

2025–26 Safeguarding Annual Report

Executive Assurance Summary

Quality and Outcomes Committee

July 2026

NHS Lancashire and South Cumbria Integrated Care Board
Safeguarding

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Executive Assurance Summary

OVERALL ASSURANCE OPINION

MODERATE TO SIGNIFICANT ASSURANCE

The evidence presented in the ICB Safeguarding Annual Report 2025/26 demonstrates that safeguarding arrangements are established, active and subject to governance oversight. Assurance is not yet fully mature in all areas; identified gaps are under active management and require continued Committee oversight during 2026/27.

This provides the Committee with a clear line of sight that safeguarding risks are recognised, governed and actively managed, while identifying where further evidence of measurable improvement is required.

1 Purpose

- 1.1** This report provides the Quality and Outcomes Committee with an executive assurance summary of the NHS Lancashire and South Cumbria Integrated Care Board Safeguarding Annual Report 2025/26.

It sets out how the ICB has discharged its statutory safeguarding responsibilities, the evidence supporting assurance, the limitations and residual risks, and the priorities requiring continued oversight in 2026/27.
- 1.2** The Committee is asked to receive assurance that safeguarding remained embedded as a core statutory function during a period of organisational and system change, supported by established governance, accountability, provider assurance, audit, learning and risk management arrangements.
- 1.3** The report demonstrates significant progress against the Safeguarding Strategic Plan 2024–2027, with activity aligned to person-centred safeguarding, stronger system assurance and governance, and learning and improvement. Fourteen priorities were identified for 2025/26. The majority were fully achieved or showed significant progress
- 1.4** The Committee is also asked to note that assurance remains partial in a number of areas and to maintain oversight of the actions and mitigations described in this report.

2 Executive Assurance Position

2.1 The Annual Report evidences that the ICB continues to discharge safeguarding responsibilities as a commissioner, employer and statutory safeguarding partner across children's safeguarding, adult safeguarding, Children in Care and Care Leavers, the Mental Capacity Act, Court of Protection, Prevent, Domestic Abuse and the Serious Violence Duty.

2.2 Assurance is derived from multiple sources rather than activity reporting alone. These include statutory accountability arrangements; regular Quality and Outcomes Committee reporting; the safeguarding risk register and dashboard; provider Safeguarding Assurance Framework returns; Section 11, S-CAT and MIAA assurance; single and multi-agency audit; safeguarding supervision; statutory learning reviews; partnership intelligence; performance information; and evidence of action planning and escalation.

This triangulated approach strengthens confidence that assurance is based on evidence, challenge and follow-up rather than activity reporting alone.

Throughout the year, full representation has been maintained within Safeguarding Partnership arrangements for adults and children, and Children in Care / Care Leavers.

The ICB has provided assurance submissions against its safeguarding responsibilities:

- Quarterly Safeguarding Commissioning Assurance Toolkit (S-CAT)
- Annual Section 11 Audit
- MIAA Safeguarding Audit

The ICB has undertaken a review of its safeguarding arrangements against the requirements set out within the NHS England Safeguarding Protocols and associated safeguarding accountability expectations. This review has provided assurance that appropriate governance, leadership, professional expertise, commissioning oversight, partnership engagement, safeguarding supervision, workforce development and quality assurance arrangements are in place to support the effective discharge of statutory safeguarding duties. No significant gaps in compliance were identified. Where opportunities for further strengthening have been recognised, these have been incorporated into safeguarding priorities and improvement plans for 2026/27.

2.3 The evidence supports an overall opinion of moderate to significant assurance. The system is governed and improving, but there are areas where performance, compliance or the evidence of impact is variable and therefore requires continued scrutiny in 2026/27.

