Nottinghamshire Safeguarding Adults Board

Stop abuse and neglect

NSAB

Annual Report

2023/24

CONTENTS

Message from the Independent Chair

It is my pleasure to introduce the annual report of the Nottinghamshire Safeguarding Adults Board (NSAB) for 2023/24.

This annual report, written in line with Care Act requirements, details the work that the NSAB undertook during 2023/24 to achieve the objectives of its three-year (2022-2025) strategic plan, as well as highlighting contributions from our partner agencies.

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

- **Prevention**
- **Engagement**
- **Assurance**

As in previous years, during 2023/24, the NSAB met quarterly, and hosted six-monthly partnership events for the wider network. These events are pivotal to emphasising some of the key issues affecting vulnerable people and how we need to collaborate as a safeguarding system to improve outcomes for people and prevent abuse and neglect.

Our partnership is based on the premise of high support and high challenge, working collaboratively to resolve issues and monitor the impact we have made together. I am very aware of the challenges ongoing within the public sector locally and nationally, particularly related to increased demand, as well as budget and workforce pressures. Despite this, our senior leaders remained visible, engaged, and dedicated to working collectively to ensure we effectively safeguard and promote the wellbeing of our most vulnerable people. I personally meet with the executive leads from the statutory partners on a quarterly basis, as well as with the chairs of the four subgroups that drive the business of the NSAB. This supports our wide range of partners to maintain a clear focus to deliver the partnership's priorities and workstreams, but also provides a governance framework for accountability.

At the time of writing, the Board is fully appraised of the current challenges within Nottinghamshire Healthcare NHS Foundation Trust, which has received extensive local and national scrutiny – as has the Police service – following the tragic events in Nottingham City in June 2023. The Board, including our executive members principally, is actively engaged with the Trust, both supporting its progress, but also providing scrutiny to ensure a partnership lens is adopted within its improvement journey. This is being developed out of the internal evaluation and recommendations from the regulatory bodies – Care Quality Commission (CQC) and NHS England.

The NSAB continues to work together on agreed priorities but is also reactive to new issues as they arise. An example has been the significant work undertaken collaboratively with the Integrated Care Board to engage and connect with independent hospitals in the area to understand the cultures within these provisions following a series of high-profile cases reported in the national media showing awful abuse and neglect. This is not the first time cases of this nature have occurred and unfortunately is not likely to be the last, but as a partnership we have to be vigilant and seek assurance by scrutinising and supporting this sector to, wherever possible, prevent future abuse and neglect.

Positive steps have been taken with the ICB leading on the creation of a collaborative forum with our local independent hospitals and undertaking a non-mandatory safeguarding adult review (SAR) allowing for learning within this sector. This will be an ongoing focus for the NSAB, as we look to understand cultures across organisations within the partnership and, in particular, the processes around freedom to speak up.

Another example of a reactive project is the work undertaken with Serco (referred to in the report) to ensure that the multiple layers of vulnerability that exist within the refugee and asylum seeker community are considered and monitored within this sector.

I am pleased with the NSAB's progress in developing relationships and representation within the partnership to inform the work of the Board. Positive steps are being taken to strengthen the voice of lived experience, to feed into the work of the partnership. Gaining this feedback will allow us to be more data-informed and collaborative and will enrich the insights and direction of the Board as we look to develop a new three-year strategy for 2025-2028, which will be developed and reported upon in next year's annual report.

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 would like 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

Nottinghamshire can demonstrate a strong partnership approach to safeguarding adults. As the statutory director responsible for this, I feel that our statutory partners in the Integrated Care Board (ICB) and Police are active in leading our partnership Board and we have very good engagement from partners right across our social care system coming together to share good practice and commit to action in delivering real change for people. This report sets out how we are doing that. During 2023/24 we increased our focus on coproduction and took extra steps to place the views of people and their lived experience at the heart of our plans and indeed our safeguarding work.

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

The Nottinghamshire Safeguarding Adults Board has the vital role of bringing organisations together, with the common objective of stopping abuse or neglect of vulnerable adults. The ICB ensures that our local NHS plays its part and harnesses resources to support our common goal. We see safeguarding as core to all of our work, whether in delivering services or in planning how services should work, and in maintaining standards. This includes raising staff awareness and providing training, so that they recognise concerns and know the right actions to take. It also includes investigating when harm occurs, learning lessons and changing how we work. This may happen in single organisations or as part of the wider partnership.

I am proud to be part of the partnership and to contribute to work that helps to keep people safe. I am also proud to chair the Safeguarding Adults Reviews subgroup. We receive referrals from different agencies and have a strong philosophy of continual learning and improvement.

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

As part of Nottinghamshire Police's vision to deliver an outstanding service that we can all be proud of, we are committed to continually improving the way we safeguard those in our communities who are vulnerable to abuse, neglect or harm.

We achieve so much more when working together as a collective than we can in isolation, as evidenced by the successes we have achieved with our 'right care, right person' approach.

Working collaboratively with our partners across the county, we've been able to review our processes when responding to incidents at private hospitals, ensuring those involved get appropriate help as quickly as possible.

We've kept our partners fully data-informed by presenting on domestic abuse and making enquiries with the coroner's office to understand information held on homelessness deaths, expanding and strengthening understanding and use of intelligence. We've also provided key support in delivering safeguarding adult reviews.

I am proud to be a part of this collaborative approach to achieving our strategic objectives. Working together in this way will help us to implement real improvements in protecting and safeguarding those at risk in society.

Richard Bull,
Lead for Public Protection,
Nottinghamshire Police

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) including Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
- All Nottinghamshire district councils
- East Midlands Ambulance Service (EMAS)
- Nottinghamshire Fire and Rescue Service
- Nottinghamshire County Probation Delivery Unit
- POhWER
- Department for Work and Pensions
- Care Quality Commission

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

The Board is a strategic partnership, and its main aim is to ensure that local safeguarding arrangements and partners work together to protect and support adults in the area who may have been abused or neglected, and to prevent future occurrences 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 or neglect, and that learning is embedded by organisations to safeguard and improve practice.

