Safeguarding

Score: 1

1 - Evidence shows significant 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 approach to managing safeguarding contacts and enquiries had improved over recent years. However, safeguarding enquiries were not always prioritised and there were challenges in staff confidence and delays in processes which meant enquiries were not always timely. Not all staff were clear about roles and responsibilities around safeguarding.

The local authority had responded to concerns from a peer review regarding their safeguarding model and implemented a 'hub and spoke' approach and launched the Safeguarding Adults Hub. This was in response to findings in 2022 in which there were 2000 outstanding safeguarding concerns and unallocated enquiries. In this new approach, all safeguarding concerns were reviewed in the Safeguarding Adults Hub by senior social workers and should be risk assessed within 24 hours. Where these resulted in safeguarding enquiries (section 42 enquiries) they were then allocated to the appropriate professional to complete the enquiry: this included partners, providers, and operational social care teams. A section 42 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.

Some staff expressed concerns about this process, which had been in place for around a year at the time of our assessment. Several staff recognised the benefits of the model, understanding the completion of s42 enquiries by staff who knew the person and the area provided a more person-centred approach. Some staff were positive about the model, appreciating the development and maintenance of key social care skills. Others were concerned s42 enquiries affected the relationships people and their families had with their allocated worker. There were some concerns from staff there was a gap in a shared understanding of all safeguarding roles and a level of uncertainty in the process that was challenging to manage.

The local authority conducted an evaluation of the safeguarding model in April 2025. There were a series of clear recommendations to improve training, practitioner confidence, guidance, and support staff wellbeing for example. Recommendations were made through this evaluation on improvements, though not all actions were robust or clearly progressed. For example, some feedback indicated there were system recording issues such as a lack of case notes or closures without notifications from the Safeguarding Adults Hub to other operational teams, but this was not identified for any further investigation or action. The local authority provided guidance to staff but it was clear from their evaluation there was more to do to ensure staff could attend training and build confidence with the guidance to better support safeguarding activity. A safeguarding practice forum was in place to provide opportunities for staff to get support with any active work.

The local authority's evaluation of their safeguarding model was confident staff had the skills to effectively support safeguarding work. However, there was a difference in this perception for staff. Some staff told us the right level of support around safeguarding concerns and completing safeguarding enquiries was not in place. They said there was a gap in shared understanding of each other's roles in regard to safeguarding. The evaluation indicated the safeguarding training offer was under review and that some bitesize training had not been well attended. This contributed to a lack of practitioner confidence.

Overall, national data indicated people felt safe: 79.58% of people who used services felt safe, which was better than the England average of 71.06% (Adult Social Care Survey – ASCS, 2024). Additionally, 92.12% of people who used services said those services have made them feel safe and secure, which is somewhat better than the England average of 87.82% (ASCS, 2024). This was similar for carers: 86.02% of carers felt safe, which was somewhat better than the England average of 80.93% (Survey of Adult Carers in England, 2024).

Partners could access local authority run training on safeguarding, which was free for their commissioned services. We received mixed feedback from providers and partners about the availability of safeguarding training and learning shared with them following specific enquiries. A cascade training model was in place where some voluntary and community sector organisations had been trained up to deliver safeguarding training to other case sector organisations in the area. National data indicated the suitable skillset of staff completing safeguarding work: 49.35% of independent or local authority staff completed MCA DoLS training which was better than the England average of 37.58% (Adult Social Care Workforce Estimates, 2024). According to the same data, 60.42% of independent and local authority staff completed safeguarding adults training which was significantly better than the England average of 48.70%.

The local authority had arranged a further review of its safeguarding processes in the months following our assessment.

Responding to local safeguarding risks and issues

The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area. The local authority worked in collaboration with a range of partners and the roles and responsibilities for identifying and responding to concerns were clear. The local authority took an active role in relevant boards and subgroups.

The local authority was a statutory member of the East Riding Safeguarding Adults Board (ERSAB). The ERSAB included the police and Integrated Care Service as statutory partners alongside a range of other partner agencies, including representatives from the prisons in the area, fire and rescue services, and advocacy and community sector organisations. This represented wide involvement in the activity of the board and opportunities to understand the safeguarding risks and issues in the area from a variety of sources. An oversight board was in place to consider children's and adults safeguarding issues and a crime reduction partnership supported a joined-up approach to system understanding of local safeguarding risks and issues.

The local authority, supported by the ERSAB, understood the safeguarding risks and issues in the area. The priorities for adult safeguarding were outlined in the ERSAB Strategy 2022-2025. This identified key priorities linked to safeguarding risks and issues in the area, including engaging with communities and seldom-head communities, modern slavery, transition protocols and improving the experiences of people with a learning disability in safeguarding processes. There had been specific work to reach out to voluntary and community groups in the area to ensure understanding of safeguarding. This had been a key priority of the ERSAB Strategy.

