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 are protected from abuse and neglect. 75.6% of people who used services in Middlesbrough said they felt safe according to the national Adult Social Care Survey. This was slightly better than the England average of 71.6%. 85.3% of carers felt safe, which was also better than the England average of 80.9%.

All referrals came through the local authority's 'Access and Safeguarding Team.' Referrals were screened by a duty worker for the level of risk and if necessary further information was gathered. A risk management tool and professional judgement was used to triage cases and determined what happened next. For example, was a welfare visit needed immediately or what actions could reduce or mitigate imminent risk. Within 48 hours a decision was made as to whether the matter was high-level and required a Section 42 investigation.

Internal self-auditing was undertaken to ensure the systems and processes were conducted properly and were effective. Staff used an audit checklist to monitor their own cases which was then reviewed by a manager. All cases due to be closed were approved by a manager to make sure they were satisfied all appropriate actions were taken.

Staff monitored safeguarding data through their electronic database, which was interrogated at team meetings for any cases that required escalation as well as monitoring themes and trends, which was fed back to the senior leadership team.

The local authority worked with the Teesside Safeguarding Adults Board (TSAB) and partners to deliver a coordinated approach to safeguarding adults in the area. There was a strong Tees wide approach to safeguarding which 4 local authorities in the region were a member of including Middlesbrough. Policies and procedures approved by TSAB supported staff in their day-to-day work. They told us TSAB was very effective.

TSAB had developed a quality assurance framework which described the impact and outcomes they expected as a result of delivering on the priorities. The Board expected all its statutory partners to deliver on the aims, objectives and actions set out. The plan was clear with measurable outcomes. Staff told us they had recently been audited through this process which had a positive result.

TSAB had subgroups across all 4 local authorities which were chaired and led by a member of each specific council. In addition, each subgroup had a 'task and finish' group to share learning, monitor performance and quality, and drive improvements. An operational work plan was a tool used to measure the subgroups performance against the TSAB strategic plan. It was reviewed at regular intervals to ensure they were on track to meet their objectives. The subgroup was required to report to the Board on their progress at each of their scheduled meetings.

There was a strong multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place, so concerns were raised quickly and investigated without delay. For example, every morning safeguarding staff sat in with police for briefings and received intelligence from the past 24 hours. This helped them identify and support people known to social services quickly. Staff explained that a lot of people in Middlesbrough were exploited or involved in crime, and the daily briefing helped coordinate effective information sharing and action.

Staff were clear about safeguarding being everyone's business. They described working with staff in the community hubs and housing teams to ensure safety in local areas. They also described working with hospital staff and having bi-monthly meetings to oversee any investigations they were leading to ensure effective communication and timely outcomes. Safeguarding staff attended the Multi-Agency Public Protection Arrangements (MAPPA) meetings to give advice on safeguarding and help with risk-assessing situations. They also supported the Multi-Agency Risk Assessment Conference (MARAC), which was a meeting where information was shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing, domestic violence advisors and other specialists from the statutory and voluntary sectors.

All staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively. Staff told us training was really encouraged, and they were always afforded the time to learn. The safeguarding team reported being a close and supportive team. They always ensured there was safeguarding staff represented in the office for other staff to approach for advice and guidance in person. Staff outside of the safeguarding team told us they had received good safeguarding training around different specialist topics.

Regular peer support groups took place where cases could be reviewed, and reflective practice was discussed. Staff received a regular supervision session with their manager which included reviewing caseloads for safety and efficiency as well as providing support where required.

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.

Middlesbrough had several key safeguarding risks which arose from high levels of crime and deprivation, such as sexual exploitation, homelessness, and domestic violence. There was also an awareness of generational issues such as the transmission of poverty within families and reduced employment opportunities, as well as children approaching adulthood who had experienced trauma or had disabilities that had not been diagnosed or addressed.

Leaders had taken action to address these key risks. For example, there was a high-risk adults panel in place which took a multi-disciplinary approach. The panel consisted of local authority safeguarding staff as well as the police and probation services. This was a clear route of escalation for staff to take their cases to.

There was additional support for people who were at risk of being sexually exploited or trafficked for example. Specific safety plans were in place for these people and community outreach teams kept in close contact with them. There was an overview panel for sexual exploitation with partner organisations to identify cases and people at risk. If it were agreed a person met the criteria, they would be assigned an officer to gather the evidence and support an investigation. Staff told us this has been beneficial and highlighted the scale of this issue.

Trauma informed training and supervision sessions were carried out with staff to develop their skills and knowledge in this area.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice.

Between November 2022 and May 2024 Middlesborough local authority had 5 safeguarding adults' reviews (SARs). There were an additional two SARs from 2021 which were still active. Of the total reviews, 1 was not progressed, 2 had been published with action plans being developed and 3 were still in progress. The TSAB meeting dated April 2024 included a review of open SARs. There were 11 cases open at various stages, from being reviewed, final reports to action plans. Lessons learned through TSAB and SAR outcomes were shared to support learning and improvements in practice to reduce future risks. Staff told us a senior leader had delivered a staff briefing on SARs to further enhance staff knowledge and drive improvement.

