Nottingham City Safeguarding Adults Board

Annual Report

April 2022 – March 2023

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For explanation of acronyms used throughout this document please see the glossary of terms on page 40.

Our vision

'A city where all adults can live a life free from abuse or neglect'

Message from the Chair

Welcome to Nottingham City Safeguarding Adults Board's Annual Report for 2022/2023. As Independent Chair, I am proud to present the report to you and share with you the work Partners have undertaken to safeguard adults across the City. I hope that as you read through the report you will see the commitment from Partners.

The report describes what we have achieved through the year and our priorities for 2023/2024. The priorities have been developed following a successful Board Development Day held in January 2023 where Partners shared their understanding of local issues which we have collectively agreed to focus on.

The report also shares with you details of two safeguarding adults reviews and provides assurance that actions are being taken to learn from these sad incidents. I had hoped that these reports would be published in year however am confident they will be published in June 2023. A further non -statutory review has been accepted during the period and we hope that it will be concluded in the autumn 2023.

Agencies have reported throughout the year that they have seen an increase in the complexity of needs for people accessing services; this adds additional pressure on Partners. When coupled with continued recruitment and retention issues, Partners are concerned about lack of service and staffing capacity to meet Nottingham's citizen's needs. Despite the increased pressures, Partners continue to prioritise safeguarding work. This assurance is critical for the Board, however there is a concern that some areas of service (for example supporting people at risk of domestic abuse) are struggling to maintain services at the level they would hope. Consequently, workforce pressures have been included on the Boards Risk Register and continues to be monitored.

As always the Board and its subgoups have seen a number of changes in membership. The Board is extremely grateful for all the hard work those members have contributed and a special acknowledgement is given to Ross Leather, Board Business Manager for ensuring the Board delivered and to Julie Gardner from Nottingham Health Care Trust for her commitment and constructive challenges over the years to the Board.

Finally I would like to take the opportunity to say thank you to all the practitioners and managers who are committed to keep people in Nottingham safe.

Lesley Hutchinson

Nottingham City Independent Chair

Case study

Concern

A referral for ‘John’ was received from the Street Homelessness team. John is a young man diagnosed with ADHD and ASD who had fled his family home in Nottingham and who had been rough sleeping for several weeks. John had fled the family home after a long history of physical abuse and financial abuse from both his parents.

Making Safeguarding Personal

The Safeguarding Social Worker engaged with John and supported him to express how he wanted his life to be safer, and different. John said he:

- Would like support to find somewhere permanent to live in a safe area away from his parents’ home.
- Would like an income that was paid directly to him.
- Wanted his ID to be retrieved from his parents address so that he could make a claim for benefit payments.

How we supported John to achieve his desired outcomes

- The Social Worker established a trusting relationship with John, including signposting him to young people’s talking/counselling services
- Worked closely with the DWP to explore mental capacity, displace Appointeeship, and to arrange a universal credit claim.
- Worked closely with the Homeless prevention worker and police to ensure John gained access to his ID documents from the family home.
- Supported his Housing application.
- Reported allegations of abuse into the City MASH where a police investigation remains ongoing.

Outcome

John is now settled into his shared accommodation in a young people’s project. He likes his support worker and has 24 hours support available should he need to contact someone. John lives in shared accommodation with tenants he says he gets on well with. John says he feels safe.

John is now in receipt of the appropriate benefits and feels he is able to comfortably afford the things he needs. John does not feel at risk from his family anymore and is making plans for the future including wanting to learn to drive.

Core duties of Nottingham City Safeguarding Adults Board

Each local authority must set up a **Safeguarding Adults Board (SAB).**

The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out in the Care Act (2014).

The SAB has a strategic role that is greater than the sum of the operational duties of its core partners. It oversees and leads adult safeguarding across its locality and is interested in a range of matters that contribute to the prevention of abuse and neglect.

A SAB has three core duties:

Strategic Plan

- It must publish a strategic plan for each financial year that sets out how it will meet its main objective and what the members will do to achieve this

Annual Report

- It must publish an annual report which details what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy, as well as the findings of any safeguarding adults reviews (SARs) and subsequent action.

Safeguarding Adults Reviews (SARs)

- It must conduct any SARs in accordance with Section 44 of the Care Act

Our strategic priorities and what we achieved

The Board's Strategic Plan for 2022-2025 has three key strategic priorities, with three operational priorities sitting underneath for 2022-2023. The Board have worked throughout the year to make good progress across these operational priorities.

Strategic priority 1: Prevention

- ✓ **Increase public and professional awareness of adult safeguarding**
- ✓ **Reduce abuse of adults in specific risk areas**
- ✓ **Ensure learning from case reviews is embedded across the partnership to improve practice**

Priorities include ensuring that lessons from Safeguarding Adult Reviews improve staff practice and that our adult safeguarding data reflects the latest local demographic information contained in the national census

What we achieved:

- Started to review and update the Board's public and professional facing Communications and Media. The aim is that public and professionals alike will have an increased awareness and understanding of adult safeguarding, the forms it can take and what to do if they encounter it. This work is being led by the Training, Learning and Improvement (TLI) subgroup.
- Continued the Board's Strategy of amplifying local, regional and national safeguarding adult messages through the TLI Subgroup. By amplifying local, regional and national messages, the Board increases awareness and understanding of adult safeguarding issues and how to address them.

- Identified, shared and improved access to training, learning and improvement opportunities between all partnership agencies. By increasing access to training, the Board will be improving the quality of response to adult safeguarding by Board partners.
- Gained assurance regarding local implementation of the IICSA (Independent Inquiry into Child Sexual Abuse) Anglican Church report recommendations, and that the Council IICSA plan remains on track.
- Started work in partnership with the Safeguarding Children's Partnership (SCP) and Crime and Drugs Partnership (CDP) to tackle DVSA (Domestic Sexual Violence & Abuse) by raising issues relating to MARAC (Multi-agency Risk Assessment Conference) to the Domestic Abuse Commissioners Office.
- Sought partner assurance that work remains ongoing regarding 'closed cultures' in light of the recent Care Quality Commission (CQC) reports and a recent Norfolk Safeguarding Adults Review (SAR).
- Supported partner efforts to address the issue of reduced footfall in care home and home care settings and the consequent reduction in adult safeguarding referrals. This issue was largely Covid-19 related and so will not continue into 2023/2024.
- Ensured learning from case reviews is embedded across the partnership to help improve practice.

Strategic priority 2: Assurance

- ✓ **Receive assurance from all partner agencies on the effectiveness of their safeguarding adult arrangements**
- ✓ **Receive assurance that arrangements in specific areas promote effective adult safeguarding practice**

Priorities include making sure that care home and home care provision remains safe, and that effective transitional safeguarding arrangements are developed.

What we achieved:

- Received, in conjunction with Nottinghamshire SAB, annual assurance from all partners via completion of the Performance Assurance Tool (PAT) that their adult safeguarding arrangements remain effective
- Started the process to improve the range and quality of safeguarding data available to the Board to provide assurance and inform partnership decision making. The new data dashboard will come into use in 2023/2024.
- Started to develop a new Quality Assurance Framework which will set out the annual Quality Assurance activity of the Board including receipt of single agency reports, a refined and expanded data set and multi-agency audits.
- Established routes to gain assurance that the Integrated Care Board (ICB) workstream plans consider adult safeguarding arrangements and that effective reporting and scrutiny mechanisms exist between the two bodies.
- Held meetings with the Chairs of the CDP and SCP to effectively address 'crosscutting' issues

- Engaged with the Department of Work and Pensions (DWP), nationally and locally, as it continues to improve the effectiveness of its adult safeguarding arrangements
- Commenced work seeking assurance of partners adult safeguarding arrangements when working with people experiencing 'multiple exclusion homelessness'
- Maintained a central Risk Register to monitor current and emerging risks
- Commenced work seeking assurance of partners adult safeguarding arrangements when working with people experiencing 'multiple exclusion homelessness.'
- Undertook a brief audit on cases which were categorised as discriminatory abuse to provide assurance that agencies are identifying these cases effectively.

Strategic priority 3: Engagement

✓ **Ensure there is a strong commitment to 'Making Safeguarding Personal' across the partnership and that the principles are embedded in local safeguarding practice**

Priorities include seeking assurance that frontline staff work in accordance with 'Making Safeguarding Personal' best practice and that referrals to local advocacy services continue to be promoted.

What we achieved:

- Agreed with partners to receive regular 'practice example' case studies at the Board as an effective way of maintaining partner focus on overarching priorities.
- Sought assurance that the commissioned advocacy agency (POhWER) continues to have regard to adult safeguarding, and that partner agencies utilise advocacy services effectively.
- Sought assurance regarding the quality of 'frontline' Making Safeguarding Personal (MSP) practice by undertaking a multiagency staff questionnaire.

Case study

Concern

Bob was a middle-aged man living in rented accommodation. His relative was released from prison, with no fixed abode so moved into Bobs address. Bob disclosed to his GP that his relative was spending his benefit and was not contributing to any bills, so he was getting into debt. His relative was also encouraging Bob to buy and take illicit substances and inviting other homeless people to stay at his address. Bob felt unable to say no. Bob also felt his upstairs flat was not meeting his needs, as his mobility was deteriorating.

Making Safeguarding Personal

The Safeguarding Social Worker engaged with Bob which took some time as he was afraid his relative would punish him for disclosing his concerns. Bob wanted to:

- Move out of his property
- Be debt free
- Stop using substances.

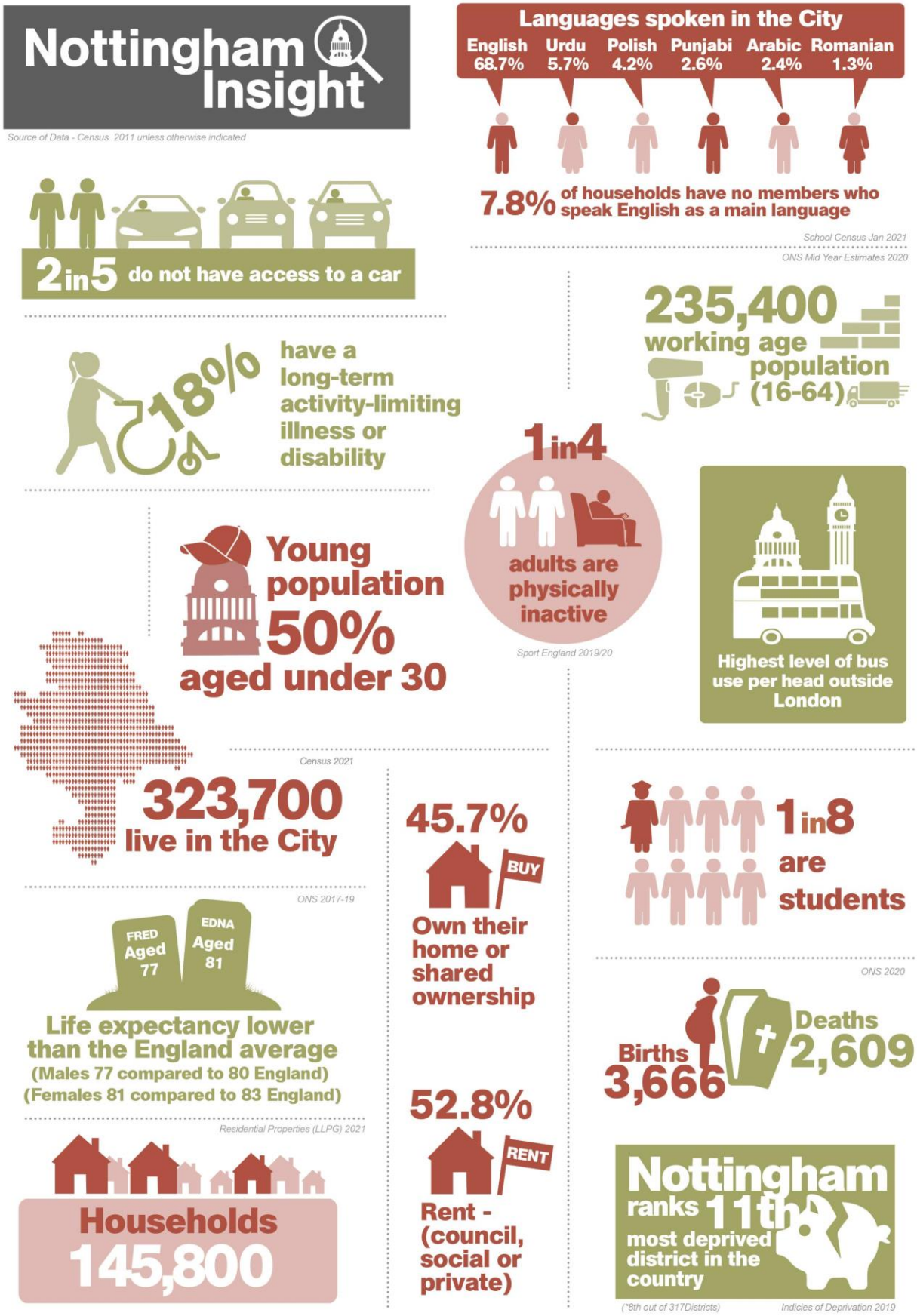
How we supported John to achieve his desired outcomes

- The Social Worker had safety discussions with Bob, so he knew what to do if he felt threatened in his property
- Maximised Bobs benefit entitlement and ensured the DWP held back payment until safeguarding measures were in place
- Worked collaboratively with the Housing Provider to explore options around the removal of the relative, so that this was not deemed by the relative as result of Bobs actions.
- Explored new housing options
- Liaised with Citizen's Advice about debt support services
- Provided information for a self-referral support around substance reduction
- Provided information on social opportunities and a referral to Community Connectors to make safer connections and friendships

Outcome

The relative is now no longer at the address following action taken by the Housing Provider regarding breach of tenancy. Bob has the support in place to pursue a move and an improved financial income. Bob reports that he feels safer, healthier, and connected with some local social groups which have made him feel much less isolated.