What we do

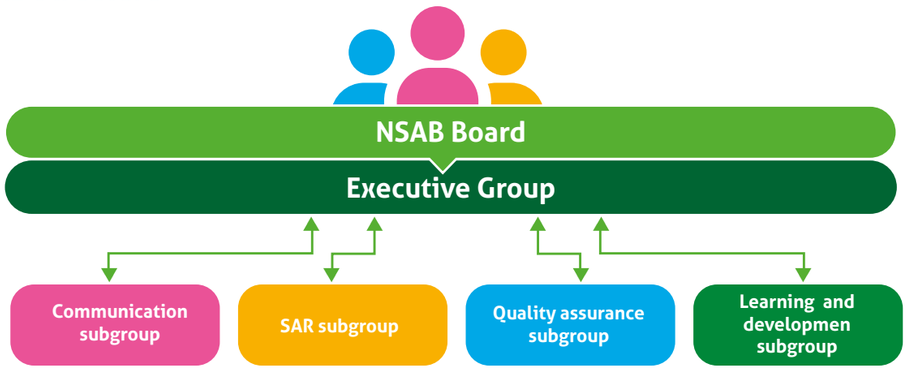
The three core duties of the Board are to:

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

How we do it

The governance arrangements which support the Board to deliver the strategic plan and fulfil its statutory duties are shown 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.

NSAB structure



The Board's strategic priorities

Prevention strategy and focuses	Partnership working
• We continue to operate the NSAB prevention strategy with an action plan detailing how we will work towards goals. • We are capturing management information to allow us to be data-informed, and to measure impact and success in the following four focus areas: - Support for carers - Domestic abuse including controlling and coercive behaviour - Social isolation/self-neglect - Rough sleeping	During 2023/24, we built on our working relationships with the Nottinghamshire Safeguarding Children Partnership, Safer Nottinghamshire Board, Health and Wellbeing Board, and Nottingham City Safeguarding Adults Board, working together on areas of mutual interest such as domestic abuse, transitional safeguarding and promoting 'open cultures'. (Closed cultures, by contrast, are often defined as poor cultures that can lead to harm, including human rights breaches such as abuse. In a closed culture, it is unlikely that many outsiders enter, and fewer external people can observe everyday practices. The only people present daily are those who use the services or work for the service provider, making them part of the provider's organisational culture, although whistleblowers may maintain a separation.) Sharing our strategic objectives and priorities across partners helps ensure that we work in a collaborative and complementary way to achieve the shared goal of reducing the risk of abuse and neglect of adults with care and support needs in Nottinghamshire.

Publicity campaigns	What we've done
• We continue to promote the Making Safeguarding Personal (MSP) approach within our learning opportunities and outward communications. MSP is a framework aimed at improving the safeguarding response for adults at risk by ensuring that interventions are person-centred and outcome-focused. It involves having a conversation with the individual about the safeguarding concerns and the outcomes they would like; it is about working with the people we support, not 'doing for' them. • We delivered publicity campaigns for notable events such as Elder Abuse Awareness Day and National Safeguarding Adults Week. • We supported and raised awareness of the messages in the Joint Carers Strategy 2023-28 about providing high quality support to carers across Nottinghamshire	• We created a new Communication and Engagement subgroup, with broad membership across our partners. This subgroup will develop and grow outward-facing communications, including our ebulletin, public website, informational and educational materials, and social media presence. We also continue to build closer working relationships with partner organisations. • We implemented recommendations from the Nottinghamshire safeguarding adults partnership review undertaken by an independent author. This identified four key themes: **1. Structure and support functions** • We implemented new governance arrangements and a new structure for the Board, developing an executive group to give senior leads space to discuss safeguarding pressures across the system and have a more focussed lens on risks and budgets. • We recruited to vacant positions within the Board, allowing us to do more. • We uniformed all formal Board documentation and rebranded. **2. Quality assurance and performance monitoring** • We began looking at partners' data to become better informed. This included developing the local authority safeguarding dashboards and introducing 'spotlights' to understand partners' datasets. • We implemented a quality assurance framework overseen by the Quality Assurance subgroup. • We set a standing item on the Quality Assurance subgroup agenda to learn from audits undertaken by partners. • We undertook a regional peer audit of safeguarding adults reviews. **3. Partnership and collaboration** • We were involved in shaping the terms of reference for the Association of Directors of Adult Social Services in England (ADASS) communities of practice and used the forum to share SAR learning more widely. • We revised information sharing agreements for SARs. • We began work on transitional safeguarding (see update below).

> "Prevention is a core principle for the local NHS and care system. Our Place Based Partnerships are taking a holistic approach to supporting people. For example, in Bassetlaw, slow cooker courses have been held to support people with food insecurity. There is myriad activity in communities, reducing social isolation, and helping people to access advice and support where needed. This may be through the use of green spaces, peer support and community networks."
>
> **Amanda Sullivan, Chief Executive,**
> **Nottingham and Nottinghamshire Integrated Care Board**

The 'CHARLIE-P' approach to fire safety

Nottinghamshire Fire and Rescue Service (NFRS) created the **'CHARLIE-P' approach** to help people remember the characteristics that increase an individual's fire risk. (The 'P' stands for Previous risk of fire.)

A video on YouTube, **'Importance of smoke alarms'**, shows how quickly an accidental house fire can take hold. The video is being used in NFRS's awareness-raising work and highlights the significance of functional smoke alarms.

NFRS has also worked to raise awareness of the importance of safe and well checks, incorporating this as a means of safeguarding vulnerable adults. In turn, this enables professional curiosity to flourish.

We supported promotion of this approach by presenting it at subgroups and by circulating promotional material via our e-bulletin. The approach was also discussed in a training session on 'difficulty engaging' which was held in June 2023 and attended by 38 people.

Engagement

Learning and development opportunities

We continued to provide a range of **free learning opportunities** to support staff with safeguarding adults. These sessions covered topics including:

- Understanding safeguarding concerns
- Working with people experiencing severe and multiple disadvantages
- Domestic abuse including coercive and controlling behaviour
- Disclosure and Barring Service
- Trading Standards fraud and scams
- Organisational abuse and closed cultures
- Advocacy services

Between 1 April 2023 and 31 March 2024 we held nine 'understanding safeguarding concerns' training events. Between 35 and 40 people attended each session.