A recent SAR identified improvements in the consideration of alcohol use alongside self-neglect. One partner echoed this for example: they told us there wasn't always a good response to safeguarding concerns related to alcohol or mental health issues. A local authority leader told us alcohol dependence in safeguarding had been identified as a training gap. Training for staff was commissioned in response in conjunction with the voluntary and community sector. The ERSAB had also launched a Multi-Agency Risk Management Procedure (MARM) in May 2025 to facilitate effective multi-agency working with adults at risk of harm and who are deemed to have mental capacity.

Mental capacity was a feature of this and other recent SARs. Some local authority staff identified this was still a concern in some partnership contexts, for example in relation to hospital discharge. The ERSAB Annual Report 2023-2024 identified application of mental capacity assessments as an area for improvement. The ERSAB's learning and development focussed subgroup took forward any partnership training. The local authority had released a variety of guidance documents and 'what if' cards to support their staff to understand mental capacity, alongside other safeguarding concern areas. Hoarding had also been identified as an increasing area of concern. Practitioners from adult social care worked with ERSAB to develop training on hoarding disorder, resulting in e-learning and resources. This supported the hoarding protocol, developed in partnership with a lead from the fire and rescue service. This example indicated a collegiate approach to responding to local safeguarding risks and issues.

The ERSAB had an engagement strategy and was undertaking specific work with voluntary and community sector organisations to increase the participation of people with lived experiences in safeguarding work. This included engaging community advocacy organisations to lead SAR activity in response to people's needs. The local authority chaired the ERSAB's Actions and Assurance subgroup to deliver, monitor and execute the actions relating to SARs. This ensured it was central to progressing actions from SARs.

Responding to concerns and undertaking Section 42 enquiries

Process changes made significant improvements to local authority backlogs related to safeguarding contacts and enquiries in recent years. The local authority's model prioritised people at highest risk. However, there were delays for some people in the progression of safeguarding investigations linked to staff capacity and process delays. Recording and reporting information did not provide a clear picture of enquiry progress.

Leaders told us their safeguarding model meant all contacts were screened within 24 to 48 hours. The median time from receipt of a safeguarding concern to an outcome of the concern (including the decision to progress to a s42 enquiry) was 8 days between June 2024 and June 2025. Activity at this stage included initial fact finding and risk assessment, and initial safety plans where needed. Some staff raised more consistency in these safety plans as an area for development with us and in the safeguarding model evaluation in April 2025. The local authority said that interim plans were dependent on circumstances individual to the contact and context.

Staff told us that the system for recording safeguarding contacts could be convoluted: if staff identified a concern, they had to complete an external form, rather than use the case management system, for this to be triaged and then usually passed back to the originating team on the case management system. Staff told us this created delays.

The local authority set out expectations for external organisations completing s42 enquiries in writing through a letter for every enquiry. This included a checklist to ensure people's voice and outcomes were considered within the enquiry. We received mixed feedback from partners about the safeguarding process. Some partners said it was easy to make a referral, they were talked through the process, and they found the process clear and responsive. Others said the process was less supportive and consistent than previously and they received little practical guidance to understand decision making. One provider said they regularly chased the local authority for outcomes where they had completed the s42 enquiry. The local authority recognised this needed improvement in their self-assessment.

The number of safeguarding concerns received by the local authority had been rising over recent years. According to Safeguarding Adults Collection data for 2024, between April 2020 and March 2021 there were 2,515 safeguarding contacts to the local authority. For April 2023 to March 2024 there were 5,690. One partner told us there had been increased awareness raising of safeguarding across the sector and this had contributed to an increased number of contacts. While safeguarding contacts had increased, the percentage of concerns progressing to s42 enquiry had decreased from the April 2020 and March 2021 period: 37% of concerns progressed to s42 enquiries, compared to 17% of concerns between April 2023 to March 2024. While this conversion rate was lower than in 2020, the rate had remained level at 17% for the last 3 years. The conversion of safeguarding contacts to section 42 enquiries could be due to several factors, and does not, on its own, indicate safeguarding practice. According to local authority data, there were 437 open safeguarding concerns at the time of our assessment at the start of June 2025, with 55 of these progressing through initial fact finding. The remaining 383 were awaiting this initial fact-finding work.

Some staff said due to pressure on caseloads, staff who knew the person and their family often couldn't pick up the enquiry and the intended benefits of the local authority's safeguarding model were not realised. The median wait time for a s42 enquiry to start was 7 days, for the June 2024 to June 2025 period, though there was some evidence there could be significant variation. The local authority's internal evaluation indicated 34% of enquiries commenced within 7 days, and 67% within 28 days. The remaining 33% had significant wait times longer than 28 days. The median time for completion of a safeguarding enquiry was 49 days for internal staff and 6 days when the enquiry was completed by an external organisation. This reflected feedback from staff who said it was difficult to prioritise safeguarding work amongst their wider caseloads.