About Nottingham City



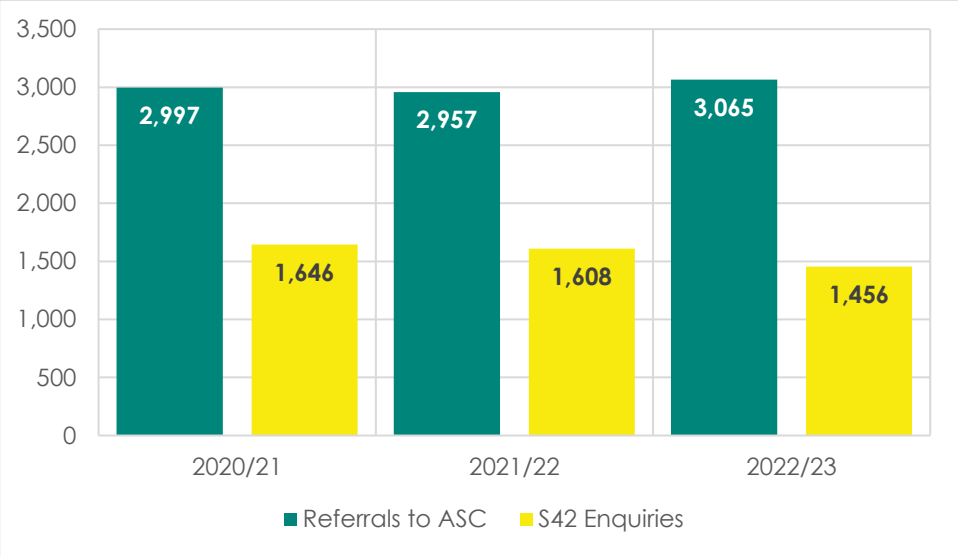
Safeguarding Adults Activity

Section 42 of the Care Act 2014 requires local authorities to make enquiries, or cause others to do so, if they believe an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect and if so, by whom. These enquiries are commonly referred to as 'Section 42 enquiries'.

The charts that follow are drawn from local authority safeguarding data and show key safeguarding measures.

NHS Digital Safeguarding Adults Collection data analysis for 2022/23 was published on 7th September 2023 and provides the benchmarking information for this report and safeguarding activity and outcomes.

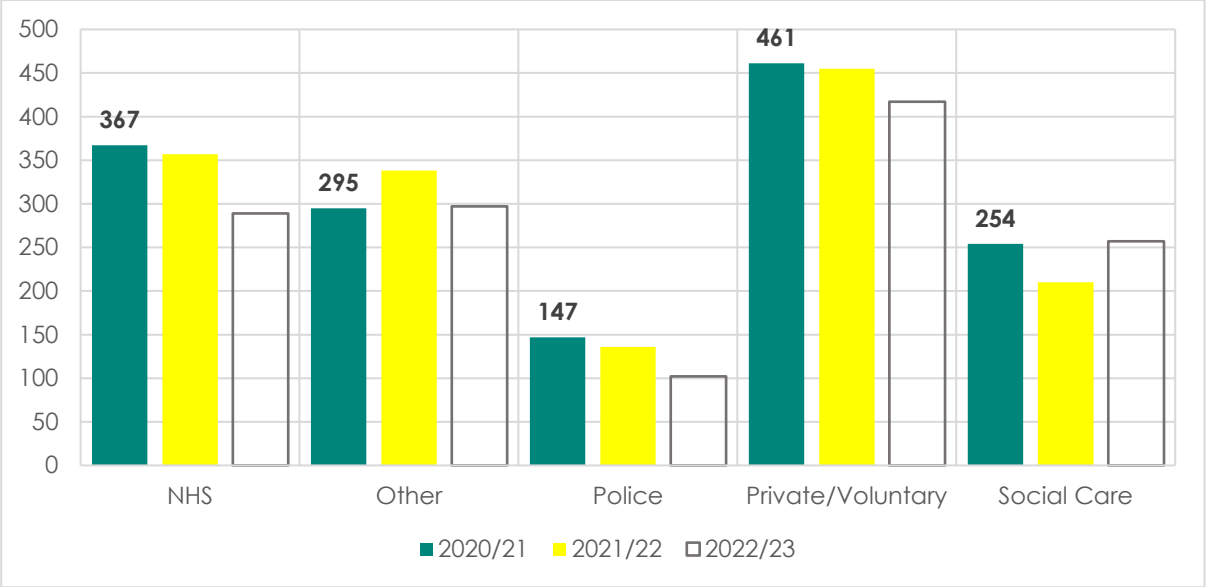
Chart 1: Adult safeguarding referrals and Section 42 enquiries by financial year



There has been a national increase of 9% in the number of concerns raised, which is the same annual growth rate as last year. In comparison, Nottingham City's data shows a 3.65% increase in adult safeguarding referrals when compared to 2021/2022 which is less than the national average and goes against the decrease seen the year before. When considering S42 enquiries, there is a significant decrease of nearly 10% (9.45%) which goes against the national trend which shows an increase of 7%. This demonstrates a lower number of referrals leading to S42 in Nottingham City when compared to 2021/2022.

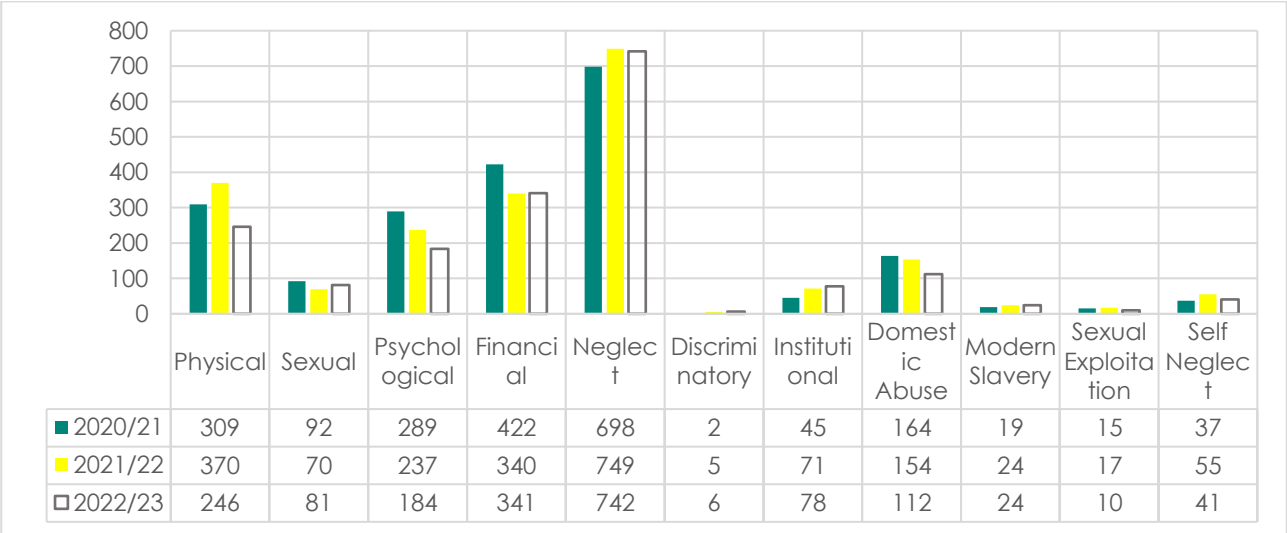
The SAB will seek assurance to ensure all concerns are being raised where appropriate, that agencies are well informed about when to raise a concern and demonstrate good decision making.

Chart 2: Volume of Section 42 enquiries by referral source



With the reduction in the number of S42 enquiries, the chart above is expected showing a reduction from all sectors with the exception of Social Care which saw an increase on 2021/2022. In line with the 2021/2022 annual report, the Board will seek to undertake further analysis of the 'other' category within the new data dashboard.

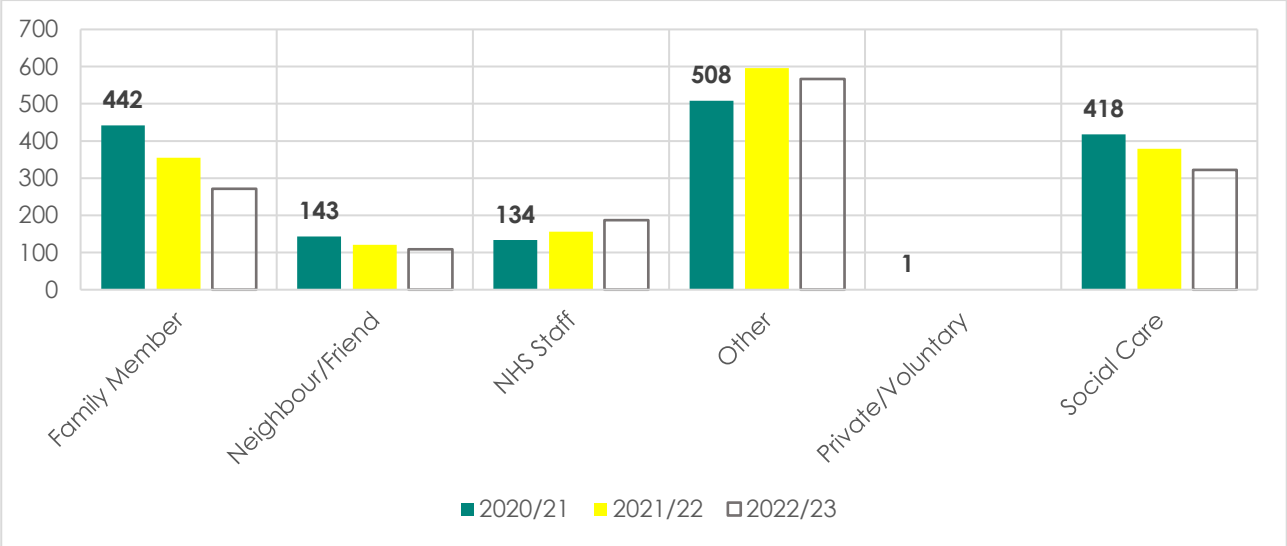
Chart 3: Volume of Section 42 enquiries by type of abuse



	Physical	Sexual	Psychological	Financial	Neglect	Discriminatory	Institutional	Domestic Abuse	Modern Slavery	Sexual Exploitation	Self Neglect
2020/21	309	92	289	422	698	2	45	164	19	15	37
2021/22	370	70	237	340	749	5	71	154	24	17	55
2022/23	246	81	184	341	742	6	78	112	24	10	41

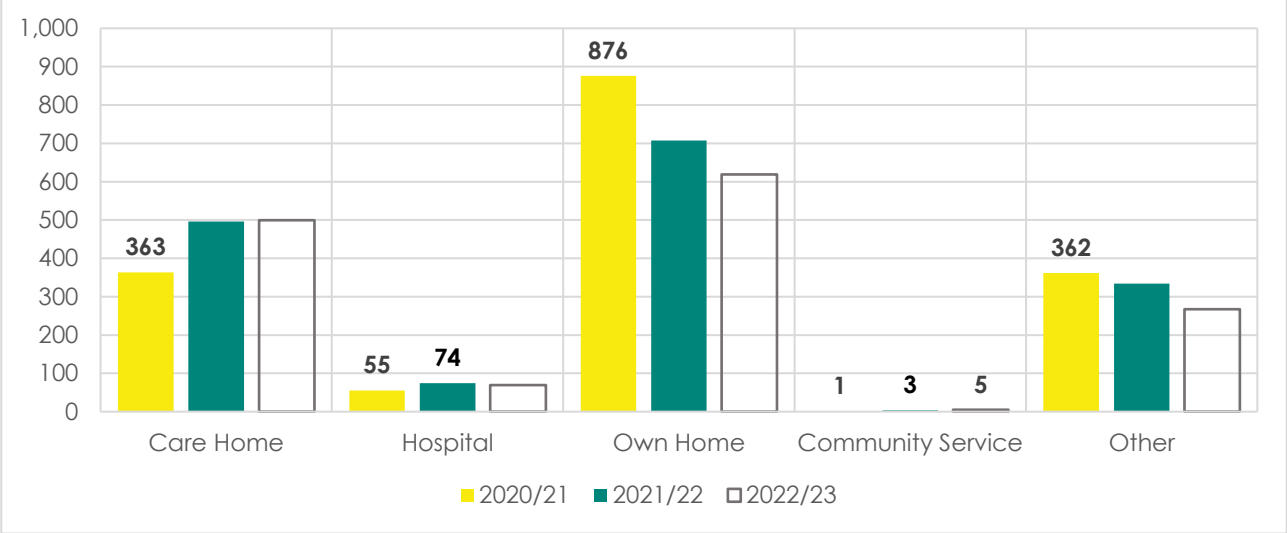
Nationally, the most common type of risk in Section 42 enquiries that concluded in the year was Neglect and Acts of Omission, which accounted for 32% of risks. In Nottingham City, neglect and acts of omission are also the most common risk, followed by financial abuse, physical and then psychological risks. Some categories have seen a significant change since 2021/2022, with S42 enquiries for physical abuse reducing by around a third, and a reduction in domestic abuse, psychological abuse, sexual exploitation and self-neglect. There have been small increases in S42 enquiries for sexual abuse and institutional (organisational) abuse. Figures for financial abuse, neglect and acts of omission, discriminatory abuse and modern slavery have remained consistent since 2021/2022. Neglect and acts of omission account for nearly 40% of S42 enquiries. Discriminatory abuse remains consistently low, something which has been raised nationally as an area for Safeguarding Boards to focus on.

