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 had effective systems, processes and practices to protect people from abuse and neglect. Following a Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) bespoke peer review on safeguarding effectiveness, the local authority had produced a safeguarding improvement action plan and made changes to their systems. This included action to improve responses to safeguarding concerns and section 42 (s42) safeguarding enquiries in a timely manner. A 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.

Prior to the review, safeguarding work was carried out by 3 teams, the central safeguarding team, the mental health team and the learning disability, autism, and transition team. To make improvements, the local authority amended their operating procedure and reviewed their Operational Safeguarding Model. They made a change for practitioners in other teams to undertake safeguarding work where they were already allocated and working with a person. This change supported people to be supported by staff that were known to them following safeguarding referrals.

The local authority worked with the Cumbria Safeguarding Adults Board (SAB) and partners to deliver a co-ordinated approach to safeguarding adults in the area. When the LGR occurred, it was decided to keep a single SAB covering 2 local authorities. A partner told us this decision had been monitored, and it had been deemed to be a success and provided continuity for all and benefited from sharing good practice. The SAB had 4 subgroups which focused on specific areas of safeguarding. The subgroups were Learning and Development, Safeguarding Adult Review, Communication and Engagement and Performance and Quality Assurance. The subgroups fed into the SAB, for example the Performance and Quality Assurance subgroup reviewed and analysed safeguarding data and monitored if learning from safeguarding adult reviews (SARs) and incidents had been embedded.

A partner told us the SAB was a mature board with a good culture, with all partners attending and able to challenge and scrutinise safeguarding practice across the partnership. They told us they were confident in the local authority's senior leaders' ability to interpret safeguarding data and highlight any issues to the board.

There was senior level leadership and oversight of safeguarding work. The SAB chair met regularly with senior leaders to discuss strengths, areas for improvement and how changes were being embedded. The local authority had a performance dashboard to support oversight and team managers had safeguarding huddles twice weekly to discuss allocations and any delays. The monthly Safeguarding Oversight Support Group meeting also had oversight of the safeguarding pathway.

Partners told us the process to raise safeguarding concerns with the local authority was simple and straightforward and most partners spoke positively about collaborative working in safeguarding, with strong relationships at strategic and practitioner level. Partners said areas for improvement were the relationships at middle management level and information sharing in relation to safeguarding. Staff teams told us there was a lot of joint working and spoke positively about relationships with partners. An example was a manager working with the police to review the vulnerable adult report the police received and identify the people who needed support from the local authority.

The changes in the Operational Safeguarding Model meant some staff were undertaking safeguarding work who did not have previous experience. However, staff teams told us they had completed safeguarding training and felt supported to undertake safeguarding duties effectively. They spoke of a variety of ways they had received support including support from managers, from advanced practice leads and joint working with the safeguarding team.

National data showed positive experiences of how safe people felt. For example, data from the Adult Social Care Survey for 2023/24 showed that 72.34% of people who used services felt safe. This was similar to the England average of 71.06%. Also 91.19% of people who used services said that those services made them feel safe and secure. This was somewhat better than the England average of 87.82% (ASCS, 2023-2024). Also, for carers, 85.64% of carers felt safe. This was somewhat better than the England average of 80.93% (SACE, 2023-2024).

Responding to local safeguarding risks and issues

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. The SAB had clear systems to support decision making on whether referrals met the criteria for a SAR. For the 2 years up to the end of January 2025, the local authority had 3 SARs. Each SAR had a detailed action plan, which was overseen by the SAR subgroup to ensure the local authority and all key partners took any necessary action and provided assurance. Staff teams told us learning was embedded following SARs and appropriate action was taken. For example, through lunch and learn sessions, the SAB newsletter, discussion in team meetings, training with advanced practitioner leads and joint sessions with health.

There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with the SAB and safeguarding partners to reduce risks, although there needed to be further development of response in relation to self-neglect. There had been 5 referrals for a SAR where there were concerns about self-neglect. They all met the threshold, so a decision was made to do a thematic SAR, which was ongoing. A leader told us self-neglect was a key risk area for the local authority and there was some practice issues identified around professional curiosity and relationship-based practice. A partner said they had seen some good practice in this area but also saw some difficulties where self-neglect concerns had been identified too late.