Assurance at a glance

Assurance area	Assessment	Evidence supporting assurance	Residual risk / limitation
Governance and statutory accountability	Significant	Clear CEO/CNO accountability, Director of Safeguarding leadership, designated roles, partnership representation, Committee reporting and risk oversight.	Maintain statutory capacity and accountability through ICB reform.
Strategic plan and annual priorities	Moderate to significant	Most of the 14 priorities were fully achieved or made significant progress.	Complete carried-forward priorities and ensure measurable impact.
Large provider assurance	Significant	All six large providers returned SAF submissions; no major risks	Continue monitoring provider action plans.

Assurance area	Assessment	Evidence supporting assurance	Residual risk / limitation
		identified and actions are in place where compliance was incomplete.	
Wider commissioned provider assurance	Partial	Broad assurance reach across primary care, independent contractors, pharmacy, optometry, dentistry and regulated care.	Variable return rates and gaps in training, MCA, supervision, safer recruitment, LADO/PIPoT and review learning.
Audit, learning and supervision	Moderate	Broad programme triangulates audit, reviews, provider assurance, quality visits and professional support.	Strengthen evidence that learning has changed frontline practice and outcomes.
Children in Care and Care Leavers	Partial	Embedded statutory data reporting, partnership audits and improvement activity.	Variable IHA/RHA performance and sustainability of Medical Advisor arrangements.
MCA and Court of Protection	Partial	Specialist oversight, training, audit, tools and high-risk case governance are in place.	Complex practice, workload, delays, backlogs and implementation of the AGNI judgment.
Prevent, Domestic Abuse and Serious Violence	Moderate	Established statutory and partnership governance, training and programme activity.	Prevent Policy completion, review demand and sustainability of non-recurrently funded programmes.

3 Evidence Supporting Assurance

3.1 Statutory accountability and governance

- 3.1.1 Clear accountability arrangements remain in place. Overall accountability rests with the Chief Executive Officer, with delegated responsibility to the Chief Nursing Officer, supported by the Director of Safeguarding and Designated and Named Professionals.
- 3.1.2 The safeguarding risk register is routinely reviewed through safeguarding governance arrangements and reported to the Quality and Outcomes Committee. Risks are informed by provider assurance, audit, learning reviews, statutory performance indicators, partnership intelligence and emerging policy or legislative developments.
- 3.1.3 Full representation has been maintained across adult and children safeguarding Boards and Partnerships, Corporate Parenting Boards, Child Death Review Panels and Community Safety Partnerships. This supports both the discharge of statutory partner duties and the triangulation of system intelligence.

This has supported timely escalation, shared ownership of safeguarding risks and continued statutory partnership influence across Lancashire and South Cumbria.

3.2 Delivery against Strategic Priorities

- 3.2.1 The report demonstrates significant progress against the Safeguarding Strategic Plan 2024–2027, with activity aligned to person-centred safeguarding, stronger system assurance and governance, and learning and improvement.
- 3.2.2 Fourteen priorities were identified for 2025/26. The majority were fully achieved or showed significant progress. Fully achieved areas included maintaining safeguarding standards during reform, benchmarking across dentistry, optometry and pharmacy, partnership delivery, implementation of audit activity, child death governance review, service-user voice, MCA improvement and PiPoT data review.
- 3.2.3 Partially achieved priorities have been transparently carried forward. These include review of the Learning to Improve Framework, Children in Care and Care Leaver arrangements, CP-IS Phase 2, ratification of the Prevent Policy and Family First Partnership Programme delivery.

Carrying these priorities forward ensures that areas requiring further work remain visible, governed and linked to the 2026/27 improvement programme.

3.3 Assurance of Commissioned Services

- 3.3.1 The annual Safeguarding Assurance Framework (SAF) process extended across large providers, primary care medical services, small and independent contractors, pharmacy, optometry and dentistry services, and regulated care services.
- 3.3.2 All six large provider organisations submitted returns. No major risks were identified, and action plans are in place where full compliance was not achieved. This provides significant assurance for the major NHS provider cohort.
- 3.3.3 For wider commissioned sectors, the exercise identified non-compliance or incomplete assurance in training, MCA, supervision and recording, LADO and PiPoT processes, safer recruitment and embedding learning from reviews. The assurance value lies in both identifying these gaps and establishing support, action planning, reminders and potential contractual escalation for non-compliance.

