

# 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

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There were effective systems, processes, practices to make sure people were protected from abuse and neglect. The local authority had clear safeguarding procedures that ensured concerns were screened promptly and responded to according to risk. For example, safeguarding referrals were RAG-rated, with high-risk cases addressed within 24 hours and moderate risks within five days. This approach meant people at immediate risk received timely intervention, reducing harm and promoting safety.

Processes were strengthened through audits and adaptations to forms, which included immediate risk indicators and proportionality checks. Safeguarding teams reviewed referrals to confirm appropriateness and achieved outcomes in 99% of cases. This improved confidence in safeguarding decisions and helped maintain trust in protective services.

National data from the Adult Social Care Survey 2023/24 showed 69.75% of people who used services felt safe, similar to the England average of 71.06%. In addition, 86.42% of people who use services said services made them feel safe, similar to England average of 87.82%. Carers also reported positive experiences, with 81.82% feeling safe, aligning with national figures. These findings indicated that safeguarding processes had a tangible impact on people's sense of security.

The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area. The Safeguarding Adults Board provided strategic oversight and worked collaboratively with partners to implement priorities such as prevention, making safeguarding personal, and quality assurance. For example, the annual report highlighted achievements in raising awareness of self-neglect and hate crime through short videos, aiming to increase early referrals. This proactive approach helped prevent harm and supported people before risks escalated.

Partners described strong engagement and responsiveness. Advocacy organisations reported timely communication and clear outcomes from safeguarding teams. Healthwatch and voluntary sector partners valued the ability to discuss concerns openly, which supported shared accountability and improved safeguarding responses.

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The Board also sought continuous improvement by reviewing how data was presented and ensuring community forums reflected local needs. This commitment to transparency and inclusivity strengthened trust and ensured safeguarding strategies were shaped by lived experience.

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. Safeguarding coordinators worked across departments and boroughs, liaising with partners and leading statutory enquiries. For example, joint provider risk panels brought together local authority staff, health partners, and regulators to address provider concerns and agree actions. This collaborative approach ensured risks were managed effectively and decisions were defensible.

Information sharing was embedded in processes. For instance, safeguarding meetings included families and maintained confidentiality while sharing investigation outcomes. Partners confirmed that safeguarding procedures were clear and easy to follow, with monthly risk panel meetings reviewing cases and wider implications. These arrangements meant concerns were escalated promptly, and investigations were rigorous.

All staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively. The local authority monitored training compliance and competency through audits and governance boards. For example, a Care Governance Board report noted a 96% completion rate for safeguarding training but identified gaps in refresher training for locum staff. Actions were taken to improve attendance at forums and ensure staff maintained up-to-date knowledge.

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Despite these efforts, data from the Adult Social Care Workforce Data 2024/25 highlighted challenges. Only 22.82% of independent / LA staff completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training, compared to the England average of 46.27%. In addition, 29.43% of independent / LA staff completed safeguarding adults training, below the England average of 60.68%. This indicated a need for continued focus on training compliance to maintain high standards of practice.

Staff feedback showed a positive safeguarding culture, with most feeling confident to raise concerns and challenge unsafe practice. Staff surveys reported that 77% of staff felt able to use whistleblowing procedures and 81% felt confident challenging poor practice. This culture supported early identification of risks and reinforced the local authority's commitment to protecting people from harm.

## 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. The local authority had a clear picture of safeguarding risks through analysis of data, feedback from events, and themes from Safeguarding Adult Reviews. This informed strategic priorities for the next five years, which focused on multi-agency learning and improving practice across the partnership. For example, the strategic plan addressed risks such as self-neglect and hoarding by introducing a community forum and preventative work. This approach helped partners respond earlier and reduce harm.

Staff development was prioritised to strengthen safeguarding practice. For instance, the local authority created short learning sessions and podcasts to embed learning from safeguarding incidents and reviews. Managers reported these sessions were useful when safeguarding concerns did not meet the threshold for a review. This ensured staff could reflect on practice and apply learning in future cases, improving decision-making and safeguarding responses.