In response to this local risk, the local authority had launched their self-neglect strategy in October 2023, supported by briefing sessions. This was a brief strategy which gave an overview of self-neglect challenges and good practice in response to self-neglect. Although the strategy did link to a self-neglect practice tool and the detailed SAB multi-agency guidance, the strategy did not include robust localised guidance including responsibilities, timescales and oversight. The lack of localised guidance increased the risk of an inconsistent approach and there was scope for the local authority to review this further, following the more recent SARs. Further work to look at challenges in relation to self-neglect had also been identified in the bespoke safeguarding peer review, although this was not included as an action in the local authority's safeguarding plan. The local authority recognised an increase in self-neglect concerns and were committed to continued learning and supporting staff to respond effectively to self-neglect.

Staff teams were aware that self-neglect was a risk area and told us about actions in place to respond to this risk. For example, there was a 2-weekly meeting with the safeguarding team, the fire service and the home improvement agency to discuss concerns about people who were self-neglecting and high risk. Another example was staff using the clutter tool and the SAB self-neglect checklist to support the assessment of risk. A staff team also told us there was a focus on relationship building with the person where self-neglect was identified and joint working with other teams.

The SAB were introducing regular multi-agency practitioner forums for staff working with people at risk to promote good practice, share safeguarding examples and further understanding of roles and responsibilities. It formed part of the Cumbria SAB Learning and Development Strategy 2024/26 and was to be hosted on a quarterly basis, facilitated by colleagues across the partnership. The first forum was focusing on self-neglect and mental capacity and was to be co-chaired by a leader in the local authority. The local authority had commissioned training around safeguarding adults, 'complex cases', expected outcomes and the Mental Capacity Act, all of which included response to self-neglect and staff could access the Safeguarding Oversight and Support Group (SOSG) for advice and support around people at risk. However, a staff team felt there was still a gap in training around self-neglect and drug and alcohol use.

Responding to concerns and undertaking Section 42 enquiries

Systems supported consistency in decision making about when s42 safeguarding enquiries were required. Safeguarding concerns were received via the SPA team and went to the safeguarding, mental health or learning disability, autism and transition duty teams to decide whether the criteria was met to progress to a s42 enquiry. Decisions to close or progress safeguarding concerns were overseen by managers. This approach gave consistency in decision making, and the number of triage workers in the safeguarding team had recently been increased to support with the volume of safeguarding concerns.

Provider and partner feedback however, highlighted a lack of clarity in the understanding of safeguarding thresholds for referrals, and providers told us there had been no support or training from the local authority in this area. Some partners said the safeguarding threshold for a s42 enquiry was high, and in their experience very few safeguarding concerns progressed to a s42 enquiry. They shared an example of a referral where there were concerns about risk, but the person didn't meet the safeguarding threshold and there was a lack of support and contingency planning. A staff team told us there was a SAB threshold tool to support partners, but this was quite outdated and due to be updated. They shared an example of a session that was carried out with a specific partner who needed more support to understand safeguarding, however, they were not aware of any wider training for partners or providers.

The local authority had made changes to their safeguarding systems to ensure more timely identification of safeguarding concerns which met the threshold of a s42 enquiry. Delays to this decision making had been highlighted in the bespoke safeguarding peer review. The s42 decision was made by the duty worker in the safeguarding, mental health or learning disability, autism, and transition team. The practitioner would contact the person for more information to aid decision making. Managers told us prior to these changes, the decision to progress to a s42 enquiry was being made later in the process, causing delays. They told us oversight through data had helped them to understand the delays and to act. This had supported more timely safeguarding processes.

Local authority data submitted in June 2025, showed no safeguarding concerns were awaiting initial review. This showed an improvement from data received in February 2025, when 59 safeguarding concerns were awaiting initial review. Where a safeguarding concern progressed to a s42, the person's case was triaged as medium or high risk. Staff teams told us urgent work would be allocated to a worker on the same day and where the safeguarding was triaged as medium risk this would be overseen by a manager to allocate. Data received by the local authority in June 2025 showed for s42 enquiries there were 47 enquiries awaiting allocation: with the median wait time for allocation being 6 days and maximum wait time being 29 days.