Other specific training delivered in 2023/24 was

Training	Date	Delivered by	Number of attendees
Working with those who have difficulty engaging	9 June 2023	NSAB	38
DBS workshop part 1 – disclosure	28 June 2023	NSAB	34
DBS workshop part 2 – disclosure	29 June 2023	NSAB	35
Domestic abuse and coercive control	11 July 2023	Equation	21
Domestic abuse and coercive control	5 October 2023	Equation	35
MARAC and DASH RIC training	20 November 2023	Equation	36
Domestic abuse and coercive control	25 January 2024	Equation	14

Partnership working

We provided ongoing training and awareness programmes through various channels including written materials, online resources, and in-person sessions, to enhance and strengthen our safeguarding practices.

The table below shows the numbers of people who accessed our online safeguarding adults awareness training between 1 April 2023 and 31 March 2024.

Level	Views	Users
Level 1	180	119
Level 2	278	145
Level 3	235	139

Level 1 is for people who contribute to safeguarding adults but do not have specific organisational responsibility or statutory authority to intervene; **level 2** is for people who are responsible for making safeguarding adults referrals within their organisation and who need to contribute to local and national policies, legislation, and procedures; **level 3** is for people who are responsible for effective and efficient management and delivery of safeguarding adults services.

- Our website continued to offer guidance materials for professionals and the public. The 'resources' section contains items such as learning from reviews, fact sheets, information around suicide prevention, and useful links. It received 1,157 views between 1 April 2023 and 31 March 2024.
- The resources section also includes '7-minute briefings', which offer an insight into key learning areas. New briefings added during 2023/24 covered:
  - **Mate crime**
  - **Safeguarding adults reviews**
  - **Exploitation**
  - **Cuckooing**
  - **Chronologies**
- We also sent out regular electronic bulletins to keep professionals up to date.

Training good practice

Good examples of safeguarding training come from Newark and Sherwood District Council and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

The council:

- Provides mandatory safeguarding training in-house to all staff across all areas of the organisation.
- Offers refresher training to existing staff.
- Has implemented alternative ways to deliver training, including online modules and face-to-face sessions, to accommodate the volume of staff and new starters.
- Has created additional training modules covering modern slavery, domestic abuse, and county lines.

The Trust:

- Placed a firm focus on increasing safeguarding training compliance and ensuring all colleagues were correctly aligned to the appropriate level of safeguarding training.
- Carried out a full review of all 6,000-plus roles to review the safeguarding training alignment as part of foundation work on improving compliance.
- Identified education leads to provide support to address any re-alignments identified.
- Exceeded the Trust safeguarding training target of 90% for all safeguarding adult training including 'Prevent' from February 2024 until the time of writing (September 2024).
- Saw a notable increase in the number of Deprivation of Liberty Safeguards applications submitted (from 222 in 2022/23, to 326 in 2023/24). Anecdotally, this can be attributed to the increase in safeguarding team resources and increase in safeguarding training.

Partnership and development events

A partnership event was held with a focus on establishing our priorities and collaborating around actions and evaluation. The event was centred around the following objectives:

- The coproduction journey in Nottinghamshire and understanding how it relates to safeguarding
- The culture of mental health private hospitals in Nottinghamshire
- The role of independent advocacy on mental health wards
- The role and importance of professional curiosity
- Transitional safeguarding
- Broadening and maintaining effective communication

Network engagement

- We continued to work hard on broadening our engagement with other local partnerships and organisations, including strengthening links with the dioceses in Nottinghamshire, resulting in membership of the local Roman Catholic and Church of England dioceses governance groups.
- We developed relationships with prisons through visits and by attending a safeguarding forum at Whatton prison, offering support in relation to adult safeguarding arrangements. Whatton prison has agreed to submit a partner assurance tool (PAT) return for 2024/25 to provide ongoing assurance, and we plan to develop similar links with other prisons in the county.
- We have representation on the Communication and Engagement subgroup from the Carers Federation.
- We provided input to the development of the Carers Strategy 2023-2028 and promoted it across our network.
- We continued to work with partners around closed cultures in mental health settings. This resulted in a non-mandatory SAR being undertaken about practice at a local independent hospital with learning shared within the ICS Mental Health Quality and Safety Group. The group was developed in response to the multiagency review following the Edenfield Centre – Greater Manchester Mental Health NHS Foundation Trust television documentary, which exposed widespread neglect and abuse and evidenced the need for closer working and improved relationships with independent mental health providers across the system. The group's purpose is to develop relationships, share best practice, review any new procedures, policies, guidance and legislation, and foster an open culture of reporting and escalation across the system. An independent review into how patients perceive practice at this hospital following all the changes they have made is now being planned.
- The Quality Assurance subgroup was regularly updated by the local authority's Quality and Market Management Team on high-risk homes and themes of concern within the care provider market, demonstrating our commitment to proactive risk management.

> "Nothing is more important to an individual than knowing that they are 'seen' and heard. I learn so much from listening to people express in their own words how they are, what they feel and how they want to be treated. If we do this well and shape delivery accordingly, we will have established the essential bedrock of professional practice."
>
> **Ruth Hyde, Chief Executive Officer, Broxtowe Borough Council**

Assurance

key achievements

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

- We conducted a thorough analysis of our staff survey results, which provided valuable insights for all partner agencies. These insights were used to update our training content, ensuring that it remains relevant and effective.
- We undertook a comparative analysis of the latest national census data against the section 42 referral data, as well as data in relation to people in receipt of care and support services to see if there was any under- or over- representation in local population types and ethnicities. We will continue this work to inform our communication and engagement strategy.

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

- A task and finish group was set up to identify how best to involve people with lived experience of adult safeguarding in Board activities. It is recognised that this work will take time to fully develop and the Board will report on this in detail in the 2024/25 report.

