Nottinghamshire Safeguarding Adults Board

Stop abuse and neglect

NSAB

Annual Report

2022/23

CONTENTS

Message from the Independent Chair

It is my pleasure to introduce the annual report of the Nottinghamshire Safeguarding Adults Board (NSAB) for 2022/23. I joined the NSAB in the latter part of this reporting year as the Independent Chair.

This annual report, written in line with Care Act requirements, details the work that the NSAB has undertaken to carry out and achieve the objectives of its three-year (2022-2025) strategic plan, as well as highlighting contributions from our partner agencies.

The NSAB has continued to work towards the key aims identified within the plan:

- Prevention
- Engagement
- Assurance

As in previous years, during 2022/23, the NSAB met quarterly, and also hosted six-monthly partnership events for the wider networks, which were very positively received. Our partnership is based on the premise of mutual respect, high support and high challenge, working collaboratively to resolve issues and monitor the impact we have made together.

The NSAB ensures we continue to work together on current priorities and pro-actively on new issues as they arise. I am very aware the year continued to be shaped by the impact of Covid-19, other world events and the cost of living crisis being felt across our communities. Partner agencies continued to face additional challenges as a result.

Senior leaders from the Board's partners remained visible and engaged, working collectively to ensure we effectively safeguard and promote the wellbeing of our most vulnerable adults. Our wide range of partners maintained a clear focus on safeguarding adults, continuing to deliver the partnership's priorities and active workstreams.

The work undertaken by the Board is supported by learning and development, quality assurance, safeguarding adults review (SAR), and communication Subgroups, which have all continued to take forward the strategic priorities and update the Board on progress.

July 2022 saw a significant change take place for one of the statutory safeguarding partners; the NHS clinical commissioning groups were restructured to form a single Integrated Care Board (IBC) across Nottinghamshire and Nottingham City.

I would like to extend my thanks to all our partners for their continued support during the year, which I believe bears testimony to the positive and transparent relationships within the Board and the extended partnership.

If you do not have internet access or require this information in an alternative format or language, please email **safeguarding1.adults@nottscc.gov.uk** or contact the business support team on **0115 977 4673.**

Scott MacKechnie
Independent Chair
Nottinghamshire Safeguarding Adults Board

Message from the Executive Group Statutory Members

Across our partnership in Nottinghamshire, we take clear action together to ensure that people who draw upon care and support have their health, wellbeing and human rights safeguarded. We work particularly hard to protect people from abuse, neglect and harm, and we can only do this by making sure our colleagues and teams work together. This annual report describes how we do that through our day-to-day work or by working to improve practices, learn from the experiences of people and make changes where this is needed. I am pleased to have the support of Police and NHS colleagues through the Safeguarding Adults Board in delivering safeguarding together.

Melanie Williams, Corporate Director, Adult Social Care and Health, Nottinghamshire County Council

---

The Nottinghamshire Safeguarding Adults Board brings partners together to understand where there are safeguarding concerns and how to protect vulnerable people from abuse or neglect. NHS partners bring a wealth of passion, commitment and expertise to the partnership and work together to improve outcomes. We take our role as statutory partners very seriously. Safeguarding happens in all organisations and in every setting.

NHS safeguarding teams work across agencies to learn from each other and to tackle problems as they arise. This may be through day-to-day interactions in care settings, through reporting and investigating concerns, or through sharing learning. Our safeguarding leads come together as a community in the interest of the people we serve.

I am privileged to chair the Safeguarding Adults Review Subgroup and this receives referrals from all partners. Engagement, energy and expertise from the NHS are very evident in this group, as in all parts of the partnership. We are continually learning from each other. Collaboration is key to how we work and this is clear in the strong working relationships that have developed across NHS partners and the partnership as a whole.

Amanda Sullivan, Chief Executive, Nottingham and Nottinghamshire Integrated Care Board

---

Nottinghamshire Police are proud to be working alongside all of our partners as part of the adult safeguarding partnership. Together we work across Nottinghamshire to assure ourselves that we are doing all we can to reduce and prevent incidents of abuse and neglect towards adults at risk.

The work of the partnership is demonstrated through our yearly reports and highlights the commitment shown by all members to work in collaboration and make safeguarding personal. Our strength is in partnership working and learning from lived experience to improve our collective services.

Natasha Todd, T/Detective Superintendent for Public Protection

Role of the board

What is the Nottinghamshire Safeguarding Adults Board?

The Nottinghamshire Safeguarding Adults Board (NSAB) is a partnership of organisations responsible for safeguarding arrangements within Nottinghamshire.

These organisations include:

- Nottinghamshire Police
- Nottinghamshire County Council
- The Integrated Care Board (ICB) (Clinical Commissioning Groups (CCGs) before July 2022)
- District councils
- East Midlands Ambulance Service (EMAS)
- Nottinghamshire Fire and Rescue Service
- Nottinghamshire Probation Delivery Unit
- POhWER
- Local NHS Hospital and Foundation Trusts

The Board has an independent chair, Scott MacKechnie, who meets regularly with Board members to discuss and take forward the strategic priorities.