There were quality assurance arrangements in place for conducting s42 enquiries. Occupational therapists led on specific concerns for example, manual handling, falls or pressure damage which meant there were able to bring their specialist knowledge. Managers used a safeguarding dashboard to have oversight of safeguarding work and met twice a week to look at any delays and take action. S42 enquiries were reviewed and signed off by managers, to ensure risks were mitigated, which staff said was positive and quality assured safeguarding work. The local authority also carried out case file audits, which could include people's cases where there had been safeguarding concerns. The audit included a dedicated section on safeguarding, although the local authority did not have a specific safeguarding audit. This meant there had not been specific focus on safeguarding work and quality assuring practice across teams. However, senior leaders told us in their audits in August 2025, the local authority was specifically focusing on safeguarding practice.

The local authority was exploring more opportunities for safeguarding enquiries to be conducted by other agencies, where appropriate. This had been highlighted in the bespoke peer review as a missed opportunity and a leader told us there were plans to progress this. It was included in the local authority's safeguarding plan, with actions to use stakeholder meetings to review concerns and agree enquiry leads and engage support from the SAB to promote shared understanding and engagement. A staff team told us there were occasions where partners led on safeguarding enquiries with oversight from the local authority. For example, a health partner led on a s42 enquiry where there were risks around the person's health needs. The local authority highlighted this work was being progressed at a safe and responsible pace in support of partners.

Partners and providers gave mixed feedback about whether they were informed of the outcomes of safeguarding enquiries. Some said they did receive outcomes and were involved in safeguarding meetings and learning from safeguarding was shared. Others told us they had to chase for outcomes. Staff teams told us they had to feed back outcomes before the safeguarding enquiry was closed and there was a process in place to inform both the person and referrer of the outcome.

There were delays in assessing DoLS applications which increased the risk of people's liberty being restricted. As of June 2025, there were 774 DoLS applications waiting for allocation. The median waiting time for people was 557 days with the maximum wait at 1989 days. A staff team told us there were not enough staff to meet the level of demand, but the size of the team was increasing. Partners told us DoLS work was a challenge for the local authority and were concerned the waiting time meant some people were potentially unlawfully deprived of their liberty.

Staff and managers told us improvements were being made to systems and the recording of DoLS work had moved onto their electronic care management system in April 2025. Prior to the move DoLS data was collated on a spreadsheet. They told us moving to the electronic system would enable them to use a Power BI report so they could have accurate and live information in relation to DoLS work. However, this reporting was not available until all the data had been transferred onto the electronic record, which was still in progress at the time of our assessment.

The local authority had systems for the prioritisation of DoLS, using the ADASS national prioritisation tool which supported staff to triage applications in relation to risk and urgency, this meant the more urgent authorisations were actioned first. There was also some project work underway to check historic applications to ensure the information was still up to date, and if the person still required an assessment.

Making safeguarding personal

Systems supported consistency in decision making about when s42 safeguarding enquiries were required. Safeguarding concerns were received via the SPA team and went to the safeguarding, mental health or learning disability, autism and transition duty teams to decide whether the criteria was met to progress to a s42 enquiry. Decisions to close or progress safeguarding concerns were overseen by managers. This approach gave consistency in decision making, and the number of triage workers in the safeguarding team had recently been increased to support with the volume of safeguarding concerns.

Provider and partner feedback however, highlighted a lack of clarity in the understanding of safeguarding thresholds for referrals, and providers told us there had been no support or training from the local authority in this area. Some partners said the safeguarding threshold for a s42 enquiry was high, and in their experience very few safeguarding concerns progressed to a s42 enquiry. They shared an example of a referral where there were concerns about risk, but the person didn't meet the safeguarding threshold and there was a lack of support and contingency planning. A staff team told us there was a SAB threshold tool to support partners, but this was quite outdated and due to be updated. They shared an example of a session that was carried out with a specific partner who needed more support to understand safeguarding, however, they were not aware of any wider training for partners or providers.