Theme 3: Quality assurance and performance monitoring

- The first combined City and County staff survey of adult safeguarding practice was undertaken. We received assurance about awareness of whistleblowing amongst staff from partner agencies in the staff survey.
- The Quality Assurance subgroup, Executive Group and full Board were all kept up to date on adult safeguarding metrics and key performance indicators.
- An audit was undertaken to determine whether the local authority arranged effective multidisciplinary team meetings, sharing minutes and inviting the right professionals to safeguarding strategy meetings. This provided assurance that relevant agencies and professionals were nearly always at the relevant meetings and that minutes and actions were correctly identified.
- We received assurance from Nottinghamshire Healthcare NHS Foundation Trust about its improvement journey following adverse CQC reporting.
- We continued to engage with Serco Group to gain assurance about the adequacy of local adult safeguarding arrangements for asylum seekers and refugees. This assurance is now provided annually. We also visited one of the Serco sites to gain additional assurance about staff training and understanding of safeguarding.

Theme 4: Governance, structure and support functions

- The independent chair provided ongoing support and scrutiny to subgroups and the multi-agency safeguarding hub (MASH) through one-on-one meetings and visits.
- Together with the Children's Partnership leadership team, we committed to improving understanding of transitional safeguarding across both children's and adults' systems. During the reporting period we had expert presentations at our partnership events regarding transitional safeguarding and conducted a review of processes in place and what works well nationally.
- Together with our Nottingham City SAB partners we committed to reviewing and revising our shared adult safeguarding policies and procedures, beginning with the 'raising a concern' procedure.

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

- Ratification of the SAR impact tool was completed. This will inform six-monthly assessments of the impact of work undertaken to satisfy any recommendations identified in future safeguarding adults reviews.
- We established positive connections with coordinators of the rough sleeper initiative, giving us expertise around the needs of individuals experiencing severe and multiple disadvantages. This supported the considerations and context for the commissioned N22 SAR.
- Progress was made on broadening our membership, with new members joining from the Department for Work and Pensions (DWP), rough sleepers initiative, and advocacy services. Expanding our membership will strengthen our ability to improve the systemwide quality of adult safeguarding arrangements, as well as provide valuable insights into the support needs of these cohorts.

What the Board will be focussing on next year: 2024/25

Engagement

- We will continue to improve our engagement with people with lived experience of adult safeguarding.
- We will continue to strengthen the composition of our Board to ensure a wide range of relevant and diverse perspectives are represented.
- We will continue to promote the importance of the Making Safeguarding Personal approach in line with the current strategic plan.
- A communication and engagement strategy will be developed through consultation with partners. This plan should improve our systemwide ability to provide effective adult safeguarding arrangements.

Prevention

- A transitional safeguarding partnership development group has been established with members from both children and adult services working together to better understand how we might improve system pathways so that members of this vulnerable 14-25-year-old cohort are more effectively safeguarded.
- We will continue to improve the Board's adult safeguarding training offer.
- We will continue to improve our understanding of the challenges faced by adults experiencing severe and multiple disadvantages to improve the outcomes of any adult safeguarding enquiry they might be involved in.
- We will continue to learn from SARs, including any that might involve the deaths of vulnerably housed or homeless adults in Nottinghamshire, as well as deepen our understanding of the 'Making Every Adult Matter' (MEAM) approach to positively impact our community.

Assurance

- We will improve the performance assurance tool (PAT) to make reporting by partners easier and more valuable.
- We will continue to revise our adult safeguarding policies and procedures alongside Nottingham City's Safeguarding Adults Board to ensure we are reflecting current best practice.
- We will undertake consultation to understand how we can most effectively gain assurance that our local mental health providers are promoting open cultures.
- The Improvement Oversight and Assurance Group (IOAG) for Nottinghamshire Healthcare NHS Foundation Trust (NHT) oversees NHT's response to quality and governance concerns. IOAG shares actions taken by NHT to address and mitigate risks, ensuring sustained delivery of safe services. We are and will continue to be provided with regular and detailed updates regarding the ongoing progress. We have developed specific governance arrangements to focus on areas that affect safeguarding in the partnership arena.
- Alongside the Trust, CQC and NHS England reviews of the tragic incidents in Nottingham of last June, NHT has commissioned a thematic homicide review. We have the mechanism in place to be updated on the progress following the publications of and in particular recommendations in these reports. We have been updated on some of the additional actions and learning, which include an external review of patient safety and serious incidents, the appointment of patient safety experts, and the establishment of a Learning from Deaths and Safety Committee. We have been and will continue to seek assurance that NHT ensures improvements are embedded and sustained through regular audits, quality safety reviews, stocktakes, increased leadership presence, and the evolvement of their 'safe today' dashboard.

Case study 1: Multi-agency safeguarding hub (MASH)

A referral was received from a county hospital about a young woman, Liz (not her real name), who was living alone, struggling with her mobility, and reported to be impulsively collecting items to the point that she was unable to safely access most rooms in her home.

Adult MASH staff contacted Liz directly to discuss the referral with her, and it soon became clear that she was not coping at home, had few friends, and that her mental health was being negatively impacted by this. Taking a person-centred approach, MASH staff were able to confirm with Liz that she wanted to be able to go out more and meet people, so she didn't feel so lonely, as well as make her home more habitable and safer.

With Liz's agreement, the MASH team member made a referral to the NFRS to give her help and advice to make her house safer. Also with Liz's consent, the MASH team member contacted her GP to ask that she be given additional support with her mental health, including consideration of social prescribing. Liz explored but decided not to proceed with involvement from a befriending service run by a local charity, suggested by the MASH team member.

Liz was known to her housing association outreach service, and they had made a referral to Jigsaw, a local charity specialising in helping people with mental health issues including hoarding. Jigsaw had agreed to help Liz address this issue. Liz had also previously been assessed by the county's Approved Mental Health Professional (AMHP) Team, who had referred her to the Mental Health Reform Project, jointly run by Nottingham Community Housing Association (NCHA), the ICB and Adult Social Care, for support with preventing admission to a psychiatric hospital.

After several conversations between the MASH colleague and Liz, it was agreed that given the agencies involved, including the Trust's Crisis Support Team, the risk of her mental health worsening was reduced, and she could benefit from being given some time to engage with these agencies to properly benefit from the support on offer.

