Nottinghamshire County Council

Report to Adult Social Care and Health Select Committee

17 December 2025

Agenda Item: 5

REPORT OF THE INDEPENDENT CHAIR OF NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

PROGRESS REPORT OF NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD AGAINST 2024-25 STRATEGIC PRIORITIES

Purpose of the Report

1. To provide an update on the progress made in 2024-25 by Nottinghamshire Safeguarding Adults Board (NSAB) on the three-year strategic plan.

2. The report summarises key information held in the NSAB annual report 2024-25, attached as **Appendix 1**, produced as part of the statutory duties of the Board.

3. This report details that all Care Act statutory duties are being undertaken by the NSAB:

   - Providing a strategic plan (nsabstrategicplan.pdf (nottinghamshire.gov.uk)
   - Publishing an annual report (Annual reports (nottinghamshire.gov.uk)
   - Undertaking Section 44 Safeguarding Adult Reviews as required (Reviews (nottinghamshire.gov.uk).

Information

4. Work has progressed to meet the three strategic aims of the Nottinghamshire Safeguarding Adults Board ('the Board'): Prevention; Assurance and Engagement. Progress is reported through the annual report with highlights noted below under the five Board business plan headings:

To improve communication and engagement with the diverse communities in Nottinghamshire

5. The Board's Communication sub-group has developed a three-year communication and engagement strategy. A cross-authority approach has been adopted, working closely with Nottingham City SAB to ensure consistent messaging and coordination in external communications.

6. Through increased access to data, media campaigns have been developed addressing raising awareness. This has allowed the Board to focus on key information in its e-bulletin circulation on topics relating to Carers, advocacy services and making safeguarding personal. This was informed through staff surveys, the annual provider assurance tool and safeguarding adult review learning.

7. An analysis of the 2021 census ethnicity data was undertaken to ensure services are engaging with all communities across the county. The majority of safeguarding enquiries involve adults aged 65+, with a higher proportion of women than men affected. When looking at this information and comparing this with data held regarding people with care & support needs, it was identified that there was a slight under-representation in the Asian community in safeguarding enquiries: 3% of the population but only 1.4% involved in Section 42 enquiries and 1.7% in receipt of services. Subsequent discussion of this at the Communications and Engagement Subgroup, led to agreement that the OASIS campaign planning framework (Objective, Audience, Strategy, Implementation, and Scoring) used by Nottinghamshire Police should be adopted to address both this issue and others, with work now commencing.

To increase participation of people with lived experience in shaping services

8. In response to the Panorama programme about severe abuse in a private mental health hospital – Whorlton Hall, the Board worked with the Integrated Care Board (ICB) to address 'closed cultures' in local inpatient settings. One of the outcomes of this work was the establishment of a Quality & Safety Group chaired by the ICB, which provides a forum for open conversations and sharing best practice between independent hospitals, commissioners, the Care Quality Commission, and the Board. One of the most positive outcomes of this work was the co-produced presentation by both staff and hospital patients at a Board Partnership event about least restrictive practices.

9. As part of the work above, the Board requested whistleblowing and complaints information from all local independent hospital providers, as well as securing the support of Nottinghamshire Healthcare Trust to commission Healthwatch to survey patients at the Priory about their experiences since its improvement programme was concluded. The Board has also worked with an advocacy service to enable a better understanding of the young carers journey in the M22 mandatory SAR. This provided an opportunity for their voice to be heard and help to shape the learning within the review and the Board plans to engage with the young carer when it reviews the impact of the learning with organisations this reporting year.

10. A Board task & finish group was established, which included consultation from Healthwatch, to develop approaches for capturing feedback from adults with lived experience of adult safeguarding enquiries, as well as seeking their active involvement in Board activities. This resulted in the creation of two brief surveys being shared via text message to people who had previously consented to being contacted. From this, the Board received largely positive feedback about the safeguarding performance of Adult Social Care, as well as securing the agreement of four respondents to engage with the Board regarding how their experiences could inform the work of the Board. This has improved the Board's understanding of through learning from complaints and the need to make materials more accessible. This exercise will now form part of the annual cycle of improvement and engagement of the Board, via the QA subgroup.