Chart 4: Volume of Section 42 enquiries by perpetrator relationship



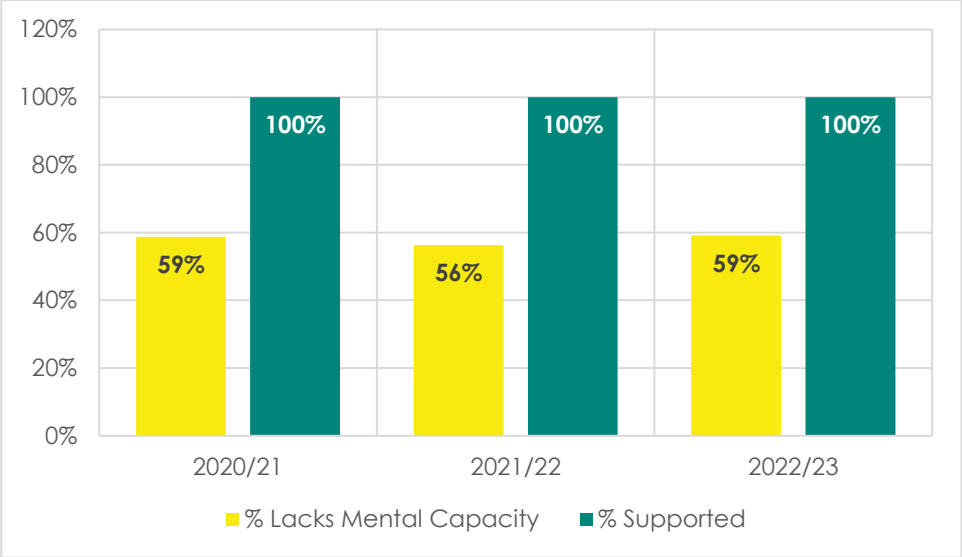
While most categories have seen a decrease when compared to 2021/2022, there has been a small increase in NHS staff as perpetrator. It is possible this corresponds with the implementation of the SAB PiPoT (People in Positions of Trust) Guidance in Q4, and is something the Board will be seeking to explore in 2023/2024. The Board is also keen to explore the category of 'other' to be assured about which types of perpetrator relationships are included.

Chart 5: Volume of Section 42 enquiries by location of abuse



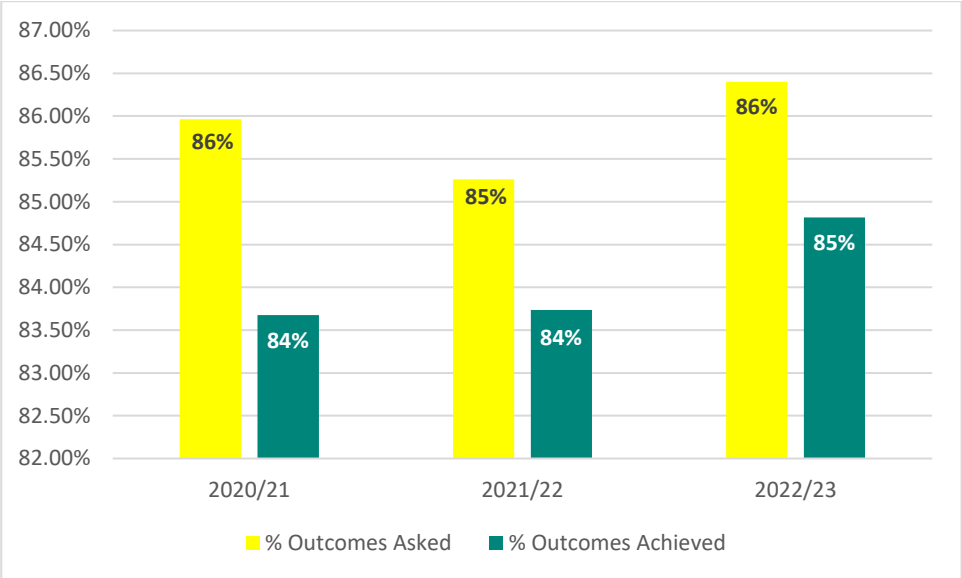
Nationally, the most common location of the risk in Section 42 enquiries that concluded in the year was the person's own home at 47%. Nottingham City has seen a decrease in 'own home' and 'other' as the location of abuse when compared to 2021/2022. Care home and hospital remain consistent, with a small increase in Community service.

Chart 6: Proportion of Section 42 enquiries where the adult lacked mental capacity



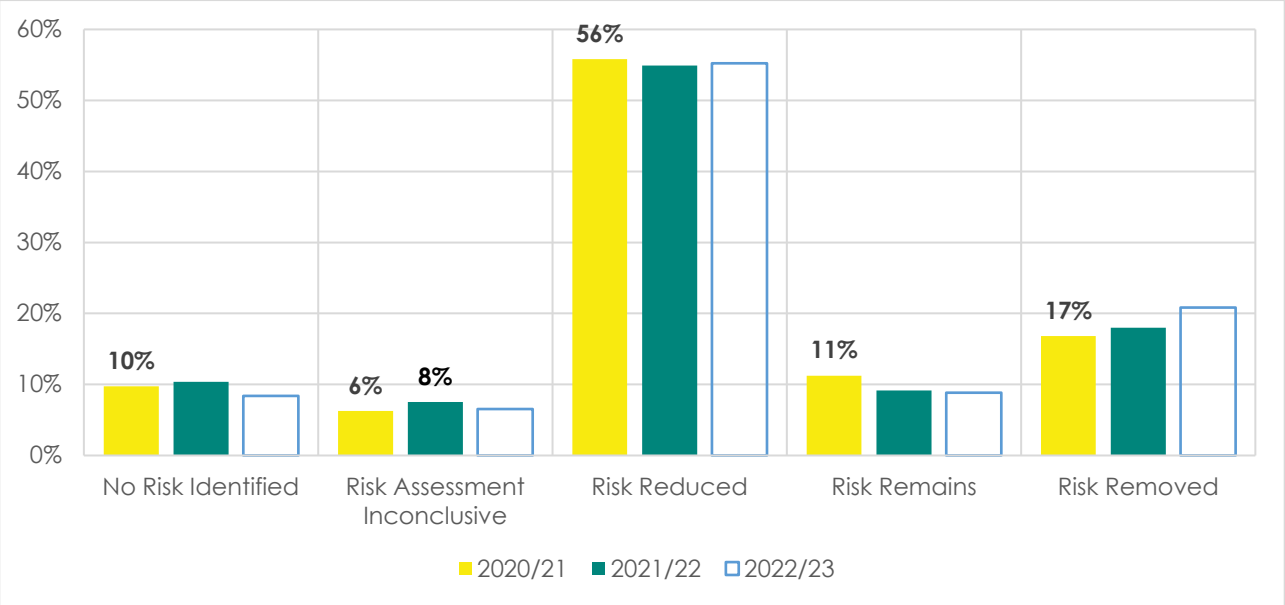
The data above has remained consistent over the last few years. It is extremely positive to see that 100% of people who 'lacked mental capacity' are supported through the safeguarding procedure; this is exactly as would be expected. The advocacy provider will be invited to the Board in 2023/2024 to share data and will be included in the next annual report.

Chart 7: Section 42 enquiries where the adult was asked about their desired outcome



The percentages of individuals asked what outcomes they wanted, and of outcomes achieved, were both slightly higher than in 2021/22, something the Board were keen to see this year. The Board will continue to seek to understand the reason why 14% of individuals were not asked what outcome they wished to achieve. Making Safeguarding Personal sites within the Engagement strategic priority of the Board and this chart is part of the evidence the Board uses to assure itself that safeguarding support is personalised to people's views and situations.

Chart 8: Percentage of Section 42 enquiries by risk outcome

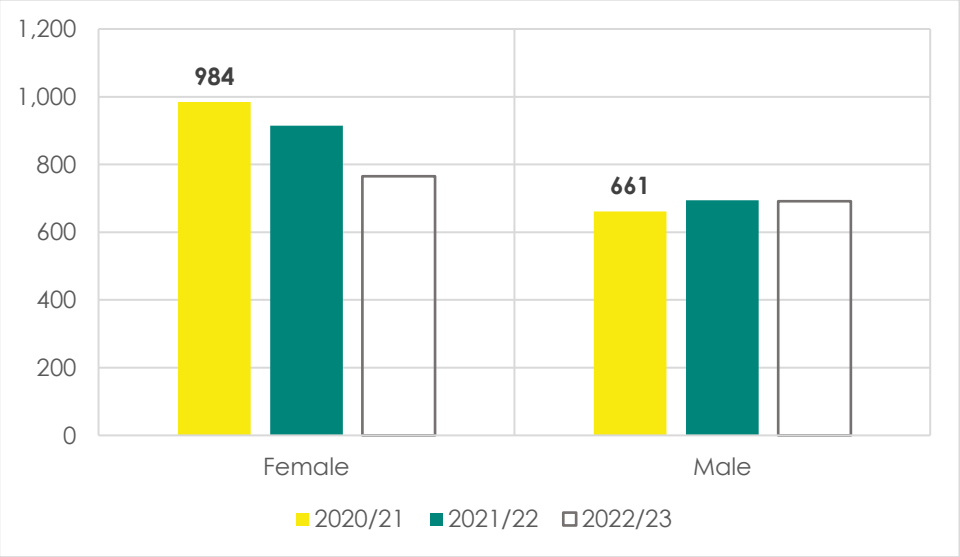


Nationally, in 91% of concluded Section 42 enquiries where a risk was identified, the reported outcome was that the risk was reduced or removed. In Nottingham City, in 84% of cases the risk was reduced or removed, or no risk identified. However, if we included those cases which were inconclusive, the percentage would be 91% which is the same as 2021/2022 and fits with the national average. The Board will seek to monitor this though the quarterly data received but accepted that risks might always remain for some situations. The Board will seek reassurance that monitoring arrangements are in place to ensure citizens are supported.

As identified in the 2021/2022 Annual Report, further assurance has been sought on gender and ethnicity as set out below.