The Board's main responsibility is to work together to help adults who may have been abused or neglected and to help prevent instances of abuse or neglect.

We treat cases of suspected abuse extremely seriously and all the organisations within the NSAB work closely together, using the same policies and procedures to ensure that all adults are protected from abuse.

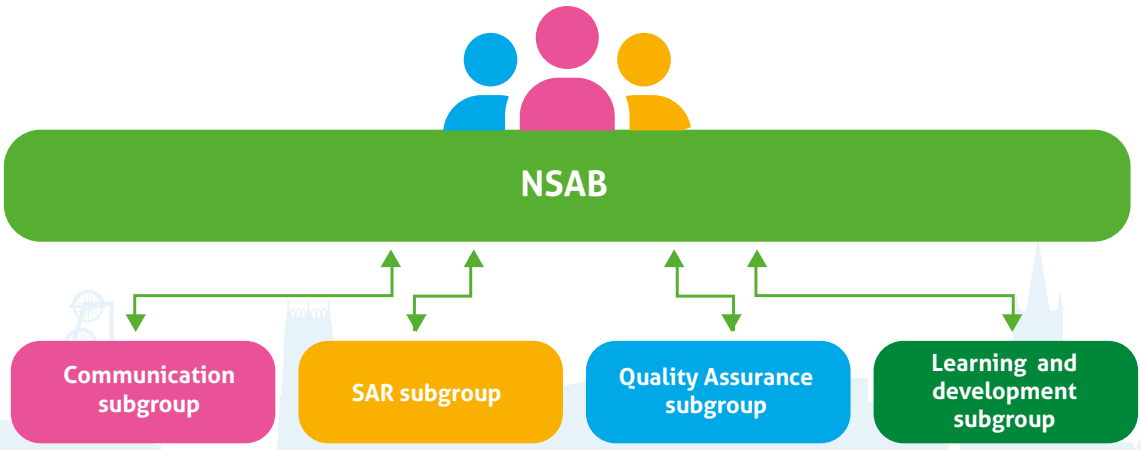
What we do

The three core duties of the Board are to:

- Publish an annual strategic plan
- Publish an annual report
- Undertake safeguarding adults reviews (SARs)

How we do it

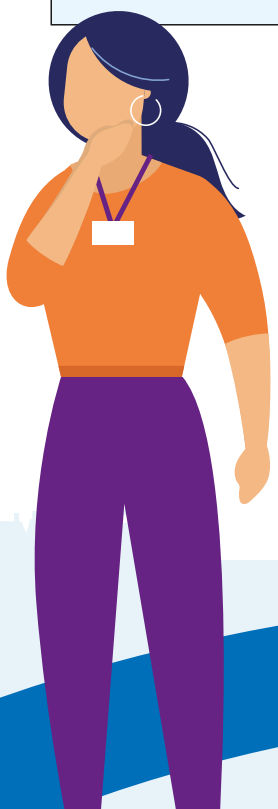
The Board governance arrangements to deliver the strategic plan and fulfil its statutory duties are shown in the structure below. The subgroups take forward agreed priority areas from the business plan; the work described in this report represents the partners' contributions to safeguarding across Nottinghamshire.



Prevention

Prevention strategy and focuses	Partnership working
We updated and developed the NSAB prevention strategy with an action plan detailing how it will be achieved. We are developing management information to allow us to measure its impact and success in the following four focus areas: • Support for carers • Domestic abuse including controlling or coercive behaviour • Social isolation/self-neglect • Rough sleeping	• We continued developing our working relationships with the Nottinghamshire Safeguarding Children Partnership, Safer Nottinghamshire Board and the Health and Wellbeing Board, working together on linked agendas and ensuring we remain within relevant workstreams e.g. Domestic Abuse, Homes for Ukraine, Transitional Safeguarding and Closed Cultures. • Sharing our strategic objectives and priorities with local strategic boards and partners ensures that we all work in a collaborative way to reduce the risk of abuse and neglect of adults with care and support needs in Nottinghamshire.

Publicity campaigns	Next steps
• As ever, the NSAB heavily promotes the Making Safeguarding Personal approach within its learning opportunities and outward communications. • During 2022/23, publicity campaigns were carried out for notable events such as Elder Abuse Awareness Day and National Safeguarding Adults Week. • Media campaigns were also promoted on social media channels as well as in the NSAB's regular ebulletin.	• Formation of a new Communication subgroup, with broader membership and remit to look at and develop outward-facing communications, including our ebulletin and public website, informational and educational materials, as well as continuing to build good relationships with current and new partner organisations. • Collaborative working with partners and meaningful coproduction with adults with lived experience, to help to shape the approaches taken to prevent abuse and neglect occurring in the communities of Nottinghamshire.



"A social prescriber is able to take a holistic view about an individual's needs and can signpost them to appropriate services, thereby reducing the number of attendances at hospitals and GP surgeries for issues which are not always medical."