Accordingly, the section 42 safeguarding enquiry was concluded, with a safeguarding plan opened and scheduled for review by her local community social work team in three months' time.

Case study 2: Multi-agency safeguarding hub (MASH)

The MASH received a referral from Juno Women's Aid who were worried about Sue (not her real name), an older adult woman living in her own home with her adult son, Bob (not his real name). Bob was being repeatedly verbally abusive to her when intoxicated with alcohol.

Sue had multiple physical health conditions which meant that she was unable to protect herself from the risk of abuse or neglect from her son. Sue told MASH staff that she would like her son to leave, however, she did not want to see him homeless, nor for her relationship with him to deteriorate because of this. There was no reason to doubt Sue's ability to make these and all subsequent decisions.

A request was made for the police to provide relevant information. They reported that Bob had a criminal offending history, the majority of which involved alcohol, although none of the offences included violence or were against his mother. This information helped inform several subsequent conversations about risk and keeping safe that MASH staff had with Sue. Whilst it was evident that Sue could, in the main, do this, her declining health, along with her expressed wishes that her son moved out, meant that further action was necessary.

With Sue's agreement, it was determined that adult MASH staff would contact Bob to begin a conversation about how he could be supported to meet his own needs, on the basis that it was not disclosed that she wanted him to move out. Whilst Sue was Care Act eligible and her son received carer's allowance, other family members could support her to remain independent, even if her son moved out, so she made the decision to decline a Care Act assessment and proceed as planned.

Although wary at first about why he had been contacted, Bob agreed to a referral being made on his behalf to Age UK's 'Connect' service, who could offer him information, advice and guidance about his housing options. Bob was grateful for the conversation with MASH staff, acknowledging that he too wanted to live in his own home.

After discussion with Sue, it was concluded that further enquiries would not be proportionate; however, a safeguarding plan was completed, with a review scheduled in a month's time for the local community team to undertake, with a view to reassessing the situation and engaging with Sue and Bob as required to meet their future needs.

Local safeguarding data

Section 42 of the Care Act 2014 is as follows:

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 needs 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, 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 states that all three criteria must be fulfilled before partner organisations can conclude that 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 criterion (that the adult is unable to protect himself or herself as a consequence of their needs) before deciding whether to proceed to a s.42 part 2 enquiry.

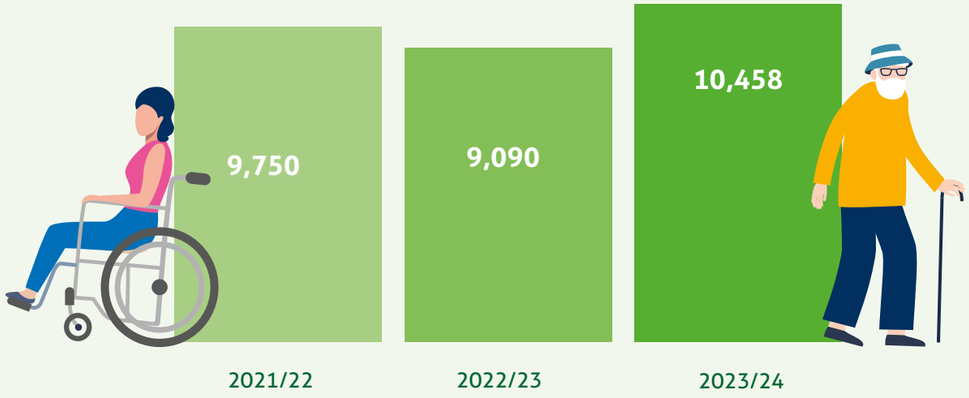
Within the data below, 'safeguarding concerns' are a referral (s.42 part 1), and 'safeguarding enquiries' are a section 42 enquiry (s.42 part 2).

The following data consists of:

1. All safeguarding concerns and enquiries that were started between 1 April 2023 and 31 March 2024.
2. All safeguarding enquiries that were completed between 1 April 2023 and 31 March 2024. This includes referrals and enquiries which started in previous years.

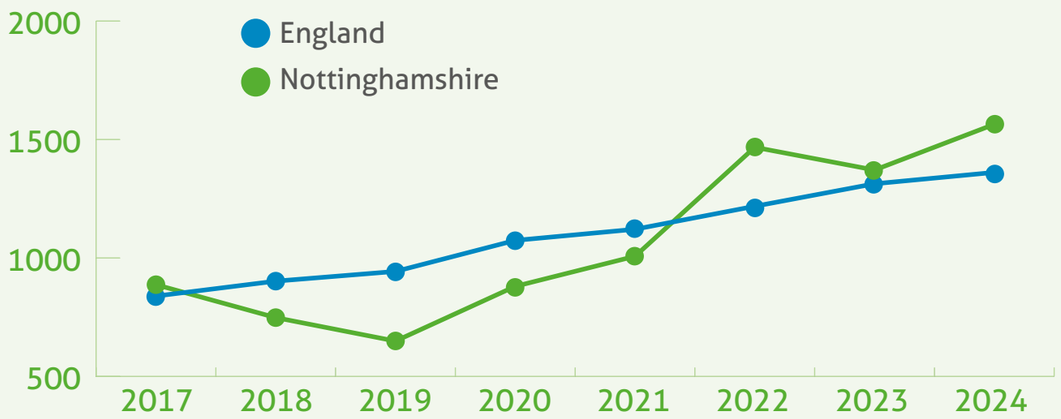
Note: Some of the totals reported below exceed the number of people supported because some people were involved in multiple enquiries during the year and experienced more than one type of abuse.