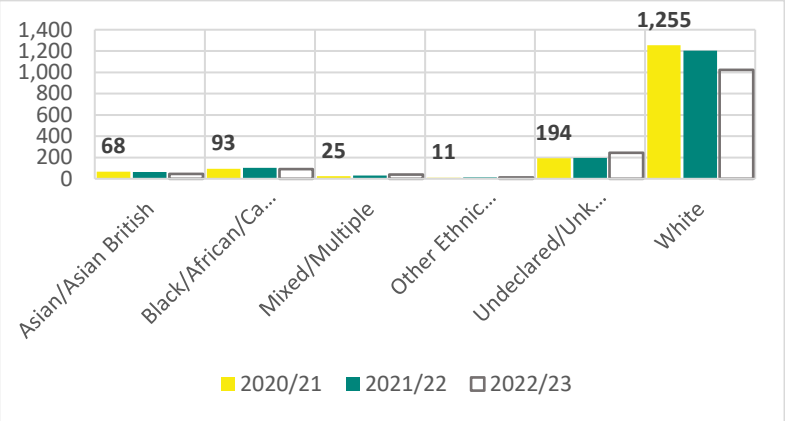
Demographics

Gender



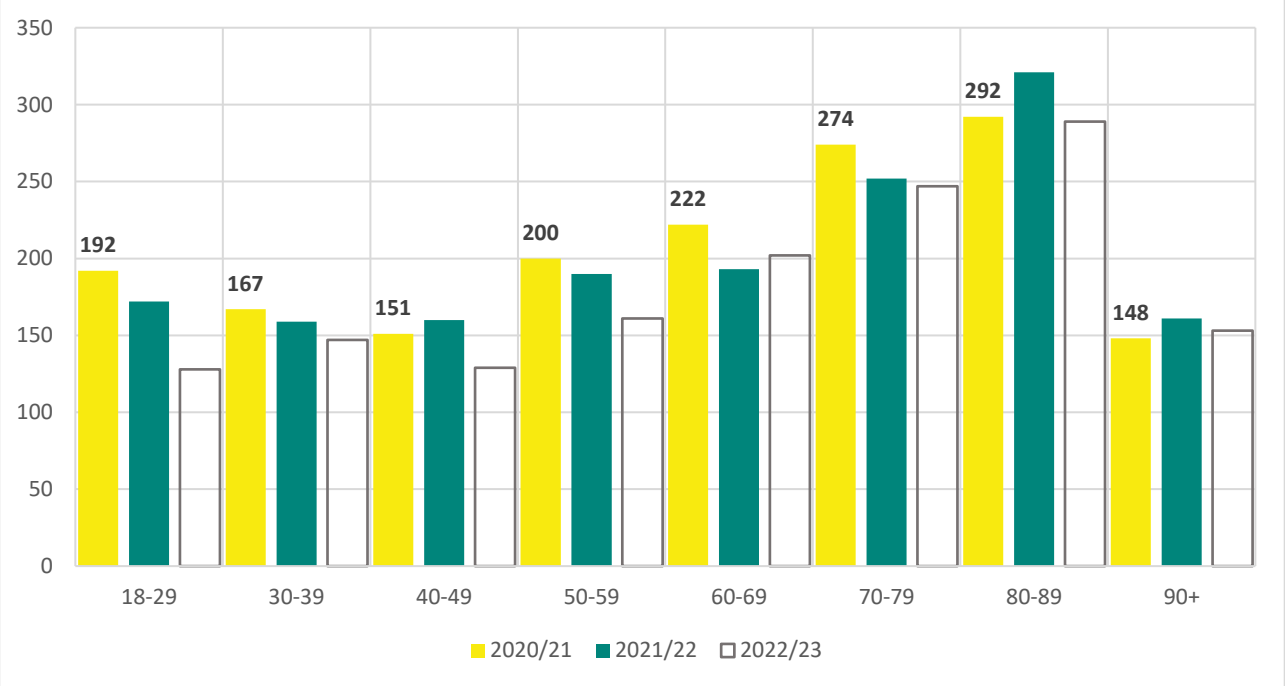
There has been a decrease year on year since 2020/2021 in the number of S42 enquiries for females, however the number of males has remained consistent in the last two years following a small increase in 2021/2022.

Ethnicity



The majority of S42 enquiries are for citizens that are white, with numbers for Asian/Asian British, Black/African/Caribbean/Black British, Mixed/Multiple, Other ethnic group and Undeclared/Unknown constantly lower over the last 3 years. The Board will be utilising census data in 2023/2024 to better understand how the S42 data reflects the local demographic of Nottingham City and identify where communities may need support to identify safeguarding concerns.

Age



The majority of S42 enquiries are for adults in the 80-89 age bracket, which is consistent with the figures for the previous two years. There has been a decrease in S42 enquiries for adults aged under 59 years old or over 70 years old, with a slight increase in only one age bracket, the 60-69 year olds.

Who sits on the Board and how does it work?

Throughout 2022/23, the Board was chaired by Lesley Hutchinson. Ross Leather was the Board Manager until July 2022, and Anne-Marie Furnell commenced a secondment into the Board Manager role in September 2022.

The Board met quarterly, with senior representatives attending from the following organisations:

- Nottingham City Council Adult Social Care
- Nottingham City Council Community Protection
- Nottinghamshire Police
- Nottingham and Nottinghamshire ICB
- National Probation Service, Nottinghamshire
- Department for Work and Pensions
- Nottinghamshire Fire and Rescue Service
- East Midlands Ambulance Service (EMAS)
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham CityCare Partnership
- Nottingham University Hospitals NHS Trust
- Nottingham Community and Voluntary Service
- HMP Nottingham
- Nottinghamshire Healthwatch
- Nottingham City Homes

Funding

Nottingham City Council, Nottinghamshire Police, and Nottingham and Nottinghamshire ICB jointly fund the Nottingham City Safeguarding Adults Board. During 2022/23 these statutory partners continued to provide financial support in line with previously agreed contributions, and the budget was balanced at year end.

Board Constitution

How the Board works is set out in the published Constitution, which states that:

- ✓ The aim of the Board is to ensure the effective co-ordination of services to safeguard and promote the welfare of adults in accordance with the Care Act 2014 and the Statutory Guidance.

- ✓ The NCSAB is a multi-agency Board that will coordinate the strategic development of Adult Safeguarding across Nottingham City and ensure the effectiveness of the work undertaken by partner agencies in the area.

- ✓ The Board aims to achieve its objectives through partner agencies supporting individuals in maintaining control over their lives and in making informed choices without coercion.

- ✓ Whilst NCSAB has a role in coordinating and ensuring the effectiveness of work being done by local individuals and organisations in relation to safeguarding adults, it is not accountable for their operational work. Each Board Partner has their own existing lines of accountability for safeguarding adults by their services. The Board does not have the power to direct other organisations but aims to assure itself that members and partners act to help and protect adults experiencing or at risk of abuse and/or neglect.

The Board has three subgroups to support it:

The Quality Assurance subgroup

This is a proactive subgroup, responsible for supporting Nottingham City SAB in its assurance responsibilities by collecting evidence concerning the quality of local safeguarding interventions and the performance of agencies and their staff in carrying out their safeguarding responsibilities. This includes a focus on the principles of MSP.

The Safeguarding Adults Review subgroup

This is a reactive group, responding to any SAR referrals the Board receives and responsible for the operation of the SARs it commissions to ensure that agencies learn lessons and improve the way in which they work with adults at risk. The SAR subgroup seeks to develop SAR processes in line with the Care Act and local and national best practice.

The Training, Learning and Improvement subgroup

This is both a reactive and a proactive group, responsible for disseminating learning identified in SARs as well as acting as a conduit for identifying and passing on safeguarding messages and available training to partner workforces. Additionally, the subgroup can arrange training on behalf of the Board as well as reviewing the effectiveness of multi-agency learning and improvement activities.

In addition to the three subgroups and the quarterly main Board, the independent Chair and representatives from the three funding agencies meet with the subgroup chairs and Board manager on a quarterly basis at the Business Management group to assist in the implementation of the Board's annual action plan.

Quality Assurance (QA) Subgroup

Achievements

Partner Assurance Tool

The subgroup received the annual Partner Assurance Tool (PAT) submission from partner agencies including Adult Social Care, Community Protection, Citycare, Nottinghamshire Fire & Rescue, Nottinghamshire Police, NCVS (Nottingham Community and Voluntary Service), Integrated Care Board (ICB), Nottingham University Hospital (NUH), Nottingham Healthcare Foundation Trust and Probation.

PAT returns were all of good quality, and it was noted that lot of thought and detail went into the returns. Statutory organisations raised issues around Liberty Protection Safeguards (LPS) with a varied response as to how this will be managed when implemented. Some are putting plans in place and screening Deprivation Of Liberty Safeguards (DoLS), identifying the most vulnerable citizens. New appointments are being made to assist safeguarding leads within organisations.

All agencies are dealing with issues with capacity within the workforce and are not always able to ensure staff are attending training. Staff would prefer more face-to-face training opportunities, however this is not always possible to facilitate. All agencies are experiencing high levels of vacancy rates, with ongoing recruitment and retention highlighted as an issue.

Data

The subgroup received quarterly data throughout the year, which provided oversight of statutory safeguarding activity in Adult Social Care.

Audits

The subgroup commenced audit work into Hoarding and Self-neglect. These topics have been central to recent SAR activity.

Making Safeguarding Personal (MSP) Questionnaire

The subgroup developed and distributed a staff questionnaire on Making Safeguarding Personal. This questionnaire aimed to establish a baseline of current confidence in staff application of the principles of MSP, so that recommendations could be made to support agencies to further embed MSP in practice. The responses will be analysed and collated and presented to the Board in 2023/2024.

Impact

The collected and analysed PAT returns have enabled the QA subgroup to provide the Board with assurance around individual agency safeguarding practice, as well as a multi-agency strategic summary of issues the system is experiencing. This has directly informed the annual plan for 2023/2024.

The quarterly data report enabled the subgroup to keep the main Board and the Business Management Group informed of themes, trends and areas of concerns.

Through the MSP Questionnaire, the Board will have a clearer understanding of how fully the local system workforce understands MSP (alongside other issues) and is able to implement it in practice.

Barriers

The current data set is limited, and the baselines are now out of date. The data is not currently looked at in terms of the local demographic and compared with census data.

The MSP Questionnaire had a low return rate

Priorities for 2023/2024

- To review the current PAT to ensure that the new operational priorities for the Board are referenced within the questions. This will include new questions on Transitional Safeguarding and People in Positions of Trust (PiPoT).
- The subgroup will be trialling a new Data Dashboard in 2023/2024. Although the current data set gives a good insight into the current safeguarding picture, it remains Adult Social Care only. The new dashboard will be expanded to include data from partner agencies such as Police, Community Protection, Fire & Rescue and Public Health, and will include topics such as drug-related deaths, homelessness deaths, and high-risk missing individuals, as well as expanding on the current social care data. By making decisions that draw upon a broad and good quality evidence base, outcomes for partner agencies and adults at risk will be improved.
- New census data will underpin and inform the work of the Board, ensuring that its efforts are well placed and that a wider range of citizens than previously are successfully engaged with.
- An audit schedule will be developed in line with the new Quality Assurance Framework.
- To review, update and repeat the MSP Questionnaire to build on the intelligence gathered in 2022/2023.

Safeguarding Adult Review (SAR) Subgroup

In June 2022, Nottingham City Safeguarding Adults Board approved two Safeguarding Adult Reviews. Both these reviews will be published on the Safeguarding Adults Board webpage as soon as possible.

Reviews Completed

Billy

This Safeguarding Adult Review (SAR) relates to a man 'Billy' who died from starvation in 2018. Billy was a single man in his fifties of Black African Caribbean heritage, who lived alone in his flat as a tenant of Nottingham City Homes (NCH).

Eight months before his death, the Department for Work and Pensions (DWP) had stopped Billy's Employment Support Allowance (ESA) as Billy had not responded to requirements to review his entitlement. When his ESA ended, this meant his Housing Benefit was not paid. Billy quickly fell into arrears. Billy did not respond to NCH attempts to resolve this.

Billy had struggled for many years with his mental health as well as problems with an under-active thyroid, and following an acute episode of psychotic depression, he was sectioned under the Mental Health Act in 2015.

Although agencies were aware of Billy's depression, the SAR found that there were a series of missed opportunities to share information between services. Had information

been shared, this may have revealed the true nature of Billy's mental distress and mobilised the care and treatment he needed.

There has been significant learning for the agencies involved. Many improvements have been made since Billy died. There is evidence that these changes are making a difference to people in similar circumstances to Billy. However, the review has also identified further measures that will build on these improvements, strengthening the multi-agency response to people like Billy and reducing the risk of such a tragedy occurring again.

Valentina

This Safeguarding Adult Review (SAR) explores the sad circumstances of Valentina's death. Valentina was a white British woman with mental health needs; she had a diagnosis of Emotionally Unstable Personality Disorder and physical health needs due to her diabetes.

Valentina died in 2019, having taken a deliberate overdose of her insulin. At the time of taking the overdose, Valentina felt overwhelmed by stressful life events. Valentina had been the victim of sustained domestic abuse from her ex-partner.

In the months leading up to her death, Valentina had also been attempting to claim Personal Independence Payment (PIP) through the Department for Work and Pensions (DWP). Problems within this process caused her extreme anxiety and distress. This additional stress significantly increased her risk of self-harm and suicide.

Valentina received a high level of support from her family and from agencies. The Nottingham City Safeguarding Adult Board (NCSAB) believed that there was learning about how agencies had worked together in relation to supporting Valentina and reducing the risks of harm arising from stressful events. The review also considers the changes that have been put in place since Valentina died and additional learning that can improve future multi-agency responses to people in similar circumstances to Valentina.

Additional Review

In March 2023, an independent reviewer was appointed for a non-mandatory SAR with themes of hoarding and non-engagement with services. Terms of Reference have been agreed, a practitioner workshop has been scheduled and it is anticipated that this review will be completed in late Autumn 2023.

Ongoing Action Plans

Actions plans for both the Billy and Valentina reviews have progressed steadily throughout the year and are monitored through the Boards subgroups. Both reviews contained recommendations of national interest, which were escalated through the National Safeguarding Adults Board Chairs network.

An action plan for a further mandatory SAR which was completed in the previous year has now been completed. This review is currently unpublished as there is an ongoing criminal investigation.

There are currently no outstanding actions from SAR's which are not under review by the subgroups.

Additional Documents

A SAR Guide for Families and loved ones has been developed which contains information about what a SAR is, why they are carried out, what their purpose is and who families need to contact for further information. This will be published on the Safeguarding Adults Board webpages.

To better understand the impact of SARs and to ascertain how embedded the learning is, a SAR Impact Tool has been developed which will be sent to individual agencies 6 months after publication and/or completion of the action plan. The completed tool will be submitted to the Training, Learning and Improvement subgroup for analysis, and any concerns or areas of good practice will be escalated to the Board.