Amanda Sullivan, Chief Executive, Nottingham and Nottinghamshire Integrated Care Board

Engagement

Learning and development opportunities

As in previous years, the NSAB provided a range of free learning opportunities to support colleagues in their work in safeguarding adults.

These covered topics including:

- Understanding safeguarding concerns
- Working with those who have difficulty engaging
- Domestic abuse including coercive or controlling behaviour
- Disclosure and Barring Service
- Trading Standards - raising awareness of fraud and scams
- Organisational abuse and closed cultures
- Advocacy services

Partnership working

- We maintained regular training and awareness raising opportunities for practitioners and citizens to develop and improve safeguarding practice using written, web based and face-to-face means.
- We continued to publish our ebulletins to inform professionals.
- Our website now hosts publications and information relevant to safeguarding to support all partners and citizens including Covid-19 related support and prevention of abuse. We ensured partners were aware of these so they could share them more widely in their communities.
- We continued to recognise communication and information sharing as a means of prevention and early intervention.

Partnership and development events

During 2022/23, the NSAB hosted both a partnership event and a development day to identify our priorities and work collaboratively to discuss what actions to take and how to measure their impact. These events focused on:

- Domestic abuse
- Rough sleepers
- Strategic safeguarding and Multi-Agency Safeguarding Hub independent review recommendations
- Transitional safeguarding
- The cost of living

Network engagement

- During 2022/23, the NSAB worked hard on broadening its engagement with other local partnerships and organisations.
- We now have a representative on the Learning and Development subgroup from the Rough Sleeper's Initiative and a local housing association.
- We have built on relationships with partners such as the ICB regarding closed cultures in mental health settings and the local authority's Quality and Market Management department, to support work with external care providers.

> "We have learnt how important patience is in developing a trusting relationship. Individuals have lost trust because they feel they have been let down so often, so it is essential to be able to listen, to be non-judgemental, and to follow through on what is said and keep the individual updated."

Ruth Hyde, Chief Executive Officer, Broxtowe Borough Council

Assurance

Key achievements

Theme 1: To improve communication and engagement with the diverse communities in Nottinghamshire

- Analysis of last year's annual 'Safeguarding Awareness' survey was undertaken, which helped the Learning and Development subgroup change how adult safeguarding training and content were delivered.
- Improvements in data collection were made, alongside widening the scope of data analysis with the introduction of a 'spotlights' section to the Quality Assurance subgroup, showcasing partner adult safeguarding intelligence to better inform the Board.

Theme 2: To increase participation of people with lived experience in shaping services

- An initial review of people's protected characteristics and care and support needs was undertaken. This was later broadened to encompass analysis of the 2021 national census, with the Board confident that it will be able to report on how successfully partners have engaged with district and ethnic communities in respect of adult safeguarding.

Theme 3: Quality assurance and performance monitoring

- Strategic board managers and chairs across the Nottinghamshire partnership now meet quarterly to look at alignment and cross-over of priorities. Governance arrangements have been reviewed and alterations made to ensure the board has a suitable structure in place to take forward the strategic priorities and assess the impact being made as a partnership. Evaluation of these changes and their effectiveness will be considered during the January 2024 development day held with strategic partners.

- In response to the abuse and neglect reported by a BBC Panorama documentary within a mental health hospital and other published reviews of closed cultures, the NSAB requested assurance from the newly established ICB.
- During the report period a review of the quality assurance framework has resulted in a more robust mechanism to seek assurance and assess risk. This approach will continue to evolve as part of the strategic plan.

Theme 4: Governance, structure and support functions

- The Person in Position of Trust guidance was developed and agreed to support best practice across the system.
- The independent review recommendations were progressed and the Board's terms of reference and membership reviewed.
- A new independent chair was recruited to take forward the recommendations and a revised structure to include an executive group was agreed.
- Key recommendations from the safeguarding independent review were implemented.
- New arrangements for governance and structure of the NSAB were implemented.

Theme 5: Collaboration and partnership working to continuously learn and improve

- A regional thematic review of safeguarding adult reviews (SAR) was undertaken with recommendations made to strengthen working across the East Midlands adult safeguarding network.
- A new quality assurance cycle was developed and agreed by partners. This sets out an ambition to be more data-informed and increases the Board's ability to listen to feedback e.g. from staff and practitioners through an annual survey.
- Listening to people with lived experience is a central priority for the Board. Engagement on the national review and invitation to the 'our voice' coproduction group started to shape this journey in 2022/23.
- Two published SAR action plans were progressed and implemented with further learning expected through upcoming mandatory and non-mandatory SARs.
- A task and Finish group was created following the Panorama television programme exposing the abuse of adults in a mental health hospital, to seek assurance from partners that such 'closed cultures' did not exist locally.
- Rough sleeping is a priority of the Board's prevention strategy, so links with the Rough Sleeper Initiative were improved to help the Board better understand the adult safeguarding needs and challenges of this group.
- Assurance was received from the ICB regarding the ongoing national Learning Disability Mortality Reviews (LeDeR) (Learning from lives and deaths – People with a learning disability and autistic people).