Figure 1: Safeguarding concerns received in Nottinghamshire by year



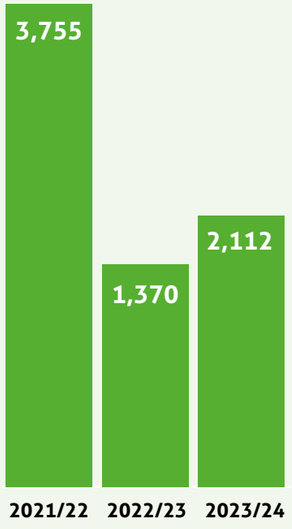
The number of concerns received in 2023/24 increased to over 10,000 for the first time. Whilst that represents a 15% increase on the previous year, it should be noted that Nottinghamshire saw a drop in referral numbers received in 2022/23 compared to 2021/22, bucking the national trend of year-on-year increases. This decrease has since reversed and the county has fallen back into line with the national picture, with early indications being that this trend will continue into 2024/25.

Figure 2: Safeguarding concerns received during 2023/24



The total number of safeguarding concerns reported by local authorities in the UK between 1 April 2023 and 31 March 2024 was 615,530, which is an increase of 5% from 2022/23 (587,970).

Figure 3: Safeguarding enquiries started in Nottinghamshire by year



The number of enquiries started in the reporting period increased to 2,112. Whilst that is a 35% increase on enquiries compared to the previous year, again it should be seen in the context of the previous year's dip in the number of concerns received compared to the year before.

The drop in numbers from 2021/22 to both subsequent years can in part be explained by a change in recording practice, with the adult MASH team undertaking s.42-part 2 safeguarding enquiries but, due to technical constraints, being unable to record them as such. Consequently, although adults continued to be supported by Adult Social Care, that work was recorded in part 1 of the process rather than part 2. This has since been rectified and the 2024/25 reporting period is expected to show a sharp increase back to, and possibly above, the number of enquiries started in the 2021/22 reporting period.

Figure 4: Safeguarding enquiries concluded in Nottinghamshire by year

The number of enquiries concluded in the year increased by 13%, from 1,810 in 2022/23 to 2,043 in 2023/24. As with the previous charts, these figures should be seen in the context of the previous year's dip in the number of enquiries concluded. We expect the next reporting year to show a return to numbers similar to, if not exceeding, those from 2021/22.

Note that these figures are the numbers of enquiries concluded in the reporting year, regardless of when they were started, so include some enquiries that were started before the reporting period.

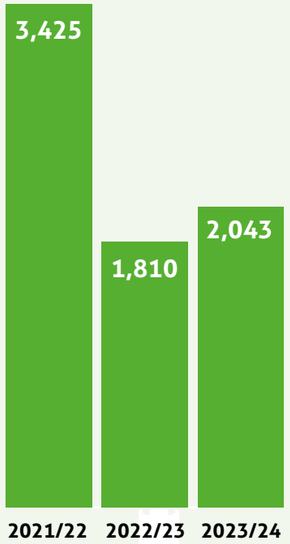
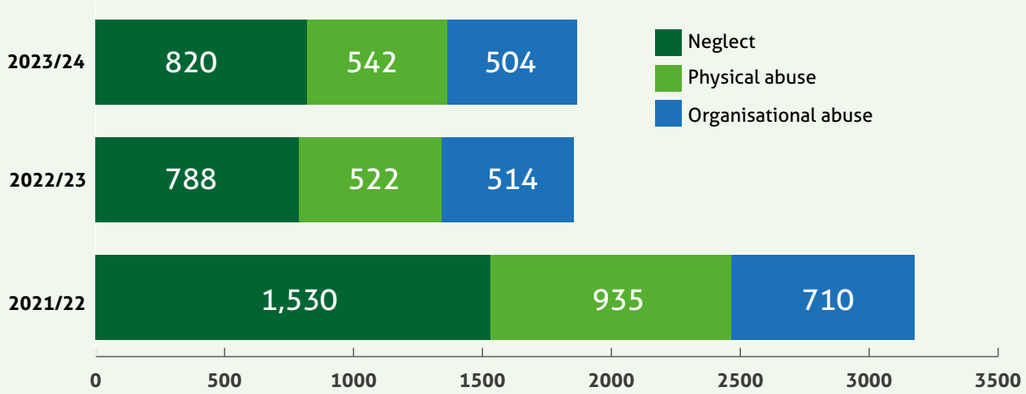


Figure 5: Type of abuse by year



The three most common types of abuse have not changed and remain neglect, physical abuse and organisational abuse, in that order. However, figures for 2023/24 do show a small increase in cases of neglect and a small decrease in cases of both physical abuse and organisational abuse compared to the previous year.

Figure 6: Location of abuse by year

The three most common locations of abuse have not changed and remain 'own home', 'residential care home' and 'in the community' in that order. This is in line with the national picture. 2023/24 saw a small decrease in the number of safeguarding concerns in the community and in a residential care home compared to 2022/23, whilst there was an increase in the number of safeguarding concerns reported within a person's own home.

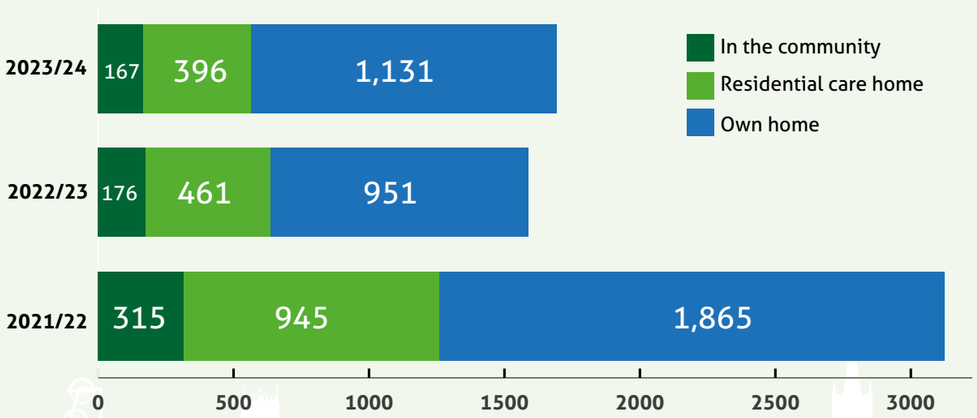


Figure 7: Source of risk in 2023/24

The 'sources of risk' referred to are those reported to government. 'Someone known to individual' remains the single largest source of risk, as it was in 2022/23.