The Training, Learning and Improvement (TLI) Subgroup

Achievements

- Promoted 'action on world elder abuse day' using a comms/media pack from National Charity Hourglass
- Updated our suite of '7-minute briefings'. These short briefings with key information for professionals in an easily digestible format have been popular with agencies, and allow them to share concise messages and learning with the workforce.
- Developed a SAR Impact Tool to facilitate evaluation of learning from SARs
- Developed a SAR Guide for Families
- Developed a 'What is abuse and how to get help' leaflet for members of the public
- Training opportunities and learning materials were shared via 'TLI distribution list'

Impact

- Both the public and professionals have a better understanding of adult safeguarding and when and how to report abuse and neglect. This will reduce inappropriate referrals and ensure professionals utilise alternative referral pathways.
- We will be able to better evidence that learning from SARs is embedded

Barriers

- There is a lack of multi-agency training for professionals available

Priorities for 2023/2024

- Identify minimum training standards that all agencies should adhere to.
- To work with the Practice Development Unit (PDU) to understand the local offer and identify areas for collaboration.
- To receive and analyse returned SAR Impact Tools and ensure that the learning from SARs is shared internally within single agencies, and embedded into practice within policies, procedures, training and staff culture.
- To carry forward training related recommendations from the MSP Questionnaire carried out by the Quality Assurance subgroup.
- Develop a Comms Strategy for NCSAB to provide structure and detail to the Board's public and professionals awareness raising.
- To review and expand existing systemwide tools that improve staff practice and legal literacy when working with people with 'serious and multiple disadvantage' and those who self-neglect / hoard.

What difference have we made?

"The TLI subgroup helped identify opportunities for collaboration and partnership working"

"Quality Assurance review of the Provider Investigation Procedure highlighting strong Multi-Agency work with partners"

"Achieving best outcomes through the revision of multi-Agency policies"

"The 7-minute briefings. These learning tools ensure consistent messages across the partnership in an easily accessible format for busy staff"

"I have been a member of the NCSAB for the past eighteen months. In this time joint working between adult safeguarding and community safety has greatly improved and there has been a fantastic amount of collaboration. It has been a great experience which has clearly demonstrated the positive impact of partnership working"

"Increased understanding of partner agency roles and responsibilities"

"Greater sharing of knowledge through the use of 7-Minute Briefings and safeguarding toolkits"

"Clear Strategic plan"

"Really helpful to have shared visions and goals"

"Sharing of SAB research, learning and themes via reflective forums"

"Staff Questionnaire on knowledge and skills in Making Safeguarding Personal which fed into training analysis and annual training plan"

"Good to be back to face to face and networking"

Partner contributions

Our partner agencies promoted adult safeguarding within their own organisations in numerous ways throughout 2021/22. These are their reports.

Nottingham City Adult Social Care

Care homes registered with the Care Quality Commission remain consistently the second highest location of abuse in Nottingham. Whilst Adult Social Care has robust structures and processes in place to investigate and coordinate Safeguarding investigations in care homes, recent urgent care home closures in Nottingham due to building compliance, low quality care delivery and contractual requirements have demonstrated that the Council and partners should review their monitoring and information sharing arrangements to develop and improve quality assurance of this sector.

While the number of Safeguarding Enquires undertaken by Adult Social Care remain relatively stable, the City Safeguarding Team is reporting an increase in the number of citizens referred with very complex needs living with high levels of risk due to their vulnerable situations such as homelessness, substance misuse or domestic abuse.

Adult Social care already have a longstanding Adult Safeguarding Quality Assurance team, with specialist Senior Practitioners who coordinate and oversee Safeguarding Investigations in Provider settings. The team also leads a monthly multi agency Quality Information Sharing meeting where agencies responsible for the monitoring and inspection of regulated care provision can share information and concerns, and decide collectively upon appropriate action. This promotes an Early Intervention approach.

In terms of resource, it is proposed that the Department of Health and Social Care 'Market Sustainability Improvement Fund' granted to Adult Social Care will be utilised to expand front line and managerial staff in the team. Work is also planned to review and revise data collection, with the aim of improving how Adult Social Care can evidence the increase in demand and complexity and gather information regarding unmet need and lack of resources.

We now have comprehensive internal Safeguarding Policy and Procedures which were drafted in consultation with the City Safeguarding team, drawing on the team's extensive experience and high quality assurance standards.

The safeguarding training has been updated in line with the revised Policy and Procedures and we have a training review framework to ensure that training is iterative; training updates are timely, progressively and responsive to meet the needs of the workforce and proactively imbed leaning. Safeguarding Social Workers have been involved in the design of the training and co-deliver the training with the Safeguarding Training Lead.

We have restarted reflective Practitioner forums and are also introducing Safeguarding reflective sessions from September, some of the topics identified so far include:

- Learning from Serious Case Reviews (SAR)
- Court of Protection
- Positive Risk Taking
- Safeguarding and the use of Legislation (Mental Capacity Act / Mental Health

Nottingham City Council are now involved in the ADASS East Midlands Safeguarding Adults Community of Practice (CoP), this is a forum for lead Safeguarding officers across the region to come together to share best practice, develop learning and drive the

safeguarding agenda across the ten local authorities within the East Midlands ADASS region.

Pay has increased and Social Work colleagues have more opportunities to progress within Adult Social Care through the introduction of a Career progression pathway. Given the demands and complexity of Safeguarding work, it is essential we recruit and retain experienced Social Workers where we are assured of high quality interventions with adults at risk.

The City benefits from a dedicated City Safeguarding Team who undertake the majority of Safeguarding Enquiries. Due to the specialism, there are strong partnerships with Safeguarding Leads in other agencies across the City, which is evidenced through the local, bespoke partnership procedures we have developed, including Cause to Enquire. Provider Investigation, and Provider Failure. The City Safeguarding Team provide advice and support to colleagues undertaking Safeguarding Enquiries in other Adult Social Care Teams, and all colleagues can access the advice and guidance of the Adult Safeguarding Quality Assurance Team.

Making Safeguarding Personal is embedded in our internal Adult Safeguarding Policy & Procedures, and our Training and development programme. Citizens expressed or desired outcomes, and whether we have met them fully, or partially, as a result of a Safeguarding intervention are recorded in every intervention in our electronic case records. We consistently achieve high percentages of meeting fully, or partially, citizens desired outcomes.

Nottingham and Nottinghamshire Integrated Care Board

In July 2022 the Nottingham & Nottinghamshire CCG aligned with Bassetlaw CCG to become the Nottingham & Nottinghamshire ICB. This has aligned core functions, policy and procedures and workstreams across the wider Nottingham & Nottinghamshire area.

Following the BBC's Panorama Programme aired on September 28th 2022 the NNICB undertook a piece of work to obtain assurance around the patient welfare and advocacy in all Mental Health in patient settings in the Nottingham City & Nottinghamshire area. We identified key areas of enquiry and made recommendations relating to these to the best placed members of the group, this included linking with the private providers and commissioning a local advocacy organisation to 'in reach' into these services to get the voice of the patient.

In August 2022 a multiagency review was undertaken across Nottingham City and Nottinghamshire in relation to the increasing number of cases being heard at MARAC, for all agencies involved MARAC pressures are resource heavy and during the review it was identified that there was an increase in the number of repeat cases being heard. Although some changes were made and repeat cases reduced, there was an increase in new cases so demand remains unchanged.

The Adult Safeguarding Team have continued to support when required the multi-agency response to the National Asylum dispersal programmes and the support for Afghan refugees. This has included working with both Local Authorities in relation to the Homes for Ukraine scheme.

The NNICB Care Home and Home Care Quality Assurance team have undertaken more than 200 face to face quality visits between April 2022 and March 2023. The team use a hybrid approach of face-to-face visits as well as virtually reviewing documents to ensure providers are progressing against their action plans.

Following learning identified in a number of Statutory Reviews including DHR's we worked with Domestic Abuse leads in Nottingham City to develop and produce a 7 minute briefing and animation on Professional Curiosity as this had been identified as learning from these reviews.

Whilst awaiting the outcome of the consultation on the Code of Practice for LPS, the ICB has continued to be proactive in its progression of those cases which are fully funded CHC and where a Deprivation of Liberty is or may be occurring for community cases through the COP processes.

The NNICB has continued to provide and deliver updates and support to Primary Care through our GP Leads programme, TeamsNet and Provider forums. Following the Covid 19 Pandemic we have decided to continue to provide these 'virtually' as this has not only allowed for session to be able to continue but has also resulted in an increased attendance.

A key theme cited in learning from both DHR's and SAR's identified a lack of Professional Curiosity. With the support of funding via the CDP an educational animation to promote Professional Curiosity and an understanding around the importance of it was developed and promoted on email signature.

Professional Curiosity YouTube link.

Significant work is underway both nationally and locally around the growing numbers and the increased risks to CYP with severe mental illness and complex needs. Supporting these individuals to ensure that they receive treatment at the right time in appropriate settings along with supporting their transition to adulthood is a priority for the ICB.

The NNICB safeguarding team continued to offer mutual aid and facilitated regular safeguarding meetings until mid 2022 with the provider leads, this helped identify and act upon emerging themes and situations which were occurring as a health system.

The NNICB continue to chair and co-ordinate bi monthly meetings of the new ICS Safeguarding & Public Protection Assurance Group (SPPAG) which includes both Acute and Community Health providers and representatives from both Local Authorities and Safeguarding Boards.

As a ICB we remain compliant with all our statutory duties in relation to the Care Act (2014) & Statutory guidance and commenced submission of statutory reviews via the NHSE Safeguarding Statutory Review case tracker from September 2022. NHSE carry out "assurance conversations" with the Chief Nurse and Assistant Directors for Safeguarding. These conversations focus upon the ICB Heat Map returns that are submitted to NHSE on a quarterly basis. NHSE base these upon emerging national key themes. The Heat Map for 22 -23 was about the development and maturity of Safeguarding within the ICS which Nottingham & Nottinghamshire ICB were able to evidence that we were fully compliant with by Quarter 3. The ICB staff training figures for Adult Safeguarding are 94% against a target of 95% at the end of May 2023.

Information sharing meetings continue between NNICB and both LA's in relation to care home and home care intelligence, these have been made stronger during and following the pandemic. There is now an Integrated Group Manager covering both the ICB and the County Council Quality and Market Management Teams. The Care Home and Home Care Dashboard has been developed from a range of data sources, this is now used across the system to identify areas of concern, prioritise resources and support providers.

NNICB has several internal teams that work directly with our patients. All receive safeguarding training which includes Making Safeguarding Personal. Over the last 18

months these patient facing teams have received enhanced MSP as part of the alignment and development of the new ICB. Mental Capacity Act (2005) has also been rolled out across all relevant staff and Primary care as part of the programme of training in preparation for LPS implementation. We have now matched Mental Capacity Training with certain job profiles to make it mandatory for the role.

Nottingham CityCare

The Safeguarding training offer has been under continual review and to align with both the Core Skills framework and the Intercollegiate documents there has been some changes to the offer. At induction all staff complete the Think Family Basic Safeguarding Session which includes Safeguarding Adults Level 1 and Safeguarding Children Level 2. There is a further session at induction for all clinical staff of Safeguarding Children Level 3 and Safeguarding Adults Level 3. The team also deliver Domestic Abuse and MCA training at induction which is now classed as essential training.

The community setting has seen an increase in complexity and CityCare teams have been working under increased pressures, related to staffing capacity and the need to deliver safe and effective high-quality care in an environment where many adults have been isolated or been impacted by economic stressors. We have therefore seen staff managing significant complexity and this highlights the need for those in clinical practice to have a good level of understanding of the Mental Capacity Act and application within clinical practice.

Compliance figures for training continue to be closely monitored, and collaborative work between Workforce Development and the Safeguarding team have seen MCA compliance increase by 15%, whilst the other topics all show a nominal increase. We also provided “bitesize” training sessions via MS teams on subjects and themes identified from local and national learning.

In 2021 a three year overarching action plan for MCA was created to build upon and further sustain the work already achieved. This action plan is on the risk register and forms the basis of our work around knowledge and application of the Mental Capacity Act in clinical practice, and to ensure that a proactive, partnership approach is being utilised so that staff are well supported when managing complex cases.

Our Freedom to Speak Up Policy is supported by our Freedom to Speak Up Guardian and Champions who are responsible for providing an independent, objective ear for all workers who wish to raise a concern which they feel cannot be dealt with informally with the manager.

Our policies and procedures are in place to ensure staff have clear guidance around how to raise a concern. Concerns that are raised via this process are monitored via “SILLF” (Serious Incident Learning Lessons Forum).

We recognise that early intervention can make a huge difference in outcomes to the lives of adults who are experiencing or at risk of abuse and neglect. At CityCare, prevention takes place in the context of person-centred support, with the aim that individuals are empowered to make choices and manage risks safely. We place emphasis on everybody having a role to play in preventing abuse and neglect and we work with a Think Family ethos, underpinning all safeguarding work.

We continue to sustain and build relationships with our partners across the ICS and we know that where there are complex cases and safeguarding concerns, we have best outcomes for our citizens when we work together, utilising different agencies expertise and skills.

The Safeguarding Service provide a “duty telephone advice line” available to all staff who have a complex case or have identified safeguarding concerns in their practice. Staff can use the advice line to get support as needed.