Key challenges	Future focus: 2023/24
Covid-19 recovery Following a prolonged period of lockdowns and changes in how we work to mitigate risks posed by Covid-19, professionals worked hard to begin understand the impact of the pandemic. This work was complex and multifaceted and will be ongoing. The safeguarding partnership continues to be sensitive to the impact of the pandemic and during 2022/23 focussed on two cohorts identified in the Prevention Plan. Sharp increases in domestic abuse cases and growing concern regarding social isolation were two areas of focus and consideration for the Board to mitigate the effects of the pandemic regarding this.	• Develop a robust communication and engagement strategy to gain insights from people and families with lived experience of adult safeguarding. The strategy will look to build on the membership of the Board through the Communication subgroup. • Consider membership of the Board to ensure it represents the diverse population and communities in Nottinghamshire. • Analyse census data to be more informed about current safeguarding issues within communities and to effectively target engagement activities. **Prevention** • Conduct a review of transitional safeguarding approaches and processes. • Develop trauma-informed approaches to better understand how recovery and resilience can be promoted. • Continue to develop preventative approaches with key cohorts e.g. survivors of domestic abuse, people experiencing social isolation, rough sleepers, those suffering from self-neglect and carers.
Seeking assurances about the culture of mental health services in Nottinghamshire The Board was keen to gain assurances from the ICB and mental health trusts about the cultures within Nottinghamshire mental health services. This was in response to the Edenfield Hospital abuse and neglect reported by Panaroma. A working group was established and identified two areas requiring further exploration: • How information is shared between professional bodies. • Oversight and monitoring of out of area placements within private hospitals. This was taken forward by a multiagency task and finish group and reported to the Board. Engagement with the Care Quality Commission (CQC) and people with lived experience to have a better understanding of these settings have been identified as key next steps. Out-of-area host commissioner arrangements continue to be a challenge, requiring ongoing discussion at a national level.	
Health and social care reforms The Board has kept abreast of and supported changes within the newly formed ICB as well as the anticipated inspection of Adult Social Care services by the CQC	

Key challenges	Future focus: 2023/24
Engaging with more stakeholders to improve the Board's approach to safeguarding As part of the Board's strategic engagement priority, links with the national Chairs Network have been strengthened. Alongside this, work will be undertaken to consult, engage and where possible, co-produce, the work of the Board, with collaboration from Healthwatch, advocacy services, carer and co-production groups already helping inform the initial stages of this aim.	**Assurance** • Embed the revised quality assurance framework into the Board's everyday practice and learn from feedback e.g. developing methods for people with lived experience to contribute to safeguarding, annual staff survey, 360-degree management reviews. • Work with commissioners to monitor and embed required improvements to culture and services that safeguard adults at risk. • Look at learning from the regional Safeguarding Adult Review (SAR) thematic review, recognising areas of strength and development points. Measure the impact of any learning on safeguarding adults work practices and processes following recommendations made in reviews. • Review relevant policies to ensure current and best practice is followed and informs the Board's training offer. • Continue to develop mechanisms to measure the impact of the work of the Board and its partners.
Mitigating risks for asylum-seekers and refugees coming to Nottinghamshire Given the challenges and potential safeguarding risks surrounding this cohort, the Board strengthened links with and sought assurance from Serco Group plc, that they had the necessary policies, procedures and training in place to keep those people in their care safe.	
Deprivation of liberty safeguards and introduction of liberty protection safeguards The continued delays in the ratification of this legislation will now go beyond the life of the current parliament. This uncertainty has caused challenges in the planning and preparation required to embed the necessary changes across the system.	

Case study 1: Multi-Agency Safeguarding Hub

A referral was made by a care home reporting that an older adult had left the home without staff's knowledge. Initially, the concern appeared straightforward because the individual had come to no harm and protective measures were now in place. Accordingly, it was determined that the Multi-Agency Safeguarding Hub (MASH) would be able to conclude the concern. However, as part of their enquiry, the MASH community care officer (CCO) requested information from the police and contacted the family and in doing so determined that the door had not been forcibly opened as reported, but rather opened automatically following a fire alarm.

Exercising their professional curiosity, the MASH worker correctly identified that they now had reason to call into doubt both the original investigation completed by the care home and the necessity for the protective measures they had put in place to safeguard the resident. Given this doubt and the need for further enquiries, the Section 42 safeguarding adults enquiry (s.42) was referred to the local district team, whilst the Quality and Market Management Team (QMMT) were informed of the incident. The Deprivation of Liberty Safeguards (DoLS) team was also alerted to the potentially overly restrictive measures put in place ahead of their own assessment. These teams all made further enquiries taking account of the new information and the concern was safely concluded.

Case study 2: Nottinghamshire County Council, Adult Social Care

A referral was received from a residential college that a member of staff had verbally abused a young adult in their care in front of others, as well as removing their personal possessions. It was recognised that this young person lacked mental capacity to be involved in the safeguarding enquiry, as they were unable to communicate their wishes verbally and did not have anyone to support them. Therefore, arrangements were made for a skilled advocate to work with them to ascertain their wishes and feelings about the outcome they would like to achieve, in line with 'Making Safeguarding Personal'.