The process gives visibility of variation across commissioned services and provides a clearer basis for support, escalation and future contract or quality oversight.

3.3.4 The 2026/27 provider assurance model will be reviewed to align with the revised ICB operating model and to strengthen safeguarding information within contracting and quality assurance tools. This will support a stronger commissioning line of sight between provider compliance, safeguarding risk and measurable improvement.

3.4 Audit, Learning and Supervision

3.4.1 A broad audit programme covered Court of Protection/DoLS, domestic abuse, Children in Care and Care Leavers, primary care, self-neglect, Prevent/Channel, Section 42 enquiries, Making Safeguarding Personal, neglect and safeguarding quality visits.

3.4.2 Audit findings were triangulated with safeguarding standards, provider assurance, partnership audit and quality visits. Recurring themes included consent, thresholds, information sharing, professional challenge, the voice of the person or child, escalation, supervision, safer recruitment, online safety, LADO awareness and MCA practice.

Triangulating these themes has helped direct learning, supervision and assurance activity towards the areas most likely to affect frontline safeguarding practice.

3.4.3 There is evidence of tangible impact in some areas. For example, IRIS is a general practice-based domestic abuse training, support and referral model that helps primary care staff identify and respond safely to patients affected by domestic abuse. Evaluation of IRIS implementation identified increased confidence among practice staff to recognise, ask and respond to domestic abuse, and recorded 250 referrals into services.

3.4.4 Safeguarding supervision and professional support have strengthened decision-making, escalation, legal literacy, resilience and relationships with provider safeguarding teams. Themes from supervision inform governance, policy, workforce planning and learning activity.

This has contributed to improved confidence, more consistent decision-making and stronger professional challenge across safeguarding practice.