A weekly report was shared with us showing how leaders tracked safeguarding activity, but this primarily focused on volume and did not track how long activity took or what risk level it related to. For example, the report asserted all concerns were triaged within 24 hours to ensure the immediate safety of the person was attended to, but no data in the report indicated this detail. This made it unclear whether this was actual or aspirational. However, the local authority indicated they had access to on demand data within a PowerBI dashboard where managers could monitor and ensure safeguarding activity was allocated and processed in a timely way. Leaders were confident that waits related to lower risk safeguarding concerns and high-risk concerns were promptly screened and allocated.

The local authority recognised recording functionality improvements were needed within the safeguarding adult's pathway. Their case management system only recorded key episodes which did not always reflect the level of work underway as part of the safeguarding process, or account for when enquiries paused, such as the progression of police investigations, or additional delays that were outside of the control of the practitioner.

The local authority had a Deprivation of Liberty Safeguards (DoLS) team responsible for the processing of applications. This supported the local authority to understand and respond to the risks to people's safety and wellbeing presented by deprivation of liberty. However, current delays in progressing applications meant people's liberty may have been restricted unnecessarily.

The local authority used a mixture of internal and external Best Interests Assessors (BIAs). At the start of June 2025, there were 907 DoLS applications waiting to be allocated to a BIA. The median wait time for the allocation of a BIA was 29 days between June 2024 and June 2025. Staff and leaders told us there had been an increase in applications in the past 12 months and recruitment issues had increased the number of people waiting. The team used the Association of Directors of Adult Social Services (ADASS) tool to support prioritisation in line with recognised practice. The DoLS team reviewed their waiting list regularly to ensure applications were prioritised and reviewing teams regularly reviewed restrictions and applications in care homes as part of their work.

The local authority recorded where applications to deprive someone of their liberty in the community had been approved by the Court of Protection. However, recording of where applications were progressing but not yet approved could be patchy and some staff told us they were not confident it was accurate. This lack of accurate recording potentially risked missing where people's human rights may be infringed as part of Care Act duties, such as in assessments, care planning and reviews.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively. People had the information they needed to understand safeguarding, how to raise concerns when they didn't feel safe, or if they had concerns about the safety of other people. The local authority was updating their concerns portal at the time of our assessment to make it more user-friendly. Use of advocacy to support safeguarding enquiries was low, which affected people's involvement in safeguarding processes.

The local authority implemented a specific safeguarding audit to complement their existing audit activity. This was in response to staff feedback and launched in November 2024. The audit centred around the 6 principles of safeguarding: empowerment, prevention, proportionality, protection, partnership, and accountability. The local authority's safeguarding data for 2023/2024 indicated that 79% of people were asked about the outcome they wished to achieve and 80% had their desired outcome partially or fully met. Principles of making safeguarding personal, including capturing the voice of the person, were present in guidance to internal and external staff when completing enquiries. Staff described ways in which they were considerate of people's communication preferences and consent when progressing safeguarding concerns and enquiries. In one example, staff described working with a provider to ensure there was private time with a person who was experiencing coercive control. This supported the individual's safety while supporting the outcomes and considerations they wanted, ensuring their human rights were respected. The local authority had a good relationship with their legal services, which allowed them to ensure any challenges related to legal obligations within complex situations were considered. In one example shared with us, it was clear there was sufficient consideration of the balance of a duty of care and the person's human rights.

The local authority's website, Your Life, Your Way, had information aimed at the public about keeping adults safe. This included information about the types of abuse, hate and mate crime, and advice about avoiding scams. The information linked to safety in the community and protection from crime and prevention of abuse alongside clear ways to contact services about concerns. This supported people to understand safeguarding and how to raise concerns when they didn't feel safe or they had concerns about the safety of other people. The local authority also outlined the concerns portal was being reviewed to make it more user-friendly for both the public and professionals, providing clarity on how to report quality concerns and safeguarding adult concerns.

Use of advocacy, however, was low. National data indicated 32.91% of people who lacked capacity were supported by an advocate, family or friend, which was significantly worse than the England average of 83.38% (Safeguarding Adults Collection, 2024). Partners and the local authority identified this needed to improve and requests for advocates were not consistent for s42 enquiries. The local authority's advocacy provider sat on the ERSAB to support partnership intentions to improve the involvement of people within the safeguarding process. Further training was expected to be provided to staff around advocacy awareness, the referral process and criteria for an advocate to be involved.