As allowed for under s.42 part 2 of the Care Act, it was decided to 'cause others' (the college) to undertake the enquiry on behalf of the Local Authority (LA). Initial action had already been taken and the staff member suspended, pending completion of the enquiry. The conclusions of the enquiry were presented to the social worker with details of what had taken place, the steps already taken to mitigate against future risk, as well as actions proposed, set out for them to consider.

As part of their enquiry, the social worker made a visit to the college and spoke to all concerned, including the advocate who confirmed that they were satisfied with the outcome of the safeguarding enquiry. Given that the risk to the young person had been removed (the worker had been relocated to another area of the site, officially warned and their work placed under supervision) it was determined that a risk protection plan was neither required nor proportionate and the enquiry was subsequently recorded on Mosaic (the adult social care record management system) and closed.

Local safeguarding data

Statutory definition: Section 42 (s.42) enquiry by Local Authority

(1) This section applies where a Local Authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

(a) has need for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Nottinghamshire Adult Social Care follows the 2020 Local Government Association (LGA) guidance: 'What constitutes a safeguarding concern', which confirms that where there is reasonable cause to suspect that all three criteria in s.42 (1) are met, namely that an adult with care and support needs is experiencing or at risk of abuse or neglect and is unable to protect themselves, this must trigger a safeguarding adults enquiry by the Local Authority.

However, the guidance also notes that neither the Care Act nor the associated statutory guidance state that all three criteria must be fulfilled before partner organisations can conclude an issue constitutes a safeguarding concern. They must only be satisfied that an adult has need for care and support and is experiencing, or at risk of experiencing, abuse or neglect, before making a referral – or safeguarding concern – to the local authority.

It is for the local authority to seriously consider all referrals, including the third criteria, that the adult is unable to protect himself or herself as a consequence of their needs (which may involve the LA gathering further information), before deciding whether to proceed to a s.42 part 2 enquiry.

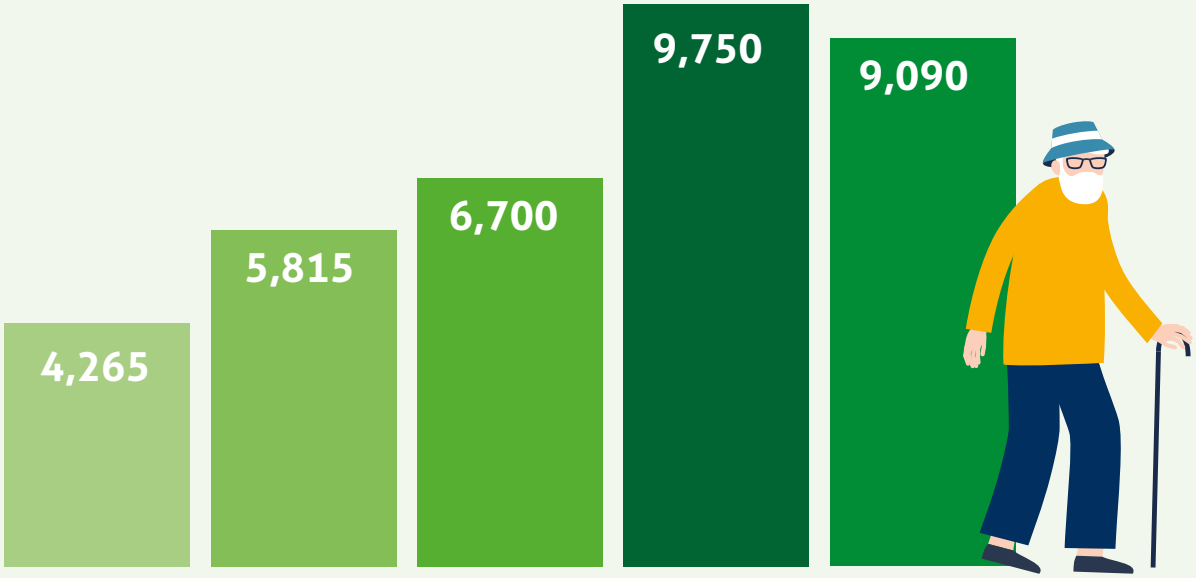
Within the data below, 'safeguarding concerns' are a referral (s.42 part 1), and 'safeguarding enquiries' are a Section 42 enquiry (s.42 part 2).

The following data consists of:

A. All safeguarding concerns and enquiries that started between 1 April 2022 and 31 March 2023.

B. All safeguarding enquiries that were completed between 1 April 2022 and 31 March 2023. This includes referrals and enquiries which started in previous years.