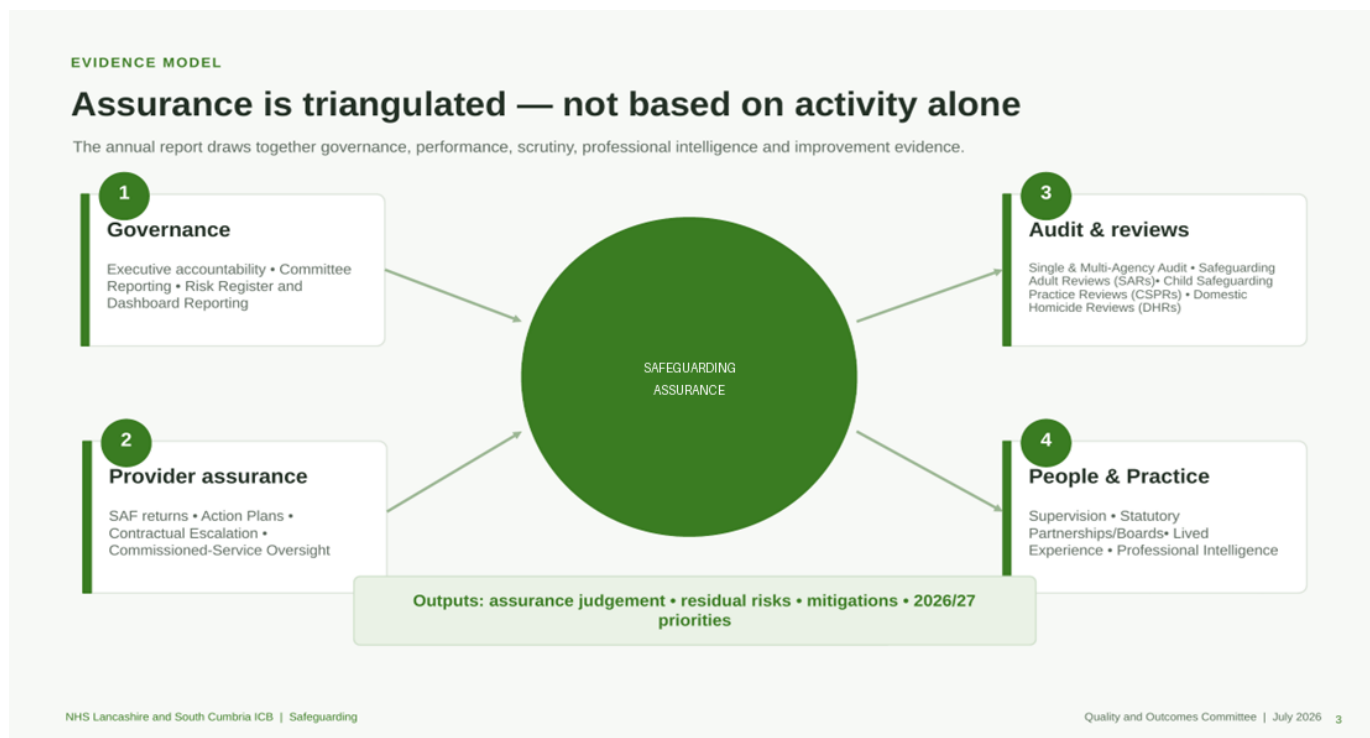


Figure 3: Evidence model

4 Areas of Partial Assurance and Required Oversight

4.1 Safeguarding Training Compliance

4.1.1 In March 2026 the ICB position shows variable compliance:

- Preventing Radicalisation Basic Awareness 92%
- Prevent Awareness 89%
- Safeguarding Adults Levels 1 - 89.1%, 2 - 87.9% and 3 at 40.3%
- Safeguarding Children Levels 1- 88.1%, 2 - 85.9% and 3 at 58.5%

4.1.2 Assurance is partial because improvement work undertaken at the beginning of 2025/26 included cleansing and refreshing the ICB training system. Mapping work commenced to ensure the ICB workforce was appropriately aligned to the Intercollegiate Document. Reporting arrangements are in place; however, data systems require further maturation, as compliance at Levels 3–5 is not yet reliably demonstrated or recorded due to ESR inputting requirements. Mandatory safeguarding training compliance is therefore a specific priority for 2026/27.

4.2 Children in Care and Care Leavers

4.2.1 System-wide statutory data reporting is embedded and multi-agency audits have identified high-quality health assessments that inform care planning. This supports earlier identification of health needs and strengthens the contribution of health information to care planning for Children in Care and Care Leavers.

4.2.2 However, Initial and Review Health Assessment timeliness and quality remain inconsistent across providers because of demand, workforce capacity, children not being brought to appointments and delays in documentation which result in delayed care planning to ensure outstanding health needs are met.

4.2.3 The permanency of Medical Advisor arrangements for adoption and fostering remains a strategic risk. Work with partners to secure sustainable arrangements must remain under governance oversight in order to support timely decision-making for children and strengthen statutory health input into adoption and fostering processes.

4.3 Mental Capacity Act and Complex Adult Safeguarding

4.3.1 MCA assurance is supported by learning resources, refreshed e-learning, supervision, audit, data reporting and tools for frontline practitioners. These arrangements are intended to improve legal literacy, support least restrictive practice and strengthen practitioner confidence in complex decision-making.

4.3.2 Assurance remains partial because risk assessment and care planning do not always sufficiently evidence least restrictive practice; co-occurring mental ill health and substance misuse create pathway challenges; and provider assurance often relies on training completion rather than evidence of application in complex practice. Continued audit and supervision are required to demonstrate that MCA learning is consistently applied in practice and improves outcomes for people with complex needs.

4.4 Court of Protection and Deprivation of Liberty

4.4.1 The Court of Protection Team managed 258 COPDOL cases and renewals requiring annual review and maintained quarterly governance oversight of higher-risk backlog cases and renewals. This provides governance oversight of people subject to complex deprivation of liberty arrangements and helps prioritise higher-risk cases.