There was a dedicated SARs manager who conducted an annual thematic review of SARs and referrals. In addition to these reviews the SARs manager also completed a national review of where TSAB ranked in comparison to national statistics.

Responding to concerns and undertaking Section 42 enquiries

Safeguarding staff at Middlesbrough local authority followed the TSAB Adult Safeguarding policies and procedures in relation to Section 42 (s42) enquiries. An s42 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. There was a clear pathway for staff to follow when there was reasonable cause to suspect their s42 duty was necessary. After a proportionate fact-finding exercise staff progressed to an investigation or signposted to alternative action such as an assessment/review, a complaint, input from other services or initiating another type of enquiry, for example when the person had died.

Staff demonstrated clarity on what constituted a s42 concern and when enquiries were required. This was applied consistently. Staff recorded a clear rationale and outcome from initial concerns including those which did not progress to a s42 enquiry. Data provided by the local authority showed between October 2023 and October 2024, on average 63% of all concerns had progressed to a s42 enquiry.

When safeguarding enquiries were conducted by another agency, such as a care or health provider, the local authority retained responsibility for the enquiries and the outcome for the person(s) concerned.

Staff told us responsibility for conducting a s42 enquiry was dependent on whether the person had an allocated social worker. The allocated worker would do some of the investigation with oversight from a safeguarding social worker and the safeguarding staff would create the s42 enquiry report. The safeguarding team still held the enquiry within their team whilst the allocated worker did their part of the enquiry and then fed back the findings. If the person did not have an allocated worker, the safeguarding staff would do the whole enquiry. Safeguarding staff held the responsibility for all safeguarding decisions, on whether cases needed to be investigated or go to the high-risk panel.

There were clear standards and quality assurance arrangements in place for conducting s42 enquiries. From April 2024, managers in the safeguarding team commenced an internal audit, looking specifically at adherence to TSAB policies and procedures and fed back themes to staff for learning and sharing best practice.

Data provided by the local authority showed there were no safeguarding referrals awaiting an initial review and no s42 enquiries awaiting allocation. As of November 2024, 203 Deprivation of Liberty Safeguard (DoLS) applications were waiting allocation, but all of these had been reviewed and risk assessed. Priority was given following strict criteria.

Most of the backlog of DoLS applications was related to people who had moved into a residential care setting. This had been escalated to the senior leadership team for action. Managers and the principal social worker regularly reviewed the priority list and checked if people's circumstances had changed. A provider confirmed that high-risk people were prioritised.

Safeguarding staff told us referrers of safeguarding concerns were involved throughout the process when it was necessary to ensure the ongoing safety of the person. However, this seemed dependent on what the concern was, and who the referrer was. Partner organisations and providers told us they were not always informed of the outcomes of safeguarding enquiries.

One partner organisation said when raising safeguarding concerns, it could be a lottery to receive an acknowledgement dependent on who was allocated to the case within the local authority team. However, in the main they participated in case conferences and were updated with outcomes. Another partner organisation told us they did not always receive outcomes of any safeguarding concerns they had raised, and said they would follow up with the local authority for updates or progress.

Providers also described an inconsistent approach, with some getting feedback quickly and being kept informed, whilst others said they did not get outcomes and had to chase the safeguarding team for information. We fed this back to the local authority during our assessment.

Making safeguarding personal

The local authority's approach to safeguarding was person-centred with policies and procedures reflecting this ethos. The local authority's safeguarding strategy was in line with the sector-led initiative 'Making Safeguarding Personal' objective to embed a culture which focused on personalised outcomes. Safeguarding enquiries were conducted sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. Staff told us they made sure people's views were personal from the initial referral. They record evidence that they have spoken to the person as part of the process. They told us that sometimes they get turned away by people, but they really do try to build trust.

A partner organisation told us they had engaged with their communities to look at what safeguarding meant to them. They had created videos for social media and promoted community champions, who were professionals who supported different community groups. This demonstrated people had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they did not feel safe, or they had concerns about the safety of other people.

People could participate in the safeguarding process as much as they wanted to and 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 they were supported to make choices that balanced risks with positive choice and control in their lives.

Staff told us they invited the person and people involved in their care to meetings so they could take part in the process. If people struggled with technology staff offered to go to their house and support them to access online meetings. They also offered people the option of attending the meeting in person.

The local authority partnered with an advocacy support service and staff could make referrals for independent advocates to support people. Staff told us there were slight waiting lists at times, but they did prioritise cases, always based on risk. Staff said if it were urgent, they would follow up a referral with a phone call to expedite that case. Safeguarding Adults Collection data dated August 2024, showed 100% of individuals lacking capacity were supported by an advocate, family, or friend in Middlesbrough.