Chart 1: Number of concerns received

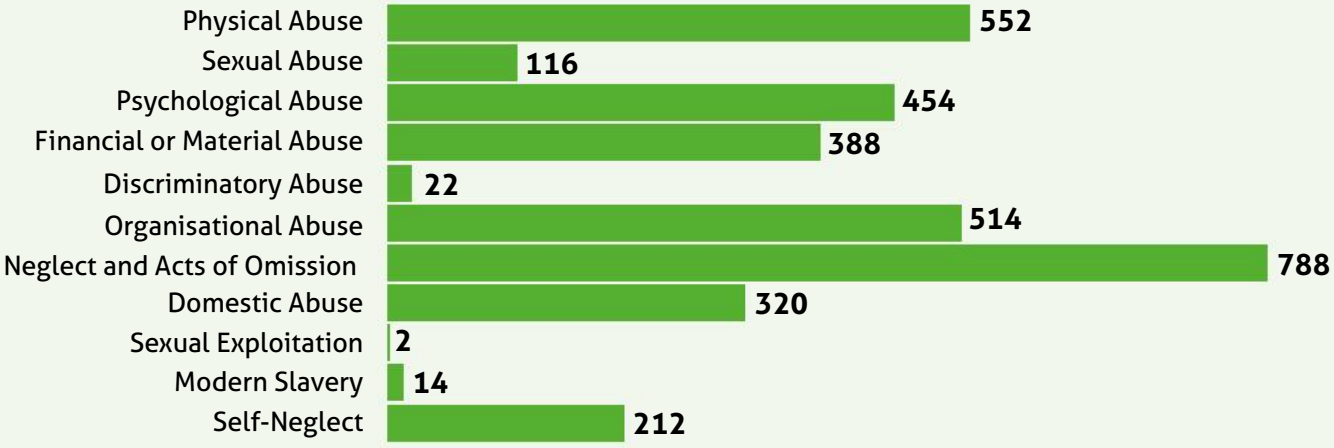


There was a 7% reduction in the numbers of safeguarding concerns received, down from 9,750 to 9,090. This is at odds with the national picture, which saw a 9% rise. As this is a single data point, it is too early to know if this is a 'one off' or indicative of a change in referral practices. The Board will continue to monitor throughout the year.

Of the 9,090 total concerns received, 7,720 were dealt with at concern stage. 1,370 were converted to an enquiry s.42 part 2. This was a 64% reduction from 3,755 in 2021/22, whilst the number concluded in the year reduced by 47%, from 3,425 in 2021/22 to 1,810.

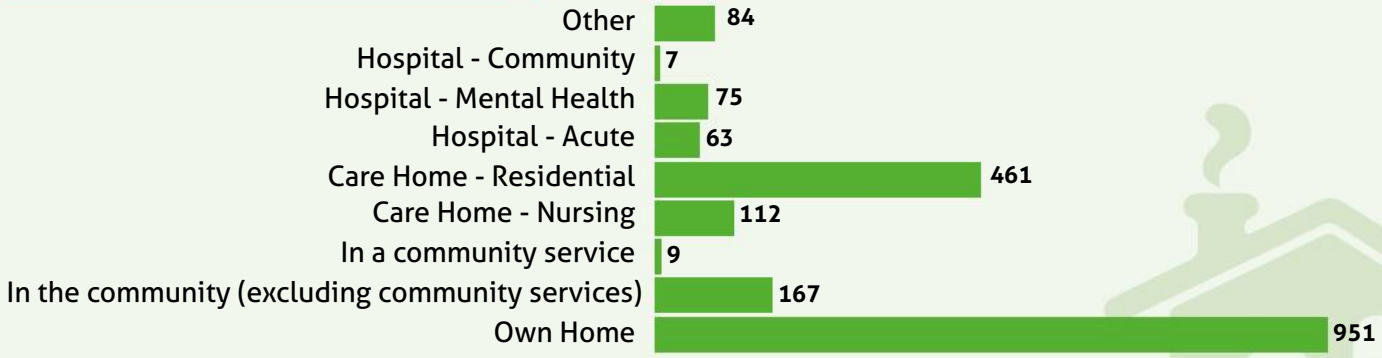
This significant change is explained by a change in recording practice, rather than by a reduction in activity. At the beginning of the year, MASH staff began undertaking safeguarding enquiries as well as triaging them on behalf of district social work teams. For operational reasons, this work was recorded in part 1 of the s.42 safeguarding process within Mosaic (the departmental electronic recording system) rather than in part 2, which meant it was not included within the national Safeguarding Adults Collection (the 'SAC return') reported to NHS Digital. For the same reason, the conversion rate is recorded as reducing from 39% to 15%, which reflected the fact that more work than previously was being concluded by the MASH team (and recorded within part 1 of Mosaic) than by the district social work teams (who recorded their safeguarding activity in part 2), rather than any change in either the quality of referrals received or the way they were triaged.