4.4.2 Residual risks arise from court delay, workforce pressures, charging arrangements for the signing of Unsound of Mind Letters from Primary Care, renewal and application backlogs, and complex Section 21A and welfare activity.

- 4.4.3** The AGNI Supreme Court judgment clarified that deprivation of liberty assessments require a multifactorial, person-specific analysis rather than reliance on a single diagnostic or care-setting factor. This requires review of existing cases, policies, templates and assessment processes, together with training and continued monitoring of emerging case law. Implementation and risk impact require formal Committee oversight.

Implementation will strengthen the legal robustness of assessments and support more person-specific consideration of liberty, risk and care arrangements.

4.5 Learning reviews and demonstrable impact

- 4.5.1** Open review activity is significant. The report records 48 open cases across Lancashire and South Cumbria in April 2026: 36 DHRs, 11 SARs and 4 CSPRs.
- 4.5.2** Mechanisms are in place to disseminate learning, the principal assurance gap is demonstrating that recommendations have been embedded and have produced measurable change in frontline practice and outcomes. Strengthening impact measurement will help demonstrate whether review learning has changed practice, reduced repeat themes and improved safeguarding responses.

4.6 Multi-Agency Safeguarding Hubs

- 4.6.1** Health capacity within MASH arrangements remains a recognised risk because of increasing demand and variation in local commissioning arrangements.
- 4.6.2** Mitigation includes escalation between the ICB, Local Authorities and providers, a refreshed MASH Position Statement and Designated Nurse oversight. Capacity and consistency require continued monitoring. Continued oversight will support more consistent health input into safeguarding decision-making for young people at risk and vulnerable families and reduce the risk of variation across local arrangements.

4.7 Serious Violence Programme Sustainability

- 4.7.1** Evaluations of Emergency Department Navigator and Trauma Informed training programmes demonstrate positive intervention outcomes. These programmes support earlier intervention with people at risk of violence and provide evidence to inform future prevention and commissioning decisions.
- 4.7.2** Continued reliance on non-recurrent funding creates a risk to workforce stability and service continuity. Sustainability, evidence and outcomes should inform future commissioning decisions. A clearer sustainability position will help protect service continuity, retain specialist capacity and support longer-term prevention outcomes.

