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 local authority's systems, processes, practices to make sure people were protected from abuse and neglect were not always effective. Oversight of the length of time safeguarding enquiries took to resolve was not always robust and investigations took longer to resolve than expected.

Feedback on people's experience of safeguarding processes included concerns around unsafe hospital discharges leading to readmissions and stress and anxiety for people and their families. Safeguarding enquiries around people's transition between services were not always robust, with the local authority's 8-step process not always followed, and recent SARs highlighted systemic gaps and areas for improvement including how the escalation of people's risky behaviours were recorded and responded to, how incidents of people's sexual safety and risks were responded to, particularly in the context of lack of mental capacity, and the timeliness of interventions from out of hours services.

Senior leaders told us they received monthly safeguarding performance reports, with quarterly operational and SAB updates analysed with the SAB Chair. Leaders were briefed on performance data including the number of initial safeguarding contacts, the number of concerns progressing to Section 42 enquires, and themes around the types of abuse being seen in different service areas of North Tyneside. Despite this, not all staff understood the data available to them or how to use it to keep people safe. Staff understanding of safeguarding data dashboards varied, with some telling us they were unaware of them. This led to confusion around performance outcomes and a lack of communication about themes and trends.

The North Tyneside SAB oversaw partnership arrangements in the borough to ensure local safeguarding arrangements were in place to help and protect adults at risk. The SAB reported into the Health and Wellbeing Board and the Safer North Tyneside Board. Scrutiny occurred through the Council's Caring Sub-Committee, which was responsible for performing the overview and scrutiny function for all matters relating to adult social care in North Tyneside.

Staff told us there were processes in place for managing safeguarding concerns. Concerns were triaged by front door teams and subsequent enquires led by frontline teams with the support of their service managers and the safeguarding team. The safeguarding team provided regular support and advice to frontline teams as well as monitoring the quality and progress of enquiries. However, despite processes being in place to monitor safeguarding enquiries, a number of concerns remained open to investigation for considerable periods of time.

Responding to local safeguarding risks and issues

There was a clear understanding of the safeguarding risks and issues in North Tyneside. The local authority worked with safeguarding partners to proactively reduce risks and to prevent abuse and neglect from occurring. Senior leaders told us there was a clear understanding of safeguarding risks and issues, with a focus on self-harm, alcohol and drug misuse, and homelessness. For example, the local authority created its first alcohol strategy, following an increase in hazardous and dependant drinking, increasing numbers of children being admitted to hospital due to alcohol intake, and an increase in the number of crimes involving alcohol.

Senior leaders told us the SAB Manager provided quarterly updates on progress against priorities to the council's Senior Leadership Team ensuring all senior leaders in the council were sighted on the work of the Board and current safeguarding issues. The SAB reported an increase in safeguarding concerns by 21% from 4,000 in 2022-2023 to 4,834 in the year 2023-2024. Section 42 enquiries increased by 14% from 1,412 to 1,611 in the same period.

Staff and leaders told us lessons were learned when people had experienced serious abuse or neglect, and action was taken to drive best practice. For example, 2024 saw developments positively impacting safeguarding practice in North Tyneside, with the launch of a Safeguarding Transition Protocol, a refreshed Exploitation Policy and Procedure, and the creation of a Multi-Agency Risk Management (MARM) Protocol.

Partners told us there were strong working arrangements and learning from SARs at local and regional levels. The North Tyneside SAB Annual Report for 2023-2024 highlighted 3 new SAR referrals had been made in the previous 12 months. Decisions were also made on 2 cases deferred from the previous year. Of these 5 SARs, 3 did not meet the threshold for review criteria and 2 proceeded to a full SAR.

Staff and leaders told us learning from the first SAR in 2024 included 8 recommendations in January 2024 in relation to multi-disciplinary responses and multi-agency knowledge about sexuality and mental capacity, professional record keeping, and incident protocols. Further learning in September 2024 identified systemic gaps and areas for improvement for partners within the system including how the escalation of people's risky behaviour was recorded and responded to, how incidents of people's sexual safety and risks were responded to, particularly in the context of a lack of mental capacity and the timeliness of out-of-hours services. Learning from the second SAR highlighted gaps in partnership working, pre-admission and assessment checks.

Senior leaders told us they had implemented a 'SAR In Rapid Time' methodology for the first time in 2024, enabling an expedited timeline to publication, ensuring timely action to address identified learning. As well as ensuring learning by agreeing actions to support practice improvement and hosting multi-agency events and briefings the local authority produced bitesize video learning to promote wider engagement from staff. North Tyneside also undertook non-SAR learning briefings, to ensure learning was taken from situations which did not meet the criteria for full SAR investigations.

Partners told us multi-agency risk pathways such as the Multi-agency Risk Assessment Conference (MARAC) and the MARM Panel ensured a partnership approach to safeguarding and high-level risks such as self-neglect, hoarding, and domestic abuse. The local authority played a lead role in the daily Multi-Agency Safeguarding Hub (MASH) triage, enabling more accurate risk assessment, shared decision making, and improved partnership working. Responding to increasing numbers of safeguarding concerns, a dedicated Safeguarding and Public Protection Practitioner from Cumbria, Northumberland and Tyne and Wear NHS Trust joined the Adult MASH in 2024, to facilitate improved communication and collaboration with involved mental health services.

Responding to concerns and undertaking Section 42 enquiries

Staff and partners told us there was clear guidance on what constituted a Section 42 safeguarding concern and when S42 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 S42 enquiries. When safeguarding enquiries were conducted by another agency, for example a care or health provider, the local authority retained responsibility for the enquiry and the outcome for the person concerned.