We also have safeguarding champions who act as link workers, promoting good practice and cascade information and learning to their teams. Our aim is that every team within the organisation will have a safeguarding champion. Over the past year the topics covered at the champions meeting include Legal Literacy and Self Neglect. Domestic Abuse is a standing item on the agenda.

Over the last year, we have continued to have weekly CityCare Holistic Incident Review Panel meetings (CHIRP). This is a multi-professional panel, including membership from team managers, Tissue Viability, Infection Control, Safeguarding and the Quality team where all moderate and high-risk incidents are reviewed.

We value the relationships that we have with partner agencies, both in the local authority and throughout the ICS and continue to work in partnership where there are adult safeguarding concerns.

The Quality Information Sharing Forum (QUIF) is a subgroup of the Quality and Patient Safety Group. Meetings are held on a monthly basis to provide a forum for CityCare staff to share information on care homes and care agencies. This includes good practice as well as patient safety concerns. The Minutes of our internal monthly QUIF meetings are shared in their entirety with the Local Authority. This enables the Local Authority QUIF to triangulate their own concerns with those held by CityCare as a provider service.

Over the last year we have continued, with the support of the Business Team, on a project looking at Safeguarding data collection and analysis across the organisation. This will allow in depth data collection around the direct work the adult services are undertaking and reflects how our safeguarding activity is impacting and supporting front line work. It is anticipated this will enable the service to readily identify themes and adapt training, communications, and supervision in a more responsive way.

Safer recruitment policies and procedures are in place and all staff working with children, young people and adults are required to undertake enhanced DBS check prior to commencing employment. We have an Allegations against staff policy and pathway which is utilised where any allegation is made against a member of staff working with children, young people, or adults at risk.

In the last year we have been invited to sit on the Nottingham City Hoarding Panel Pilot . The Hoarding Panel exists to ensure that agencies are aware of individuals at risk of harm from hoarding as identified by any partner agency. The sharing of information aims to increase the safety and overall wellbeing of vulnerable adults with a focus on strength-based approaches, prevention and monitoring.

Making Safeguarding Personal (MSP) underpins all our adult safeguarding policies and procedures, training, safeguarding supervision and advice. We have also provided additional guidance to staff on our safeguarding intranet to further support practice in this regard. MSP aligns with the principle of person-centred care which is a thread that should run throughout all healthcare interventions and staff are encouraged to talk to adults and establish their wishes and feelings and to ascertain what they would like to happen when safeguarding concerns are identified.

We have internal guidance around non-engagement, in the form of a non-engagement checklist which is available on SystmOne and can be utilised to ensure all avenues have been appropriately explored with a person in situations when they are struggling to engage with their recommended care and treatment. We use this alongside the multi-agency

guidance around non-engagement. All patients should have personalised care plans, which are created with the person to identify their priorities, their goals and how we can achieve this.

There continue to be vacancies within the service and there is ongoing work in line with the CityCare Retention and Recruitment plan. CityCare have established a Health and Wellbeing group which includes representatives from across the organisation and is chaired by the Assistant Director of Organisational Development. The Group is responsible for providing the People Steering Group with Alerts/Advise and Action Logs/reports related to all aspects of workforce health and wellbeing. The Stress management policy has been updated and there are plans for the introduction of Health and Wellbeing champions.

Community Protection (changing to 'Communities')

Domestic and Sexual Violence and Abuse

The Director of Adult Health and Social Care has sponsored a review of the Domestic Abuse Referral Team. The Community Safety Strategy Manager is leading the review alongside colleagues in Children's and Adult Services. There are a range of issues to resolve, but further discussions within the city council for tech solutions and with partners to ensure all high-risk survivors of domestic abuse are supported are planned.

The Multi Agency Risk Assessment Conference (MARAC) review is being jointly lead by the DSVA teams within City and County Councils to ensure the outcomes for the partnership across Nottinghamshire is aligned. In addition, Adult Social Care are reviewing their engagement with MARAC and have outlined proposals which are currently being considered. Liaising with the Domestic Abuse Commissioners Office (DACO) and Safe Lives to explore national best practice and discuss options for further changes to the local approach will be a priority in 2023/2024.

Severe and Multiple Disadvantage (SMD) now includes domestic abuse and the Women and SMD working group chaired by Dr Lyndsey Harris reports to both the Changing Futures Board and the DSVA Strategy Group. Domestic Homicide Reviews identified SMD as a key feature of DHR's in Nottingham and the action plan for the group reflects that. The Safe Accommodation Team based with Housing Aid and employed by Juno Women's Aid includes SMD posts and an Older women and DVA post.

Slavery Exploitation Team (SET)

There has been significant increase in referrals; in 2021/2022 the average number of referrals per month was 14, in 2022/2023 the average number of referrals per month was 23. The most common referral type in this time was financial exploitation (112 cases) which has continued to rise since the pandemic and cost of living crisis. Cuckooing continues to be a high referral type (90 cases); of particular concern is repeat offenders (one person cuckooed 11 addresses over 12 months) and more frequently, perpetrators occupying multiple accommodations in supported living blocks for the purposes of using it as a base or 'trap house' for the distribution of drugs and other criminal activity. Other case types include sexual exploitation, criminal exploitation, forced labour/labour exploitation, human trafficking, domestic servitude, false imprisonment, debt bondage, county lines, Child Criminal Exploitation and Child Sexual Exploitation.

Nottingham City Council have ownership of SERAC (Slavery Exploitation Risk Assessment Conference) including the SET holding chair responsibility. The SERAC model supports the identification of a cohort of people that don't meet care act or police

thresholds and offers a pathway to intervention. It creates an instant response to safeguard, tackle criminality and hold agencies accountable. The SERAC partnership works to find pathways to safeguard, taking into account and addressing each individual's vulnerabilities. Cases are not discharged due to 'non-engagement'. The SERAC partnership aims to ensure effective communication with relevant agencies to formulate a joint approach with clear actions. A best practice case study on NCCs SET and SERAC model was used in the Local Government Association refreshed guidance on Tackling Modern Slavery released in October 2022.

The SET does not have a statutory referral pathway so if other services are unaware of the team or chose not to refer, the team will not be aware of risks/concerns. The team is currently exploring collaborating with NGOs who deliver First Responder National Referral Mechanism training to ensure standardised training is delivered to all local services.

A RAG Rating tool was created and implemented in August 2022 to support in identifying risks in the areas of housing, disability, mental health, substance use, agency involvement, immigration status, risk of absconding, police incidents, hospital presentation and slavery/exploitation/trafficking. This allows the team to prioritise focus and action plan, but also ensures ASD is being addressed and the correct agencies brought into the SERAC multi agency arena.

Development and maintenance of a continuous process for identifying and disseminating best practice in relation to tackling slavery and exploitation and delivering Awareness Raising sessions to internal and external partners. Delivery of workshops to cohorts of newly qualified social workers via social care's Assisted and Supported Year of Employment programme.

Case study

Background

The Slavery and Exploitation Team received a referral from a support service for a vulnerable adult who had a learning disability and challenges with substance use. Concerns were that he was being financially exploited by way of being forced to pay other people's drug debts. There had been a number of physical assaults against him by both drug dealers and users.

What happened next

Observations had been made by professionals that he was struggling with mental health and personal hygiene, however substance use was preventing him from accessing support with specialist services to address this. A social care referral had been made previously but he had not been eligible.

Following immediate welfare checks by police (at the request of the SET team), effective referrals were made to adult social care, substance use services and counselling.

Multi-disciplinary meetings were instigated to explore interventions and pathways to support.

Outcome

Although deemed to have capacity, further assessments resulted in the diagnosis of a cognitive impairment disability and he was able to access mental health specialist supported accommodation. He moved 3 months after the initial referral and is continuing to engage with services around substance use, mental health and personal daily routines.

Safeguarding Gateway

The Communities directorate has multiple service areas that keep records on different IT platforms. In response to cases where earlier intervention could have been instigated, the Safeguarding Gateway was launched in August 2021. Following affiliated face to face safeguarding training to all frontline officers, the service offers assurance to service areas in the Communities Directorate that any concerns for safeguarding or welfare have been adequately dealt with and referred to the relevant agencies. Accredited safeguarding training has been delivered to all front line CP officers.

The prevent team have established links with a number of projects in the community and submitted funding proposals to the Home Office. All youth organisations in the City have been able to access local training with a specialist provider in March 2023. Training on Prevent in the Council and for partners is evaluated. Benchmarking from the Home Office shows considerable improvement in all areas of the prevent duty including communications, training and policy.

Preventing Violent Extremism

The Head of Community Safety chairs the Channel Multi Agency case conference for reducing the risk of radicalisation following a Prevent referral. Working with Police, Health, MH and Social Care a multi-agency plan is developed for each case accepted at Channel with consent.

Referrals into Nottinghamshire Prevent have decreased by 15% on the previous year. Education provided the majority of these referrals (37% in total), closely followed by policing. An emerging theme in the referrals is young people who have witnessed domestic abuse, across all ideologies. Online radicalisation, the manosphere and gore obsessions are also of concern particularly for young people. The Prevent Coordinator and Prevent Education Officer are funded by the Home Office to 2025.

Prevent

Prevent Officers and those chairing Channel have additional annual training from the Home Office, Police vetting and National Security Clearance. All Communities staff have undertaken Prevent Training over 22-23, amendments to the corporate NCC safeguarding e-learning should make sure this is refreshed every 2 years.

Community Protection Officers

Out of hours checks on behalf of adult services continue and are increasing. A new referral system has been implemented utilising digital tools. This allows the Modern-Day Slavery and Exploitation team to make real time referrals, which has seen an increase in cases and improved governance. This is all to a continued back drop of reduced staffing and conflicting demands.

Early intervention strategies have included referring citizens into community support networks and supporting multi agency structures (such as SERAC) to provide a continuation of monitoring for citizens where there are ongoing concerns for welfare.

On conducting welfare checks, officers will respond to immediate risk but also consider the individual's needs (ensuring there is food in the cupboards and people aren't without electricity/gas). On making a referral to Adult Safeguarding, officers will meet interim needs: taking a person to a place of safety (potentially hotel accommodation), sourcing a meal. Support is also offered to multi agency panels to monitor ongoing support needs.

Anti-Social Behaviour team

The ASB team lost 50% of its staffing at the end of financial year 2021 therefore there are less officers doing this role in general.

Risk mitigation in regards to missed visits is covered in partnership with CPOs, Nottingham City Housing Services and Nottinghamshire Police. Safeguarding checks are completed at this stage and referrals made when needed to the gateway and/or adult social care.

Due to the triaged operational work with CPOs early intervention strategies have included referring citizens into community support networks and supporting multi agency structures (such as SERAC) to provide a continuation of monitoring for citizens where there are ongoing concerns for welfare. ASB officers remain focused on safeguarding and per the case management risk assessment process.

Officers have completed eLearning safeguarding training, all colleagues assess the needs of victims and offenders upon being commissioned a case to the ASB team.

Environmental Health and Public Protection

Frontline officers attend relevant partnership meetings as required (hoarding panel, Complex Persons Panel, SERAC). Training around relevant safeguarding is provided for identified different groups, such as taxi drivers. This works in conjunction with proactive taxi licensing operations. Proactive visits are conducted in instances where information is received indicating concerns such as overcrowding or exploitation.

Communities

The redesigned Resident Development team (RDO) are embedded and are establishing links with partners to gain insight and better support safeguarding issues.

Refreshed safeguarding referral information has been cascaded to the team (RDO team) so they understand their role in safeguarding.

The redesign of the merger of Community Cohesion and Neighbourhood teams has been completed and the team are embedding well. Their role in safeguarding has been reconfirmed.

Women with no recourse to public funds have increased difficulty accessing refuges, especially those with no children.

There is a reduction in access to services, particularly for the digitally excluded; there has been no advertising in spaces such as public toilets or raising awareness of events.

Nottinghamshire Probation Service

Nottingham City Probation Delivery Unit (PDU) have had challenges of high workloads against a reduced staffing profile to varying degrees since last year. Whilst we have continued to commit to a core standard of service delivery as defined in the National Prioritisation Framework (PF), we have been able to allow some flexibility to our staff in terms of the sequencing of some areas of our work on cases who pose a medium or low risk of harm. The Framework does not give any flexibility around the core tasks of safeguarding and we continue to mandate attendance at MARAC/MAPPA and Child Protection Conferences. We remain committed to prioritising work with our high and very high risk of harm individuals. We have also recently implemented a policy whereby we complete child safeguarding and police domestic abuse checks on ALL of our people on probation regardless of whether they have been convicted of an offence against a child or an offence involving domestic abuse.

We have recruitment campaigns ongoing and have continual cohorts of trainee probation officers (PQUIPS) starting and qualifying nationally to improve the vacancy picture over the coming months and years. The allocation of Newly Qualified Officers (NQOs) is made divisionally at the point each cohort qualifies and then locally we are able to determine directing them to work in the most under resourced teams.