Quality assurance & performance monitoring

11. Relationships have been developed with prisons (notably Whatton prison) and the Serco Group (regarding asylum seekers and refugees). This has resulted in the refinement of safeguarding procedures at the prison and their first submitted annual 'Provider Assurance

Tool' reporting on the progress they have made in respect of having effective adult safeguarding arrangements.

12. Transitional safeguarding arrangements have been reviewed with the Safeguarding Children Partnership, leading to a joint working party incorporating both Nottingham City & County stake holders. The subsequent development group that was instigated has been focussed on improving the service response for young people at greatest risk of experiencing harm in adulthood, particularly those not transitioning from children's to adult services. Learning materials and awareness raising have been undertaken by the group, with a new focus on gathering resources and understanding data now being explored. The four boards leading on this will reconvene in May next year to review progress made.

13. The Board undertook a survey of partners to better understand their safeguarding practices and how they were embedding 'Making Safeguarding Personal' as described in the Care Act 2014. The survey was conducted across all partners, with high levels of safeguarding training and confidence reported. It was identified that awareness regarding making safeguarding personal would be useful to build on the positive experiences that 82% of people were asked about their preferred outcomes (above national average) and 97% of outcomes were fully or partially achieved *(as mentioned in point 2.3.6. of this report)*

14. Key performance indicators have been monitored, showing increases in concerns and enquiries, with over 11,000 concerns received in 2024/25, a 6% increase from the previous year *(Annual Report page 24).* The number of safeguarding enquiries (Section 42) also increased substantially to 4,782, a 126% rise on 2023/24. This reflects the correction of earlier recording limitations within the adult MASH team, which had previously prevented some Part 2 enquiries (safeguarding enquiries) from being captured. Part 1 relates to the initial referral or concern, while Part 2 records the formal safeguarding enquiry. Technical improvements have now enabled more accurate reporting of both stages of the process, bringing figures back in line with, and exceeding pre 2022/23 levels *(Annual Report page 25)*.

15. Neglect, organisational abuse, and physical abuse have remained the most common types of abuse. The most common location of abuse remained at an individual's own home, followed by residential care homes, nursing care homes, and the community, this pattern is broadly unchanged year on year *(Annual Report page 26)*. The Board has sought assurance regarding the homecare and care home markets, as well as the management of home closures. This has enabled a reportable longitudinal view to be kept under review by the Quality Assurance Subgroup.

16. Performance against Making Safeguarding Personal (MSP) indicators continues to be strong. In 2024/25, 82% of people were asked about their preferred outcomes, an increase of 5% on the previous year and slightly above the national average of 81%. Of those asked, 97% of people said their outcomes were fully or partially achieved (95% nationally), and 93% of cases saw risk removed or reduced (91% nationally). In addition, 84% of adults lacking capacity were supported to be involved in their safeguarding assessment, up from 79% in 2023/24 and just above the national average of 83% *(Annual Report page 30).*

Governance, structure, and support functions

17. The new executive group within the Board structure has enabled robust discussions about organisational pressures and risks, which has included healthy oversight of the challenges currently facing Nottinghamshire Healthcare NHS Foundation Trust. In respect of this, the Board has received ongoing updates and assurance from the Trust's 'Improvement Oversight and Assurance Group' as they continue their improvement journey.

18. Board guidance on 'raising a concern and referring' has been reviewed and updated by all partner agencies to ensure current best practice is reflected in the shared procedures.