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Partnership working supported risk reduction. For example, safeguarding leads engaged with providers and the voluntary sector to share learning and improve referral quality. They delivered sessions on what makes a good safeguarding referral and visited community groups to raise awareness of abuse and reporting processes. This helped people access support earlier and reduced the likelihood of harm escalating.

The local authority also monitored emerging risks through a safeguarding risk log. This identified issues such as workforce pressures, mental health concerns, and financial abuse linked to the cost-of-living crisis. Actions included joint workforce planning, awareness campaigns, and collaboration with partners such as the fire service. These measures aimed to prevent abuse and neglect and protect people from harm.

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. Learning from Safeguarding Adult Reviews was shared promptly and embedded into practice. For example, following a review into transitional safeguarding, the local authority developed an action plan to improve information sharing between children's and adults' services and ensure care leaver status was central to transition planning. This reduced the risk of gaps in support when young people moved into adult services.

Another review highlighted risks for people with alcohol dependency. It found that mental capacity assessments were not time-specific, which meant cognitive impairments were overlooked. In response, the local authority identified the need to strengthen multi-agency expertise in complex capacity assessments. This helped ensure people received appropriate support and reduced the risk of harm.

The local authority also improved family involvement in reviews and had created clear guidance and a leaflet explaining the purpose and process of reviews. This supported transparency and helped families contribute to learning, which informed better practice.

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Learning was shared through reflective sessions, podcasts, and newsletters. For example, after a review identified the importance of trauma-informed practice, the local authority ran targeted sessions and worked with partners to embed this approach. This improved staff understanding of how trauma affects people's lives and supported more compassionate and effective safeguarding responses.

## Responding to concerns and undertaking Section 42 enquiries

The local authority had clear guidance on what constituted a Section 42 safeguarding concern and when enquiries were required. Staff applied this consistently, and there was a clear rationale and outcome from initial enquiries, including those that did not progress to a Section 42 enquiry. For example, managers described how short learning sessions were used effectively when safeguarding concerns did not meet the criteria for a review, ensuring staff understood thresholds and acted appropriately. This clarity helped people receive timely responses and avoided unnecessary escalation.

Power BI data showed an average of 1,748 safeguarding concerns and 484 Section 42 enquiries. This indicated thresholds were applied appropriately. For example, safeguarding leads explained that they shared learning themes from deep dives with providers to improve referral quality. People were safeguarded without unnecessary processes, reducing delays and focusing resources where most needed.

When safeguarding enquiries were conducted by other agencies, the local authority retained responsibility for the enquiries and the outcomes for people. Safeguarding leads described how they worked with community safety teams on homicide reviews and ensured learning was embedded across agencies. This oversight meant people's safety remained the priority and accountability was clear.

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There were clear standards and quality assurance arrangements for conducting Section 42 enquiries. Learning from reviews was shared with partners before publication and cases were selected carefully to ensure relevance. For example reviews highlighted gaps in practice, such as people with alcohol dependency who were not homeless not being prioritised for support, and mental capacity assessments not being time-specific, leading to missed cognitive impairments. These issues meant some people did not receive timely or appropriate safeguarding responses. Learning from these reviews had informed changes to practice, improving outcomes for people with complex needs.

Data showed timely allocation for most enquiries: in July 2025, one person awaited initial review with a median wait time of zero days and a maximum of 11 days; two Section 42 enquiries awaited allocation with a median wait time of zero days and a maximum of 12 days. This demonstrated effective monitoring and reduced risks for people.

The local authority monitored safeguarding activity through risk logs and strategic priorities. For example, risks such as workforce pressures and lack of referrals for community deprivations of liberty were mitigated through joint workforce planning and prioritisation. This proactive approach helped maintain safeguarding standards and reduced risks for people during periods of increased demand.