Chart 2: Type of abuse



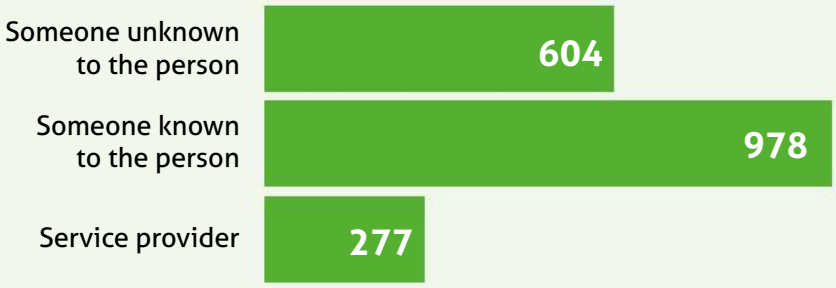
In line with the national picture, the three most common abuse types were Neglect and Acts of Omission, Physical Abuse and Organisational Abuse. This represents a change from the previous year when the third most common type of abuse was Psychological, however the change is minimal with just a 1% difference between them.

Chart 3: Location of abuse



The three most common locations of abuse remain in an individual's own home, in a residential care home and in the community. This is representative of the national picture.

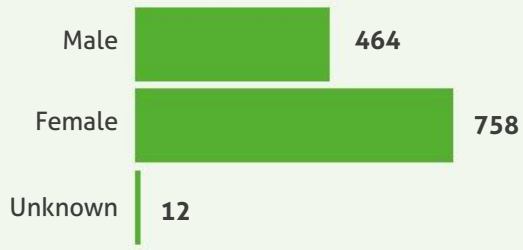
Chart 4: Sources of risk



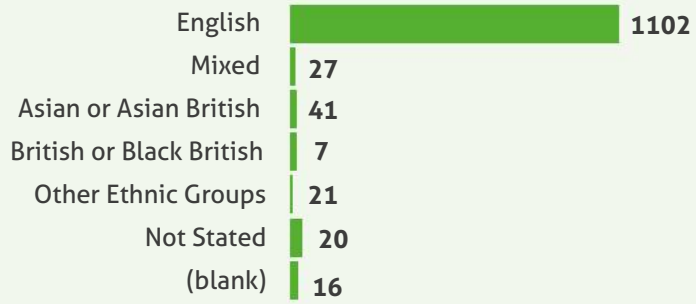
Sources of risk are categorised as 'someone known to the individual', 'a service provider' and 'someone unknown to the individual'. 'Someone known to the individual' remains the most common source.

Chart 5: Demographics for people involved in enquiries

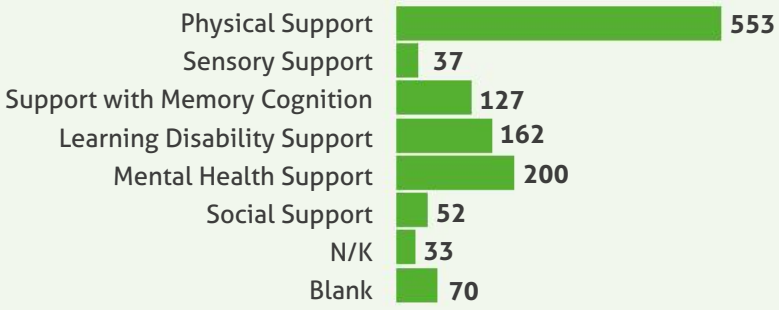
Gender



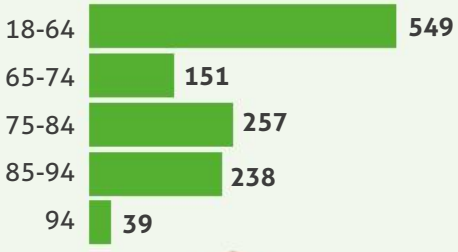
Ethnicity



Support Reason



Age



Note that the total number reported here (**1,234**) relates to the number of individuals involved in enquiries as opposed to the number of enquiries themselves (**1,370**). The latter is higher as individuals can be involved in more than one enquiry within the year.

Making Safeguarding Personal outcomes

The percentage of people who were asked about their desired outcome for the safeguarding enquiry stood at 80%, in line with the national average and slightly up from the previous year.

The percentage of people who were asked if their outcome had been fully or mainly achieved, reduced from 96% to 93%, slightly below the national average of 95%.

The percentage of safeguarding enquiries where the 'risk was removed or reduced' remained equal to the previous year at 86%, which is slightly lower than the national average.

The percentage of people lacking mental capacity to be involved in their safeguarding assessment and who were supported to do so, decreased slightly from 84% to 83%, but remained above the national average of 79%.

Local safeguarding data

Overview

The SAR subgroup manages and oversees the safeguarding adults review (SAR) process locally and is led by Amanda Sullivan, Chief Executive of the ICB.

A SAR takes place when agencies who worked with an adult who has died or come to serious harm as a result of abuse or neglect are brought together to look at lessons they can learn and implement into current practice via updated training and external communications to prevent a similar circumstance occurring again.

The subgroup met eight times throughout the year with good representation from agencies across the partnership. It undertook work in relation to ongoing SARs and referrals and continues to receive regular updates around learning disability mortality reviews (LeDeR).