19. The Board has developed training and learning materials, such as 7-minute briefings, on key topics on 'professional curiosity', 'transitional safeguarding' and 'what is a safeguarding adults referral', all of which have been positively received by professionals and partner agencies. During Safeguarding Adults Week, workshops were conducted relating to professional curiosity, and transitional safeguarding. Feedback on learning events or training is routinely sought. An example is the 'Understanding Safeguarding Concerns' training, which showed that 97% of respondents rated the content as 'Very good' or 'Exceptional', with 71% reporting that they could apply the learning in the workplace all or most of the time.

Collaboration and partnership working to continuously learn and improve

20. Following the conclusion of the K19 & L20 SAR action plans, an independent, commissioned review by 'Making Connections', a safeguarding consultancy, exploring the efficacy of the 'SAR Impact Tool' (a way to measure the impact of learning recommendations by organisations) was undertaken. This provided positive feedback about the tool, along with some suggested improvements about both the tool itself and the way it could be utilised going forward, which will be implemented.

21. Two mandatory 'Safeguarding Adult Reviews' (M22 & N22) were commissioned in the reporting period. These reports have now been published, with action plans developed in response to the recommendations made. The headline issues identified from these SARs included; the need for effective multi-agency coordination & governance; improving application of the Mental Capacity Act, with a focus upon understanding executive impairment; the need to develop and roll out pre-eviction protocols within supported housing accommodation, especially those supporting homeless and rough sleeping adults; improving the response to carers in high-risk situations, including access to advocacy services, and finally the need for organisations to improve their data Sharing & systems interoperability abilities

22. Additionally, a non-mandatory SAR was undertaken with the involvement of Priory Arnold, which included a detailed presentation about the practice changes made at the hospital to the SAR subgroup, alongside a Police review of how they respond to incidents at independent hospitals.

23. The Board was provided with regular assurance updates about the implementation of 'Right Care, Right Person' (RCRP), which was launched by Nottinghamshire Police in February 2025 after extensive planning with health and care partners. RCRP ensures people in crisis receive support from the most appropriate professionals rather than the

police when no crime has occurred. Implementation included partner training, challenge processes, and ongoing assurance through incident reviews, audits.

24. The Board has partnered with Public Health to improve the system response for people who experience Severe and Multiple Disadvantage (SMD) by supporting the SMD working group. This multiagency task force is looking at strengthening system pathways and workforce capability, having also built links with the 'Making Every Adult Matter' (MEAM) partnership, who lead nationally on developing best practice in this area.

25. The Board has promoted and supported the implementation of the 'Slavery Exploitation Risk Assessment Conference' (SERAC) across the County. Initially city-based, SERAC is a multi-agency forum tackling modern slavery, trafficking, and exploitation, now operating county-wide and offering coordinated safeguarding support.

Statutory and Policy Implications

26. The report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, residents, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

27. There are no financial implications arising from this report.

Legal Implications

28. There are no legal implications arising from this report.

Local Government Reorganisation Implications

29. There are no Local Government Reorganisation implications arising from this report.

RECOMMENDATION/S

That the Adult Social Care and Health Select Committee:

1) receives and considers the Nottinghamshire Safeguarding Adults Board Annual Report 2024/25, attached as **Appendix 1**.

2) continues to review the work of the Nottinghamshire Safeguarding Adults Board by receiving and considering its Annual Report each year.

Scott MacKechnie
Independent Chair of Nottinghamshire Safeguarding Adults Board

For any enquiries about this report please contact:

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Financial Comments (CR 03/12/25)

30. There are no financial implications arising from this report.

Legal Comments (LPW 25/11/25)

31. The Council has a duty to establish a Safeguarding Adults Board pursuant to section 43(1) of the Care Act 2014. The Safeguarding Adults Board must undertake certain statutory duties, as set out in the report. The recommendations fall within the remit of the Adult Social Care and Health Select Committee by virtue of its terms of reference.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Nottinghamshire Safeguarding Adult Board 2022-2025
nsabstrategicplan.pdf (nottinghamshire.gov.uk)

Electoral Division(s) and Member(s) Affected

All.