialogue around the rationale for this be recorded and also discussed with a manager. Leaders told us that all current enquires open over the 28 days are awaiting additional information from partners and have ongoing oversight from an allocated worker. Staff in the MASH team told us about managerial oversight of open cases, and that they are provided sufficient time to complete any S42 enquires. As part of the auditing process, we were told all team managers completed case file audits and from this dip sample, families were contacted to gather qualitative feedback about their experience.

Partners told us that they didn't always receive feedback regarding safeguarding outcomes. Providers told us that they frequently had to follow up with the local authority to find out information regarding enquires which had been completed.

The local authority had challenges with waiting lists in relation to Deprivation of Liberty Safeguards (DoLS) applications. In April 2024, the authority had 1206 DoLS applications awaiting allocation, with this identified on the authority's risk register. Staff told us cases are triaged and identified as 'high, medium and low' in terms of risk and level of deprivation to the person with higher risk applications being assessed first. However, the lengthy waiting times meant that risks to people's liberty and safety had not been fully assessed. There was a 'DoLS' team made up of internal staff as well as independent best interest assessors (BIA's) who picked up assessments each week, and a 'regulatory function' team who completed work relating to section 21A challenges. Staff in locality teams and also additional independent BIA's also completed assessments for the authority. The average wait time for a DoLS assessment at the time of our assessment was 74.63 days. Staff reported that they had vacancies within their teams, and there weren't enough staff to pick up assessments.

Making safeguarding personal

Safeguarding enquiries were mainly carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. There were some delays in completion of S42 enquires due to waiting for information from partners, which at times caused long delays. Staff provided practice examples of how they made safeguarding personal, though they weren't confident that partners understood the principals of safeguarding, specifically in relation to consent. They told us about examples of professionals making referrals without gaining consent from the person concerned. Since the assessment, the local authority told CQC that they are developing a Level 3 Safeguarding training to share with partners.

People were able to have support from an advocate if they wished to do so. 83.72% of individuals lacking capacity were supported by an advocate, friend or family compared to the England average of 83.38% (Safeguarding Adults Collection). Staff told us that when people required support from advocacy services, the response was fast and accessible, with clear pathways for people to self-refer. Advocacy services supported with consistency of advocates if people had worked with a particular worker in the past. Leaders told us about having created a pathway on the IT system due to concerns being expressed about delayed referral for advocacy, to prompt staff to consider a referral earlier on, which had helped improve the number of people using advocacy. Local authority data told us that between August 2023 to August 2024, 6 referrals were made for Independent Mental Capacity Advocate (IMCA) support. Due to low levels of referrals, a meeting was held with partners commissioned to provide advocacy support with the teams. Leaders reported that since then they have seen an increase in referrals.

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