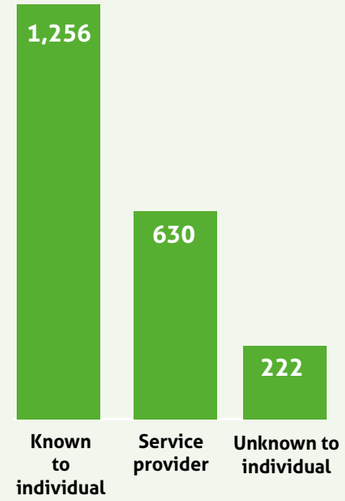


Figure 8: Primary support reason in 2023/24

A 'primary support reason' is used by local authorities to record the main reason an adult requires support as defined by the Care Act 2014.

In 2023/24, the most common type of support required was physical support, with more than twice as many cases as any other type of support.

The next most common reason was mental health support, followed by learning disability support and support with memory and cognition. Much smaller numbers of people required social support or sensory support, and in 224 cases the primary support reason was not known or not recorded.

This is the first year the board has reported on this data. Further work will be undertaken in the future.

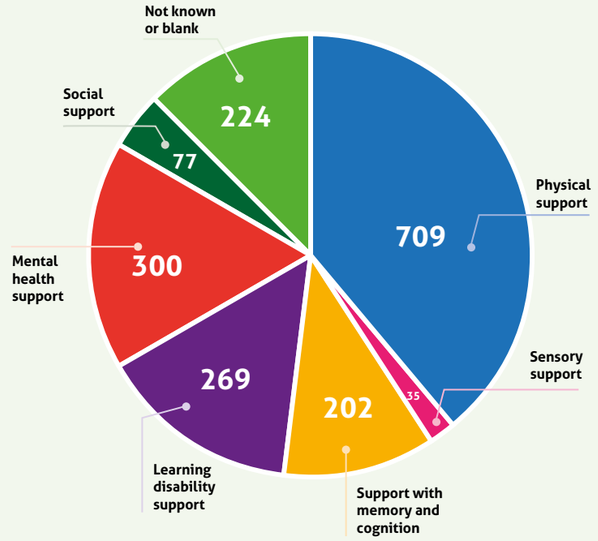
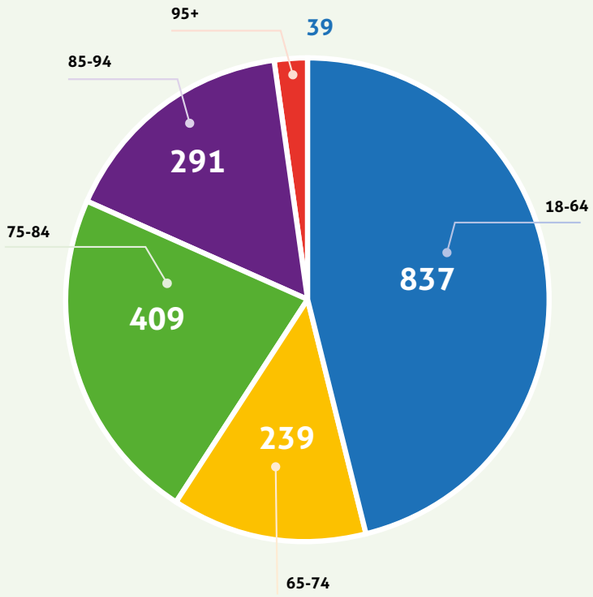


Figure 9: Age of people subject to safeguarding enquiries in 2023/24



Overall, the age of adults involved in safeguarding enquiries was similar in 2023/24 to the previous year, with just over half of all enquiries concerning adults aged 65 or above, and just under half concerning adults aged 18 to 65.

The largest cohort of adults aged over 65 experiencing abuse remained those aged 75 to 84, and the second largest cohort remained those aged 85 to 94, with the picture for the third and fourth largest cohorts also broadly replicating the ratios from the previous year.

Figure 10: Gender of people subject to safeguarding enquiries in 2023/24

Figures regarding the gender split of safeguarding concerns in the county remained roughly the same in 2023/24 as in 2022/23. Females accounted for 61% in 2022/23, dropping slightly to 58% in 2023/24. Males saw a broadly corresponding increase from 38% in 2022/23 to 40% in 2023/24, with the final increase in 'gender unknown', from 1% in 2022/23 to 2% in 2023/24.

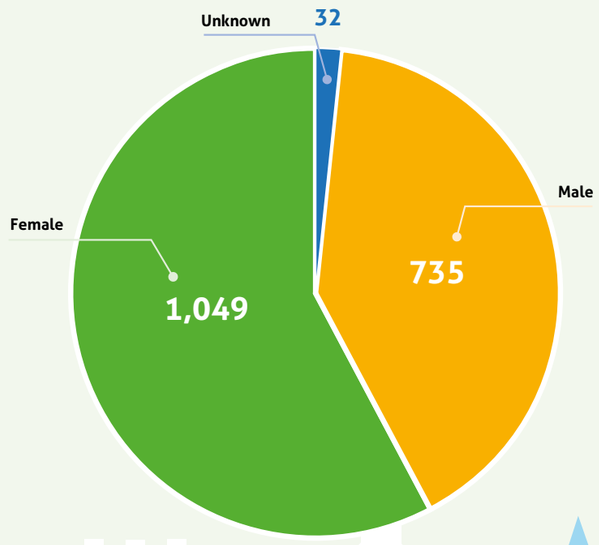
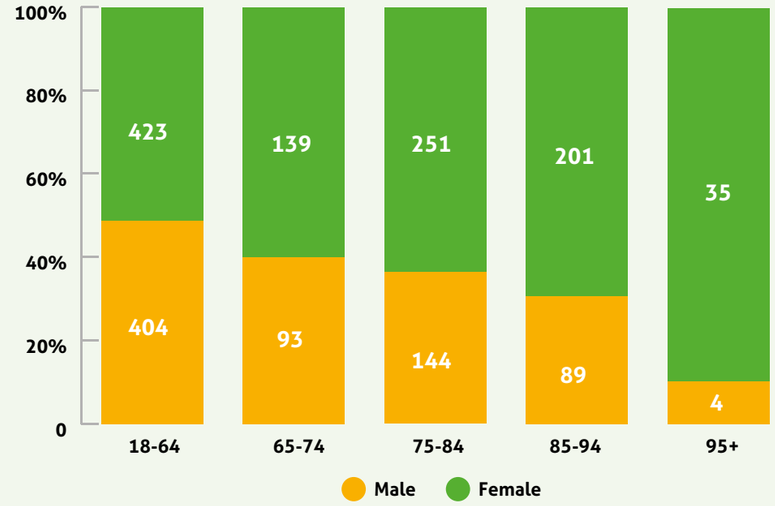