In addition, the Rough Sleeper Initiative Co-ordinator for Nottinghamshire now attends each meeting and provides information to the subgroup on cases involving the deaths of homeless individuals in the county and the themes arising from these cases.

Referrals

In 2022/23 the NSAB received three SAR referrals, each of which resulted in a SAR being commissioned, one as a joint review with the Nottinghamshire Safeguarding Children Partnership. At the time of writing, these three SARs are ongoing and the outcomes will be reported in due course.

Completed SARs

In 2022/23, the subgroup monitored the progress of action logs in relation to two SARs that were completed in the previous year:

SAR K19:

The subgroup commissioned the SAR in 2019 due to concerns around multi-agency working and missed opportunities to support and engage with Adult K. This case was reported in last year's annual report.

Work continued throughout the year to progress the actions and the learning opportunities. Completion of the action log is anticipated during 2023/24.

SAR L20:

The subgroup commissioned the SAR in 2020 in response to concerns around multi-agency working and missed opportunities to support and engage with Adult L. This case was reported in last year's annual report.

Work continued throughout the year to progress the actions and learning opportunities. Completion of the action log is anticipated during 2023/24

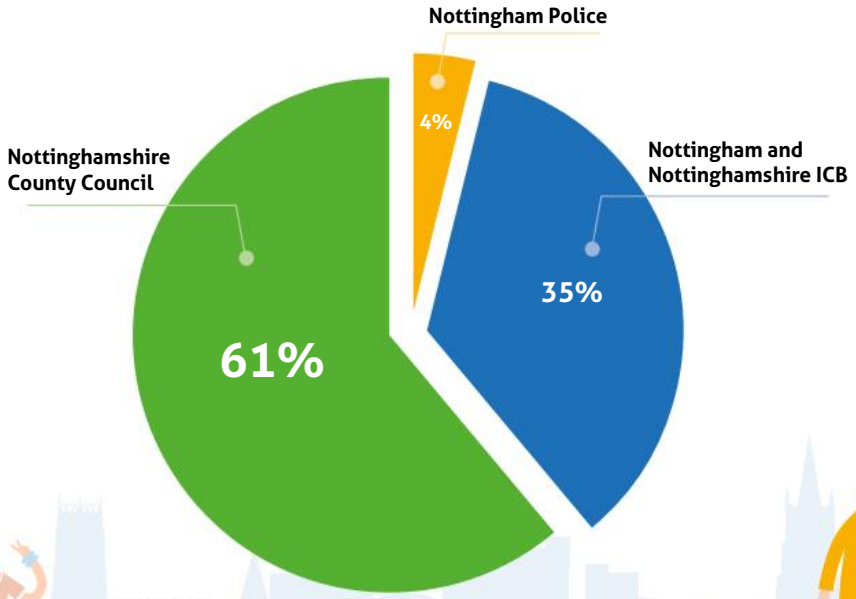
Learning from SARs

Significant learning obtained from SARs was incorporated into a comprehensive training offering by the Board. Individual courses can be found through the following links: Learning and development and Resources.

East Midlands Regional Safeguarding Assurance

In February and March 2023, the Board contributed to the East Midlands Regional Safeguarding Assurance Report. Six safeguarding adults boards took part, with a project team being set up to scrutinise the information submitted. A peer review methodology was used to conduct a desktop review of SARs and create action plans to analyse the effectiveness of the current quality assurance process. The final report identified several recommendations, which the SAR subgroup is now working towards.

Funding



How can I report abuse?

If you have been abused, or know someone who has, please report this to Nottinghamshire County Council on **0300 500 80 80** or report via the online portal

You could also report this to someone you trust e.g. police, doctor, family member, social worker. In an emergency, you should contact the relevant emergency service (police, ambulance, or fire and rescue service) by dialling **999.**

What will happen next?

We may need to inform other people or organisations, such as the person's doctor, but we will ask permission before we do this.

We will work with the person affected to find out what they want to happen following a report of abuse and keep the person involved throughout the process. People have the right to change their minds about what they want to happen during the process.

Our Partners

East Midlands Ambulance Service NHS Trust

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust

Nottingham University Hospitals NHS Trust

Nottingham and Nottinghamshire Integrated Care Board

Sherwood Forest Hospitals NHS Foundation Trust

Ashfield District Council

Broxtowe Borough Council

healthwatch Nottingham & Nottinghamshire

Ministry of Justice – National Offender Management Service

Newark & Sherwood District Council

Nottinghamshire Fire & Rescue Service – Creating Safer Communities

Nottinghamshire Police – Proud to Serve

Bassetlaw District Council – North Nottinghamshire

Gedling Borough Council

Mansfield District Council

National Probation Service

Nottinghamshire County Council

POhWER

Rushcliffe Borough Council

Report in confidence: Online at www.nottinghamshire.gov.uk/care/safeguarding/reporting-abuse or if your enquiry is urgent call **0300 500 8080**

Nottinghamshire Safeguarding Adults Board
Stop abuse and neglect