Staff and leaders told us they maintained operational leadership of safeguarding practice through a team of specialist senior social workers, providing consultation and guidance across frontline teams. This included leading on quality assurance and scrutiny of safeguarding responses, undertaking scheduled and deep dive/thematic audits, monitoring team performance, and scrutinising out-of-timescale S42 enquiries. Despite this, data provided by the local authority showed S42 safeguarding enquiries remained open for extended periods of time. For example, data showed multiple safeguarding enquiries which were still open 120 days after initial concerns were raised.

Data provided by the local authority showed at the end of January 2025 there were 268 ongoing S42 enquiries with an average length of 53 days. The longest ongoing S42 safeguarding enquiry had been open for 1,342 days at the end of January 2025. Senior leaders told us they were aware of the length of time this enquiry had been open, and the specific reasons for this, and were working in collaboration with safeguarding partners to monitor and mitigate the risk. The local authority and their partners had taken the specific decision to leave this safeguarding enquiry open to ensure the safety of the person during unique circumstances.

At the time of our assessment there were 35 safeguarding adult enquiries which had been ongoing for over 120 days. For each enquiry, a summary was provided outlining the concerns, agencies involved, and key features of the protection plan implemented to keep people safe. We were assured processes were in place to keep people safe and where enquiries were still open, this was as a conscious decision by the local authority to maintain contact with people rather than due to lack of engagement or implementation of actions to keep people safe.

Data provided by the local authority showed 4,697 safeguarding referrals had been received between April 2024 and January 2025, up from 3,899 for the same period in 2023-2024. 31.34% of safeguarding concerns received in this period were progressed to S42 enquiries. This was down 2.13% on the previous year. National data provided by SAC (2024) showed the average number of safeguarding referrals received per year by North Tyneside between 2019 and 2023 was 3,615, with the average number of referrals progressing to S42 enquiries being 1,217 (33.67%). The average for England for the same period was 30.46%. In January 2025 there were 471 safeguarding concerns received, with 133 S42 enquiries started and 266 on-going enquiries at the end of the month.

The local authority's '8 Steps' procedures defined target timescales for safeguarding adult enquiries. Information gathering and decision making on progressing safeguarding concerns to S42 enquiries took place within 48 hours of the receipt of a new concern. Monitoring enquiry duration formed a key element of Safeguarding Adults Senior Social Workers' scrutiny of performance in their aligned teams, using data to highlight enquiries which could require additional focus, support, or escalation. However, timescales could be extended with a clear rationale for doing so, with protective measures in place to mitigate risks. The local authority told us they believed this was in line with the principles of adult safeguarding, balancing person-centred practice with the duty to protect.

Following a case conference, if risks remained under-managed, the enquiry remained open with case conference reviews scheduled as a maximum every 30 working days. Senior leaders told us there was no defined maximum enquiry length. In complex situations where concerns persisted, it was felt continuing safeguarding adult enquiries provided a framework for ongoing multi-agency partnership working, and management oversight.

Staff and leaders told us the number of DoLS referrals had continued to rise year on year, with a 78% year to date increase reported in August 2024-2025 compared to 2023-2024. Despite this the number of people on the waiting list for a DoLS assessment had dropped by 13% to 501 people by the end of July 2024. Since then, the number of people waiting for DoLS assessments had begun to increase with 618 people on the waiting list in February 2025. The local authority had implemented a DoLS Project Plan, increasing the capacity of their DoLS team and streamlining the referral and assessment processes, making it easier for people to get the support they need. They had trained 11 more signatories and refreshed the Mental Capacity Assessment training available to frontline staff.

As a result of the changes made to manage DoLS assessments, staff and leaders told us waiting times had reduced significantly, from 10 months at the start of 2024 to 4 months at the time of our assessment and projected the number of people waiting for DoLs assessments would also begin to reduce significantly by mid-2025.

Staff and leaders told us risk was managed for people waiting for DoLS assessments through the use of the local authority's 'decision support tool' in conjunction with the 'Waiting Well' prioritisation of need tool which provided consistent risk criteria and actions to keep people safe for frontline teams. Senior leaders told us they used the ADASS DoLS Priority Tool to support decision making and to ensure frontline staff focused on the most urgent cases first.

Partners expressed frustration about long waiting lists for DoLs assessments, telling us how they had an impact on people receiving support as well as their families as they were not able to change their circumstances while awaiting the outcome of assessments.

Making safeguarding personal

People told us safeguarding enquiries were carried out sensitively, keeping the wishes and best interests of the person concerned at the centre. 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 others.

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, under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices which balanced risks with positive choice and control in their lives.

North Tyneside SAB Annual Report 2023-2024 showed 81.4% of adults at risk were asked their desired outcomes through the S42 process, an increase on the figures for 2022-2023 of 79%. However, data provided by the local authority's January 2025 safeguarding dashboard showed only 67.15% of people who raised a safeguarding concern between April 2024 and January 2025 had been asked about the outcomes they wanted from the subsequent enquiry. Data also showed 95.70% of those people asked, felt their outcomes had fully or partially been achieved.

Partners told us relevant agencies were not always informed of the outcomes of safeguarding enquiries and a multi-agency review commissioned by the SAB identified areas for safeguarding process development including communication needs not being considered, diversity and difference not being recognised, and MARM processes not always being followed. The findings of the review also identified examples of good practice. For example, the Mental Capacity Act 2005 was followed, action was taken to reduce risk, there was sufficient intervention, and people were generally kept informed.