Safeguarding is an integral part of all of our assessment tools this includes our main assessment tool (OASys) where there are quality expectations of these assessments which incorporates safeguarding adults and children and identifying the level of risk posed to the public, known adults, children, staff and other prisoners. Our organisation is aware of and compliant with s.42 to s.46 of the 2014 Care Act, as well as chapter 14 of the Statutory Guidance, both of which detail organisational responsibilities regarding adult safeguarding. We also have a formal process of our responsibility for identifying and referring incidents of potentially concerning practice which may meet Safeguarding Adult Review (SAR) criteria to the local Safeguarding Adults Board.

The NPS ensures that all staff are aware of their personal responsibility to report safeguarding concerns as well as ensuring that poor practice is identified and improved. Our ' new starter' induction programme ensures that staff, regardless of grade, and volunteers are made aware of their adult safeguarding responsibilities.

All of the Assurance and QA tools used in the Probation Service include guidance and require reference and assessment of Adult Safeguarding issues. We monitor the outcomes

and actions from our Serious Further Offences (SFOs), Safeguarding Adult Reviews (SARS) and Domestic Homicide Reviews (DHRs) and have regular Effective Practice and Performance meetings with our senior managers for the dissemination of learning to the wider staffing group. Whilst we do not have performance measures and / or indicators regarding adult safeguarding there are core expectations in relation to safeguarding and risk management planning which would be picked up by the quality assurance process.

Following the unification of the Probation Service there has been a renewed emphasis with our operational staff on the importance of safeguarding and this is reflected within the unification mandatory training schedule. Safeguarding discussions are also an integral feature of supervision sessions between the probation practitioner and the senior probation officer. Alongside, this our MAPPA protocols mandate consideration of child and adult safeguarding issues within all formal meetings and our assessment tool OASys also gives specific consideration to adult safeguarding issues and the safeguarding of children and vulnerable adults is clearly listed within our Quality Audit tool.

There has been work undertaken centrally to support the adaption of licence conditions to support people with learning difficulties to understand the terms of their supervision. We also utilise the Personality Disorder Project which supports us with a plan of best practice to support the individual to engage and to manage any barriers which may be problematic in this process based on the individuals' personal circumstances/needs/vulnerabilities.

The Probation Service also undertake nationally a People On Probation Survey which collates their views on their experience of supervision and this can be completed digitally or via our people on probation focus groups.

East Midlands Ambulance Service (EMAS)

EMAS are invited to attend the LSABs across the East Midlands. The Ambulance Operations Managers for each Division are expected to attend their local Board. We aim to attend 80% of boards, over a rolling 12-month period. Despite the limited attendance at Boards the team have continued, where possible, to carry out individual assurance audits, as well as when asked attended Board to give a presentation on the structure and the service EMAS provide.

EMAS continue to contribute to Safeguarding Adult Reviews, Domestic Homicide Reviews and Fatal Fire Reviews across the whole of the East Midlands.

The Trust has a Safeguarding Adults Policy (Version 14). Polices are regularly reviewed triangulating best practice guidance and learning identified locally and Nationally. To support the Safeguarding Adults Policy there is a Safeguarding Children and Young Person Safeguarding Policy, Domestic Abuse Policy, Capacity to Consent and Regional Mental Health Conveyance Policy. PREVENT and Managing Allegations are part of the existing Adult and Child Policies.

Safeguarding sits within the Director of Quality Improvement and Patient Safety portfolio and forms part of the Quality Strategy. The Executive Director of Quality Improvement & Patient Safety is the nominated Director for Safeguarding, reporting and providing assurance to the Trust Board. There are clear links from the frontline to Board and the reporting mechanisms are via the EMAS Clinical Governance Group and Quality and Governance Committee. The Safeguarding Team are also members of the Incident Review Group (IRG) and Confidential IRG Group (CIRG). The Head of

Safeguarding is the Chair for CIRG. Referral rates, participation in statutory reviews and staff allegations are presented to the Quality and Governance Committee via the Director of Quality Improvement and Patient Safety in the Quality Metrics Report monthly. This is to ensure that safeguarding remains a focus for discussion, safeguarding activity is monitored, safeguarding quality is reviewed and learning is embedded.

There are two Safeguarding Leads. The Safeguarding Adult lead role also incorporates additional leadership on Learning Disability, and Mental Capacity. The Child and Young person safeguarding lead role incorporates additional leadership on the Child Exploitation and Child Death processes. They share the lead role for Domestic Abuse, FGM and Modern Slavery. The leads provide expert knowledge, advice and clinical leadership on all aspects of the safeguarding and domestic abuse agenda. They develop and deliver education in relation to safeguarding and its associated agendas. The leads represent the Trust at strategy meetings and case conferences as well as deputise for the Ambulance Operations Manager in attendance at safeguarding boards. The leads monitor compliance with policy and procedure through audit. They author the Trust Children Safeguarding Practice Reviews, Safeguarding Adults' reviews and Domestic Homicide Reviews. They ensure that the Trust meets its statutory requirements in line with the LeDeR process.

EMAS has a safeguarding training strategy and programme that considers legislative duties and national guidance including:

- Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate Document. Fourth Edition: 2019;
- Safeguarding adults: Roles and competences for health staff intercollegiate Document First Edition:2019;
- NHS England PREVENT training and competencies framework; Safeguarding Adults Assurance Framework 2020/21 Page 19
- Key Skills for health.

EMAS continues to deliver education using a "Think Family approach" in line with the above guidance. All EMAS safeguarding training is written and developed by trained educators in collaboration with experts in safeguarding. It is reviewed by peers providing assurance that the content is relevant and of high quality.

EMAS staff are trained in the Mental Capacity Act and in recognition that any best interest decision should be proportionate and made with the patient wishes in mind and with support from those who know them best.

EMAS have been promoting Making Safeguarding Personnel prior to the Care Act with a section on the referral form asking for the patient wishes since 2014. Staff are trained to ask what the patient wishes are from a referral unless the patient doesn't have capacity or asking will put the patient or other members of the public at risk.

Nottinghamshire Fire and Rescue Service

During 2022-23 Response to operational incidents remained constant, but unlike the previous year, due to COVID there has now been an increase in Prevention activity including using Data intelligence to increase those areas in the county and city which have low smoke alarm ownership. Safe and Well visits had increased to by over 2,000 to 14,493 visits, many of these from professional referrals where the occupants had already been

seen by a professional and very few safeguarding issues were identified by NFRS.

Being a 24/7 Service, the main risk relating to Safeguarding for NFRS remains the need to ensure that all staff can identify concerns and refer them appropriately, and that Duty Managers have the qualification and competence to support the process and advise where necessary. L3 Safeguarding is now being rolled out to all stations due to the success of the training at 2 locations in March 2023.

In May 2022, NFRS launched the Vulnerable Person module which means that although we still have the same database, it will have the ability to be person centred and allow us to see specific fire risks regarding a certain person in the household, not just the property risk.

Where a threat is not immediate, NFRS has a process in place where staff report any Safeguarding concerns regarding service-users to an internal safeguarding team who triage the referral to determine a suitable course of action (i.e. a referral to MASH or for Care & Support Needs). By following this process 87.7% of Safeguarding referrals submitted by NFRS in 2022/23 to either county or city, have gone forward to a Section 42 enquiry or were already open to the enquiry from another agency when NFRS referred in.

The CHARLIE risk matrix used by partner organisations to refer, and Delivery Teams to complete SWVs demonstrates NFRS's person-centred approach towards it's service-users. The funding of an Occupational Therapist within the Prevention Department further establishes the Service's commitment to a person- centred approach, which extends to Safeguarding, and supports the Service's understanding of and adherence to the Mental Capacity Act.

MSP is embedded, and the Mental Capacity Act is referenced within the NFRS Safeguarding Policy and in-house Level 1 Alerter Training. The requirement to put an individual's needs and wellbeing at the centre of all actions is fundamental to everything the Service does.

Nottinghamshire Healthcare NHS Foundation Trust

Throughout 2022-2023 there has been a review of the Trust quality governance structures and safeguarding has been considered as to how it can be better integrated into the wider quality structure.

The current and likely future operational climate of health and social care means that staffing levels across the local health sector have been tested and as such consistency of staffing continues to be a risk. Flexible staffing arrangements such as those provided by bank and agencies have required a robust response to patient complaints, allegations, and patient safety incident monitoring as well as offers of training and support to the flexible workforce.

As the pandemic restrictions abated through 2022/23 the TSPPS recommenced face to face safeguarding assurance visits. There is a recognition that there is an inherent risk of closed cultures developing with health care settings where vulnerable people access support.

As we return to business as usual following the covid-19 pandemic the safeguarding training team have resumed face to face Think Family Safeguarding Training for all staff

induction sessions. In addition to this agreement has been given to extend the current half day safeguarding induction training to a full day to allow for practical application of safeguarding theory. During the covid 19 pandemic the safeguarding training team developed a suite of additional e-learning packages to compliment the mandatory Think Family safeguarding level 1 and level 3 training requirements; including domestic violence and abuse training which, once launched, has been agreed to be a mandatory one-off training for all staff. Other live e-learning training resources include making safeguarding personal (MSP) and modern slavery.

The safeguarding Single Point of Contact (SPOC) was developed in 2020 and has become integral to the work of the safeguarding service and as such there is a commitment to its ongoing monitoring and development. The SPOC data, intelligence from safeguarding supervision is used to inform future safeguarding priorities.

The NHCFT Sexual Safety lead developed a sexual safety policy in 2019 which has been in place since alongside training, individual service quality improvement projects, enhanced data collection and bespoke sexual safety assurance visits in specific identified areas of concern. The sexual safety lead has also co-chaired the regional community of practice for sexual safety in mental health trusts.

The TSPPS has actively worked with the quality governance team to provide safeguarding consultancy and advice in respect of the providers of sub-contracted beds and sought assurance regarding effectiveness of safeguarding systems and processes. Clear governance processes are now in place and regular meetings have been scheduled to maintain effective communication between provider organisations.

The TSPPS has worked to ensure a coordinated response with patient safety colleagues, operational leaders and employee relations, especially regarding allegations against people in a position of trust. The PiPOT policy has been reviewed due 2022-2023, including staff consultation. The TSPPS now has a clear process for our contribution to allegations against staff and more robust reporting organisationally.

The Trustwide Safeguarding Strategic Group is where safeguarding reports are presented and scrutinised. During 2022-2023 there was a broad governance review and the safeguarding reporting has aligned itself to the organisational quality governance structure reporting directly into the 3 divisional quality operational groups and up to the trustwide quality oversight group.

The TSPPS identified the need to develop a trustwide making safeguarding personal strategy. This was born from a holistic vision to demonstrate our commitment to changing the culture of and practice of safeguarding to something that is person centred and outcome focused and that follows the principles of the Care Act.

Following the recent government decision to postpone the implementation of LPS until the next parliament our plans to support the MCA team in implementing this are on hold. However, MCA remains a key theme running through our MARs and we will be working collaboratively to promote MCA within a subgroup of our Link Practitioner's forum to build confidence within the workforce around the MCA and safeguarding interface. This will be accessible to all across the Trust, not just the link practitioners

We will focus on transitional safeguarding within our QIP and work collaboratively across

the Trust and wider system to improve the outcome of children and young people transitioning into adulthood.

Nottingham University Hospitals NHS Trust

The Adult Safeguarding team continues to provide support, guidance and training for all NUH staff. We provide a single point of contact for safeguarding advice and referrals to ensure all written information shared externally is of the required quality and referred to the appropriate agency. The team ensure that appropriate information is reviewed and shared in a timely manner and support the local authority teams in gathering further information to safeguard patients. The safeguarding teams process all of the DASH forms as part of the quality assurance process in line with all safeguarding practices.

The Trust safeguarding teams continued to contribute to MARAC's in Nottingham and Nottinghamshire. The adult safeguarding lead also chairs MARAC on a rotational basis and attends the MARAC steering groups. The number of MARAC's in Nottingham and Nottinghamshire has increased significantly over the last 2 years. The increase in the numbers of high-risk cases has affected the time required by the teams to complete the research and attend the MARAC's.

The Safeguarding Teams are responsible for the management of papers relating to the detention of patients under the MHA at NUH. There is a band 7 Mental Health Specialist in post whose role is to manage the detention papers with the support of the safeguarding teams. They are developing a training programme for staff in relation to patients with mental health issues and to work closely with the liaison psychiatry teams to ensure there is appropriate management of detained patients and improve patient experience.

NUH safeguarding teams continue to work closely with the Slavery and Exploitation teams to ensure concerns are escalated and appropriate information shared.

The Acute Learning Disability Liaison Team liaise with Nottingham University Hospital NHS Trust (NUH) via the Safeguarding Adults Matron and support the clinical teams in the care of patients with Learning Disability. The aim of this service is to contribute to better healthcare for people with a learning disability by reducing health inequalities and maximising positive outcomes and experiences.

The Trust is mainly a referring agency; we share information when abuse or neglect is identified with a team of safeguarding specialists available for staff to contact for support. The team act as a single point of contact and quality assure all referrals. All staff in the team have had additional training by Equation in relation to domestic abuse and have good relationships with Equation and Juno Women's' aid to ensure the appropriate support is in place for survivors.

The Trust has a policy for Assessment and Management of Individuals who Pose a Risk, the use of which is reviewed via the audit process.

NUH has a Patient Engagement and Experience Steering Group. There is wide representation from our patient group and includes patients with a learning disability. All changes to the delivery of services are discussed at this group, and governance forums have patient representatives.