Safeguarding plans and actions to reduce future risks were in place and acted on. For example, following a review, actions were taken to improve information sharing between transitional panels and ensure care leaver status was integral to planning. These changes supported smoother transitions and better protection for people moving between services.

Providers reported receiving outcome reports with recommendations to prevent recurrence, although some noted this was more consistent when concerns progressed to Section 42 enquiries. Improved communication helped agencies respond effectively, but inconsistency risked gaps in safeguarding for people.

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Data showed that from June 2024 to June 2025, 181 new DoLS referrals were assessed, with a median wait time of 15 days and a maximum of 49 days. In July 2025, 11 DoLS referrals awaited allocation, with a median wait time of 15 days and a maximum of 49 days against a target of 21 days. While most referrals were allocated within target timescales, longer waits for some referrals highlighted the need for continued monitoring to ensure people's rights were upheld promptly.

## Making safeguarding personal

Safeguarding enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. Safeguarding practice showed a strong focus on people's wishes and best interests. For example, care records and social worker reflections confirmed that a Mental Capacity Assessment took place to ensure decisions were made in the person's best interests. The assessment was person-centred and involved the person and their representative positively. Although the person lacked capacity to make decisions, their views were considered, such as feelings about their family home. Decisions balanced the need to find the least restrictive option with the need to secure safety and wellbeing. Examples such as safeguarding teams working with providers during care placement breakdowns demonstrated collaborative approaches to maintain safety while respecting rights. Staff described how safeguarding referrals were managed even when they did not meet statutory thresholds, with onward referrals to community groups and domestic abuse organisations to reduce risk. This approach helped people feel supported and safe during complex situations. These actions meant people experienced safeguarding that respected their rights and preferences, reduced unnecessary restrictions, and promoted trust in protective services.

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People had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they didn't feel safe or they had concerns about the safety of other people. The local authority improved communication with people about safeguarding processes. For instance, safeguarding-related complaints highlighted concerns about poor referral and dissatisfaction with outcomes. In response, the local authority explained the purpose of safeguarding screenings and subsequent actions more clearly. This promoted better understanding and helped maintain trust in protective services. Partners also reported positive engagement. For example, a voluntary sector partner described how the local authority asked for the person's views and wishes during a domestic abuse referral and supported them to develop their own safety plan. This helped the person feel in control of the safeguarding process. Clear communication and personalised approaches meant people understood safeguarding, felt confident to raise concerns, and trusted the local authority to act in their best interests.

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, 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. Evidence showed people were supported to participate in safeguarding. For example, safeguarding teams described how advocacy was used in reviewing a financial safeguarding referral, alongside best interest and mental capacity assessments to ensure decisions were lawful and person-centred. Staff and leaders confirmed improvements in safeguarding practice, including training on domestic abuse and self-neglect to build confidence in applying the Mental Capacity Act. A safeguarding adult's review led to the creation of a multi-agency panel for self-neglect and hoarding, attended by fire services, police, health partners, and social care teams. This collaborative approach helped balance risk with positive choice and control for people. These actions meant people could participate fully in safeguarding, access advocacy when needed, and make informed choices that respected their rights and promoted independence.

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National data from the Safeguarding Adults Collection for 2023/24 showed positive performance in advocacy and rights-based support. 100% of people lacking capacity were supported by an advocate, family, or friend, significantly better than the England average of 83.38%. This ensured people who lacked capacity were not disadvantaged and had representation in safeguarding decisions, promoting fairness and equality.

Safeguarding and DoLS processes evolved over time. For example, Community DoLS guidance was updated in 2023, and a screening tool was embedded to manage applications by priority. Training sessions, webinars, and templates were introduced to build workforce confidence. Staff reported improvements in community DoLS practice, though acknowledged ongoing challenges with court applications. These developments strengthened safeguarding governance and improved consistency, helping people experience safer, more rights-based care.