The local authority had made changes to their safeguarding systems to ensure more timely identification of safeguarding concerns which met the threshold of a s42 enquiry. Delays to this decision making had been highlighted in the bespoke safeguarding peer review. The s42 decision was made by the duty worker in the safeguarding, mental health or learning disability, autism, and transition team. The practitioner would contact the person for more information to aid decision making. Managers told us prior to these changes, the decision to progress to a s42 enquiry was being made later in the process, causing delays. They told us oversight through data had helped them to understand the delays and to act. This had supported more timely safeguarding processes.

Local authority data submitted in June 2025, showed no safeguarding concerns were awaiting initial review. This showed an improvement from data received in February 2025, when 59 safeguarding concerns were awaiting initial review. Where a safeguarding concern progressed to a s42, the person's case was triaged as medium or high risk. Staff teams told us urgent work would be allocated to a worker on the same day and where the safeguarding was triaged as medium risk this would be overseen by a manager to allocate. Data received by the local authority in June 2025 showed for s42 enquiries there were 47 enquiries awaiting allocation: with the median wait time for allocation being 6 days and maximum wait time being 29 days.

There were quality assurance arrangements in place for conducting s42 enquiries. Occupational therapists led on specific concerns for example, manual handling, falls or pressure damage which meant there were able to bring their specialist knowledge. Managers used a safeguarding dashboard to have oversight of safeguarding work and met twice a week to look at any delays and take action. S42 enquiries were reviewed and signed off by managers, to ensure risks were mitigated, which staff said was positive and quality assured safeguarding work. The local authority also carried out case file audits, which could include people's cases where there had been safeguarding concerns. The audit included a dedicated section on safeguarding, although the local authority did not have a specific safeguarding audit. This meant there had not been specific focus on safeguarding work and quality assuring practice across teams. However, senior leaders told us in their audits in August 2025, the local authority was specifically focusing on safeguarding practice.

The local authority was exploring more opportunities for safeguarding enquiries to be conducted by other agencies, where appropriate. This had been highlighted in the bespoke peer review as a missed opportunity and a leader told us there were plans to progress this. It was included in the local authority's safeguarding plan, with actions to use stakeholder meetings to review concerns and agree enquiry leads and engage support from the SAB to promote shared understanding and engagement. A staff team told us there were occasions where partners led on safeguarding enquiries with oversight from the local authority. For example, a health partner led on a s42 enquiry where there were risks around the person's health needs. The local authority highlighted this work was being progressed at a safe and responsible pace in support of partners.

Partners and providers gave mixed feedback about whether they were informed of the outcomes of safeguarding enquiries. Some said they did receive outcomes and were involved in safeguarding meetings and learning from safeguarding was shared. Others told us they had to chase for outcomes. Staff teams told us they had to feed back outcomes before the safeguarding enquiry was closed and there was a process in place to inform both the person and referrer of the outcome.

There were delays in assessing DoLS applications which increased the risk of people's liberty being restricted. As of June 2025, there were 774 DoLS applications waiting for allocation. The median waiting time for people was 557 days with the maximum wait at 1989 days. A staff team told us there were not enough staff to meet the level of demand, but the size of the team was increasing. Partners told us DoLS work was a challenge for the local authority and were concerned the waiting time meant some people were potentially unlawfully deprived of their liberty.

Staff and managers told us improvements were being made to systems and the recording of DoLS work had moved onto their electronic care management system in April 2025. Prior to the move DoLS data was collated on a spreadsheet. They told us moving to the electronic system would enable them to use a Power BI report so they could have accurate and live information in relation to DoLS work. However, this reporting was not available until all the data had been transferred onto the electronic record, which was still in progress at the time of our assessment.

The local authority had systems for the prioritisation of DoLS, using the ADASS national prioritisation tool which supported staff to triage applications in relation to risk and urgency, this meant the more urgent authorisations were actioned first. There was also some project work underway to check historic applications to ensure the information was still up to date, and if the person still required an assessment.