Patients with a diagnosed Learning disability (LD) are alerted on Trust's computer system to alert staff and advises whom to contact for any support. The LD team work closely with the safeguarding teams and attend Adult Safeguarding Committee; they provide data and

information to this committee as part of their governance process.

The Trust continues to support the Structured Judgment Case Review and LeDeR process and ensuring any learning is shared widely and processes are implemented to support service improvement.

NUH has a dedicated team of safeguarding professionals. This includes a Head of Safeguarding, Named Doctors for Safeguarding, Named Nurse, Named Midwife, Adult Safeguarding Lead and specialist nurses and Practitioners for adult, children's and midwifery safeguarding and domestic abuse.

NUH has a suite of Safeguarding Policies procedures and associated guidelines. These are aligned to the Multi-agency Safeguarding policies and Procedures.

The Trust has approximately 180 safeguarding champions. The safeguarding teams provide quarterly training and updates to this group to support dissemination of learning from SAR's, DHR's and CSPR's across the organisation.

Safeguarding training is delivered on a three yearly rolling programme delivering content in line with the intercollegiate document.

Non-mandatory training is delivered to support clinical knowledge and understanding of safeguarding, safeguarding processes and MCA.

Implementation of the **Oliver McGowan Mandatory Training** on Learning Disability and Autism **(OMMT)** is a priority for NUH in 2023/24. The training will assist health and care staff caring in supporting people with a learning disability and autism and has been launched following a long campaign. NUH are working closely with the ICB to support the implementation and roll out of this training.

The organisation has a Safeguarding Adults Committee, this meet quarterly. The safeguarding committee receives quarterly activity data from the safeguarding team, updates from SCR's, DHR's and lessons learned from these and other complex case reviews. The divisional teams attend this committee to share relevant information and to take learning back to their divisional teams. The TOR has recently been reviewed and members are asked to provide a quarterly assurance update report to Committee, including audit feedback, training figures and actions plans. Relevant information from this committee is escalated through the wider Trust assurance/governance groups.

The Trust identified a need for a consistent response to staff allegations across the Trust. The Head of HR operations and the Head of Safeguarding and Harm Free Care have developed a rapid review process and anecdotal evidence shows that the process is improving communication between teams and offers an improved level of support for managers as well as a consistent response to allegations.

The staging and management of pressure ulcers is a responsibility for NUH as described in the **Care Act 2014.** Management and reduction of pressure ulcer incidents is a Trust Quality Priority for 2022/24, with the aim to reduce incidents by 30% over the next 2 years. A number of interventions and work streams are in progress to reduce the incidence of hospital acquired category 2 and 3 pressure ulcers, including new beds and pressure relieving mattress provision Trust wide, audit, focus work in ED, training and education for clinical staff and recruitment into a Band 7 Care Excellence Tissue Viability Fellowship. The method of investigating these incidents is changing. During 2023/2024, we will work alongside the Patient Safety Team and ICB Quality Leads to implement the Patient Safety

Incident Framework (PSIRF) in response to pressure ulcer and falls incidents, with a focus on learning and improvement.

Making Safeguarding Personal is a core principle of adult safeguarding at Nottingham University Hospitals NHS Trust. All safeguarding referrals are sent to the Trust team for quality assurance, specifically focussing on MSP and the outcomes the individual would like as a result of a referral. The NUH safeguarding referral form contains a mandatory MSP section that requires completion prior to the referral being processed. MSP is a core part of mandatory training and referrals data collects evidence around MSP, this is collected via clinical records within the electronic patient records.

Nottinghamshire Police

Domestic and sexual abuse remain a key priority for Nottinghamshire Police and our partners, further underpinned by the national introduction of the Violence Against Women and Girls (VWAG) strategy. Throughout Covid-19, we saw reductions in demand for domestic and sexual abuse services with this continuing into the 2020/21 performance year. After restrictions lifted, reported incidents rose and moving forwards to the 2022/23 performance year Domestic abuse has increased by 5.8% (YTD) and rape alone saw a 13.4% increase (YTD). Whilst we work to fully understand this increase, we can be confident that some of this is related to the increased confidence in reporting coupled with significant development of training being implemented to identify and recognise risk and safeguarding. Continued media awareness also encouraged reporting and collaborating with partners to ensure support and positive action.

Repeat victimisation rates are static and every domestic abuse incident reported to us is put through our risk assessment process for right-to-know. Subsequently, our domestic violence disclosure scheme (DVDS) applications increased, recognised during the HMICFRS inspection in early 2022, which rated our protection of vulnerable people as ‘good’.

The volume of Public Protection Notices (highlighting vulnerabilities for children and adults) has steadily increased over the period and given the level of social need emerging from the cost-of-living crisis, we plan to undertake training for frontline staff around PPN necessity and quality over the next six months.

There are several procedures which include employee risk. The overarching governance of which is via our Professional Standards Directory (PSD). In addition, there is a confidential reporting mechanism whereby colleagues can report any concerns they might have in relation to fellow officers/staff which are fully investigated by officers within PSD.

We have continued to recruit additional new officers and staff to meet increasing demands, including a ‘fast track to detective’ scheme to mitigate national shortage of PIP2 investigators. All new recruits, whether police constables or civilian roles, receive input stressing the importance of safeguarding across all areas of vulnerability.

Working alongside the Partnership measures were agreed and implemented across the MARAC system to better manage those repeat cases heard at MARAC. Whilst it is assessed that this had some initial positive impact, the benefits of this change have been off set with the continuing increase of case numbers.

The force has signed up to implement the new OP Soteria operating model. Operation Soteria was launched as part of the government’s end-to-end Rape Review (published June 2021). The programme built on Project Bluestone, pioneering work in Avon and

Somerset which begun in 2020. The new model will transform the investigation of rape offences and will be launched nationally in late 2023.

PPN Development Group has been implemented. MASH partners will discuss learning, themes, and best practise to support timely referrals and reduce unnecessary demand.

The force has agreed to introduce a Prevention and engagement Hub. The proposed structure would integrate several prevention activities into one department, aligning with the National Prevention Strategy to ensure prevention is at the heart of the policing activities. This will aid in better co-ordinating and managing performance particularly within safeguarding.

The Prevention Hub aims to enhance awareness, utilization, and enforcement of preventative and supportive orders such as DVPN (Domestic Violence Protection Notice), DVPO (Domestic Violence Protection Order), SPO (Stalking Prevention Order), and Civil Orders. This includes the processing, governance, and monitoring of these orders to ensure effective management and availability of relevant information and intelligence to local policing.

The Safeguarding team will consist of roles focused on identifying and supporting repeat victims, reducing perpetrator re-offending, developing strategies for long-term safeguarding, and breaking the cycles of victimization and offending. This will involve collaboration with partners, charitable organizations, diversionary groups, and internal crime prevention support.

The new and improved Sexual Assault Referral Centre (SARC) was launched and operationally in August 2022. The centre includes provisions required by the forensic science regulator and delivery of the UK Accreditation Standards compliance. Commissioned services are co-located within the new SARC to enhance the victim's journey from initial police contact and provide ongoing support to vulnerable victims of sexual offences.

The 'Know it, Spot it, Stop it' campaign was relaunched during this reporting period to further increase knowledge around vulnerability, both within force and to the wider public. It identifies and explains the 14 strands of vulnerability, signs that a person may be vulnerable, and how to stop vulnerability being exploited.

To support vulnerable adults in custody, an appropriate adult is available within the new custody suite in Nottingham's Justice Centre between 8am and 8pm. As well as providing a face-to-face presence, they assist in administering rights and charges over the telephone.

A bespoke auditing schedule is in place within the PP department to examine the investigative process, victim care and support, and suspect management, to ensure victims' needs (established by victim needs assessments (VNAs)) are met. Rape and serious sexual offences (RASSO), child abuse, and domestic violence are amongst areas being audited twice yearly.

Recommendations from SARs are recorded on 4action – an internal Public Protection Audit and external Force Audit regime which examines performance across a range of areas affecting vulnerability (knife crime, drugs, Antisocial behaviour) and includes areas of public protection, Rape and serious sexual offences and domestic abuse. Learnings from SARs/CSPRs/DHRs are monitored through the Organisation Learning and Risk Board chaired by the Deputy Chief Constable.

Police co-chair a joint meeting attended by all regional force leads and CPS leads for Rape and serious sexual violence and attendees include the commissioned services

providing support to those victims and survivors (ISVAs). The group share best practice and provide feedback directly from users to enhance the service provided. Feedback within this quarterly meeting has provided amendments to joint guidance highlighting when ISVA support should be offered and when charges are authorised, an agreed requirement to hold Special measure meetings with the complainant together with their ISVA, allowing for on-going support through the criminal justice journey.

To support victims through the police investigation ISVA workers are now co-located within Police stations. They have direct contact with the officers investigating rape and sexual violence, providing support during the initial contact with victims, support following Video recorded interviews and on-going support through the police investigative process.

The force continues to utilise the Victim Needs Assessment (VNA) which was informed by commissioned services. The VNA is completed at the start of the victim's journey and a further bespoke VNA is completed for any vulnerable victim to assist with the Achieving Best Evidence (ABE) process.

What next for 2023/24?

Nottingham City SAB has an exciting year ahead, and has a new action plan with activities such as developing a Comms & Engagement Strategy, a new Quality Assurance Framework, a new Data Dashboard and plans for a multi-agency Conference.

The Board will further develop its now established three-year Strategic Plan (2022–-2025) and will maintain a focus on three priorities: Prevention, Assurance and Engagement. Our annual action plan will focus on developing the evidence to demonstrate the difference the partnerships work makes to the residents of Nottingham City. The development of a new Quality Assurance Framework and multi-agency Data Dashboard will ensure we have a good overview of safeguarding activity in the City, and are focussing our resources in the right place. We will also be utilising recent census data to recognise 'communities of identity' from new national census that are underrepresented in adult safeguarding data, and engage with representative community groups to promote adult safeguarding messages.

Having completed two SARs, we will now seek to publish them and to continue monitoring the action plans. The new SAR Impact Tool will be launched in 2023/2024 and will support the Board to understand how learning is embedded in practice. We will continue to receive and consider new SAR referrals eligibility and undertake statutory and non-statutory reviews as required. Partners will work more closely with Public Health and Housing colleagues and consider drug- and alcohol-related deaths and homelessness/rough sleeper deaths.

We will be reviewing our existing policies, procedures and protocols as necessary through a comprehensive Policy and Procedure Review Schedule. All current Terms of Reference for the subgroups and the SAB Constitution will be reviewed, we will be launching the new SAB People in Positions of Trust (PiPoT) Guidance, and finalising the SAB Information Sharing Agreement.

We will be establishing a local multi-agency working group to look at Transitional Safeguarding and establish what the current picture is and what agencies are doing in this emerging area of safeguarding. We anticipate this will provide the foundations for further work to continue into 2023/2025 where we can develop a local multi-agency approach.

Finally, we will be supporting National Adult Safeguarding Awareness Week in November 2023 and will seek to use new methods to raise awareness and share learning with professionals and citizens.

Reporting abuse

You may know a person carrying out abuse and be worried about reporting them. If you are being abused, you do not have to put up with it. If someone you know is being abused, or you have a concern that they may be, you should first make sure that they are safe if it is possible to do so.

Tell someone you trust or call Nottingham City Health and Care Point on **0300 1310 300 and select option 2.** Our offices are open from 8am to 6pm. If you live outside Nottingham City but within Nottinghamshire County boundaries, call Nottinghamshire County Council on **0300 500 8080.** If you are unsure, call either of the numbers and report what is happening to you or the person you are concerned about.

If it is an emergency, dial 999

You can report abuse to us in the strictest confidence and your identity can be kept private.

Glossary of acronyms

ASC	Adult Social Care
CDP	Crime and Drugs Partnership
CHARLIE-P	Care and support needs; hoarding and mental health issues; alcohol and medication; reduced mobility; lives alone; inappropriate smoking; elderly; previous signs of fire
CHC	Continuing healthcare
COP	Court of Protection
CQC	Care Quality Commission
DBS	Disclosure and Barring Service
DHR	Domestic Homicide Review
DNACPR	Do not attempt cardiopulmonary resuscitation (CPR)
DoLS	Deprivation of Liberty Safeguards
DSL	Designated safeguarding lead
GDPR	General data protection regulation
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
ICB	Integrated care board
ICP	Integrated care partnership
ICS	Integrated care system
IICSA	Independent inquiry into child sexual abuse
LD	Learning disability
LPS	Liberty protection safeguards
MAPPA	Multi-agency public protection arrangements
MARAC	Multi-agency risk assessment conference
MASH	Multi-agency safeguarding hub
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NCVS	Nottingham Community and Voluntary Service
NICE	National Institute for Health and Care Excellence
PiPoT	People in a position of trust
PoP	People on probation
PP	Public protection
QA	Quality assurance
SAB	Safeguarding Adults Board

SAR	Safeguarding adults review
SERAC	Slavery and exploitation risk assessment conference
SPOC	Single Point of Contact
SWV	‘Safe and well’ visit
VAPN	Vulnerable adults provider network