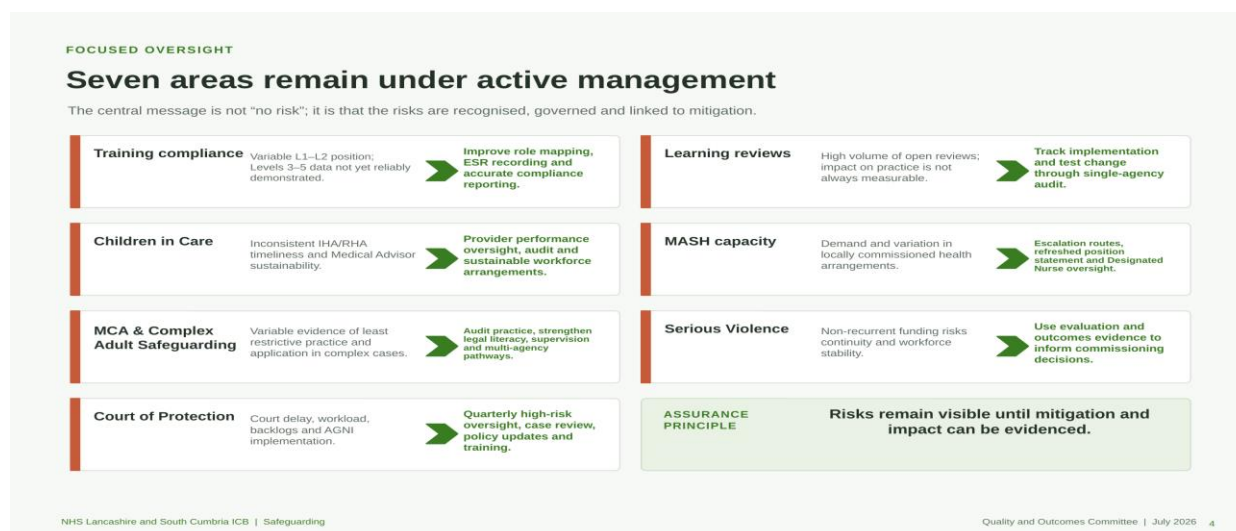


Figure 4: Focused oversight visual summarising seven partial-assurance areas under active management.

5 Priority Assurance Actions for 2026/27

2026/27 PRIORITIES

Move from assurance activity to demonstrable impact

The next phase strengthens the commissioning line of sight and tests whether learning changes practice and outcomes.



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Figure 5: 2026/27 priorities grouped around assurance architecture, practice/outcomes and statutory change/sustainability.

- Strengthen safeguarding assurance through commissioning, contracting and provider oversight arrangements.
- Review the Safeguarding Strategy and Learning to Improve Assurance and Accountability Framework in line with the ICB operating model.
- Demonstrate that learning from reviews, audits, supervision and provider assurance has translated into service improvement and improved outcomes.
- Improve and accurately report mandatory safeguarding training compliance.
- Strengthen Corporate Parenting responsibilities and address health assessment and Medical Advisor sustainability risks.
- Continue implementation of CP-IS Phase 2 across healthcare settings.
- Strengthen the voice, participation and influence of people with lived experience.
- Ratify and implement the ICB Prevent Policy and continue Domestic Abuse partnership commitments.
- Support sustainability of Serious Violence Prevention Programmes.
- Enhance the consistency and legal robustness of MCA practice through training, audit and shared learning.
- Implement the AGNI multifactorial assessment approach, reduce COPDOL backlogs and maintain oversight of high-risk cases.
- Strengthen assurance that recommendations from SARs, CSPRs and Domestic Abuse Related Death Reviews are embedded.
- Redesign provider safeguarding assurance to align with the revised ICB operating model.

6 Conclusion

- 6.1** The evidence supports moderate to significant assurance that the ICB maintained and discharged its statutory safeguarding responsibilities during 2025/26. Governance, accountability, statutory partnership participation, provider assurance, audit, supervision, learning and risk management arrangements are established and active.

This provides the Committee with assurance that safeguarding statutory duties have continued to be discharged through established governance, accountability and risk management arrangements.

- 6.2** Assurance is strongest in relation to statutory governance, major NHS provider engagement and the breadth of audit and partnership activity. Assurance remains partial where performance or compliance is variable, where sustainable capacity is not secured, or where evidence demonstrates activity and action planning but not yet measurable impact on practice and outcomes.
- 6.3** The Committee should therefore be assured that the principal risks and gaps are recognised and subject to mitigation, while maintaining focused oversight of training compliance, wider provider assurance, Children in Care health assessments, Medical Advisor permanency, MASH capacity, MCA and Court of Protection pressures, AGNI implementation, review learning impact and Serious Violence programme sustainability.

Maintaining focused Committee oversight will support continued mitigation of the principal safeguarding risks and ensure that improvement activity remains linked to outcomes for people and practice.

7 Recommendations

1. Receive the Safeguarding Summary Annual Report 2025/26 and note the assurance provided regarding the discharge of statutory safeguarding responsibilities.
2. Note the full Annual Report contains a detailed and comprehensive account of safeguarding activity against ICB accountability and responsibility.
3. Note the areas of significant progress, including governance, statutory partnership leadership, provider assurance, audit, supervision and learning arrangements.
4. Note the areas of partial assurance and require continued reporting on the associated mitigations and improvement actions.
5. Support the 2026/27 safeguarding priorities and the redesign of assurance arrangements to align with the ICB Strategic Commissioning Operating model.