Figure 11: Number of safeguarding enquiries started in 2023/24 by age and gender of people involved



This is the first year that we have reported on the age and gender of adults involved in safeguarding enquiries. It would appear that as age increases, the proportion of women experiencing abuse and/or neglect compared to men also increases. However, the figures should be viewed in the context of the national trend of women living longer than men.

Making Safeguarding Personal outcomes

- In 2023/24, the percentage of people who were asked about their preferred outcomes was 77%, down 3% on the previous year, and slightly below the national average of 81%.
- Of those people asked, the percentage who were either fully or mainly satisfied that their outcomes had been achieved stood at 95%, up from the previous year by 2%, and exactly in line with the national average of 95%.
- The indicator results for 'risk removed or reduced' reduced to 83% from the previous year's figure of 86%, which in turn was below the national average of 91%.
- The number of people without capacity being supported to be involved in their safeguarding assessment decreased slightly from 83% in 2022/23 to 79% in 2023/24. The national average increased to 83%. It is likely this reduction was due to the council's advocacy provider experiencing ongoing difficulties recruiting qualified and trained advocates.

Safeguarding adults reviews

Overview

The SAR subgroup manages and oversees the safeguarding adults review (SAR) process locally, and is chaired 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 identify what lessons can be learnt and implemented into current practice to prevent a similar situation occurring again.

The SAR subgroup met seven times during the reporting period, with wide representation from agencies. Alongside coordinating SARs, the group continued to receive regular updates about learning disability mortality reviews (LeDeRs) from the ICB, and about deaths of homeless individuals in the county from the rough sleeper initiative coordinator.

Referrals

In 2023/24, the NSAB received five SAR referrals:

- A non-statutory SAR was commissioned as a result of one of the referrals, which related to the death of an individual who had been admitted to a mental health hospital. The case did not meet the criteria for a SAR to be commissioned under the Care Act 2014, but the subgroup agreed that there was significant learning to be obtained.
- Two referrals were received from the rough sleeper initiative coordinator in relation to the deaths of homeless individuals. Both were discussed by the SAR subgroup but neither met the criteria for a SAR to be commissioned. However, additional information was sought from specific agencies to inform the work of the rough sleeper initiative coordinator.
- One referral was progressed to a full mandatory safeguarding adults review, P23. The review was commissioned and the findings will be shared in the 2024/25 annual report.
- A further referral was received from Nottinghamshire Police relating to the death of an individual following their discharge from a secure hospital. The referral was reviewed in conjunction with the Nottingham City Safeguarding Adults Board, but it was agreed that it did not meet the criteria for a SAR.
- The final referral was received from East Midlands Ambulance Service in relation to two separate incidents which involved the same individual and which evidenced neglect. While it did not meet the criteria for a SAR to be commissioned, it did raise concerns around a provider which were taken forward by Adult Social Care.

Completed SARs and active action plans

SAR K19

The subgroup commissioned SAR K19 in 2019 due to potential concerns around multi-agency working and missed opportunities to support and engage with Adult K. This case was reported on in the 2021/22 annual report.

Work continued throughout 2023/24 to progress the actions and learning opportunities. Completion of the action log is anticipated before autumn 2024.

SAR L20

The subgroup commissioned SAR L20 in 2020 in response to potential concerns around multi-agency working and missed opportunities to support and engage with Adult L. This case was reported on in the 2021/22 annual report.

Work continued throughout 2023/24 to progress the actions and learning opportunities. Completion of the action log is anticipated before autumn 2024.

SAR M22

SAR M22 was commissioned by the subgroup in 2022 in response to potential concerns around multi-agency working and missed opportunities to support and engage with Adult M.

The SAR was concluded in March 2024 and led to a number of recommendations being made. Themes which emerged from the review included:

- Resource constraints and growing demands placed on services
- Quality of Mental Capacity Act assessments
- The importance of holding effective multi-agency meetings and development of multi-agency risk management plans
- Carers' needs in relation to severe and multiple disadvantage

Details of the case can be found at: **m22executivesummary.pdf (nottinghamshire.gov.uk).**

At the time of writing, a task and finish group had been established to take the recommendations forward. These will be reviewed in conjunction with the recommendations from SAR N22 due to some crossover in learning across the two SARs.

SAR N22

SAR N22 was commissioned by the subgroup in 2022 in response to potential concerns around multi-agency working and missed opportunities to support and engage with Adult N.

The SAR was concluded in March 2024 and led to a number of recommendations being made. Recommendations which emerged from the review included:

- Review of the effectiveness of supported exempt housing provider arrangements around risk assessment and management
- The need for housing exempt accommodation providers to establish pre-eviction protocols and support plans to mitigate and manage risks posed to individuals
- Referral pathways to advise practitioners about how to respond to homelessness and rough sleeping
- The need for Mental Capacity Act training to include consideration of executive impairment

- Reasserting the value of holding multi-agency meetings to share information and develop multi-agency risk management plans
- A review of the approach to vulnerable persons panels
- The need for development of joined-up, sustainable, long-term housing solutions which include appropriate support for people with experience of severe and multiple disadvantage
- Ongoing promotion of professional curiosity

Details of the case can be found at: **n22executivesummary.pdf (nottinghamshire.gov.uk)**

At the time of writing, a task and finish group had been established to take the recommendations forward. These will be reviewed in conjunction with the recommendations from SAR M22 due to some crossover in learning across the two SARs.

Non-statutory SAR

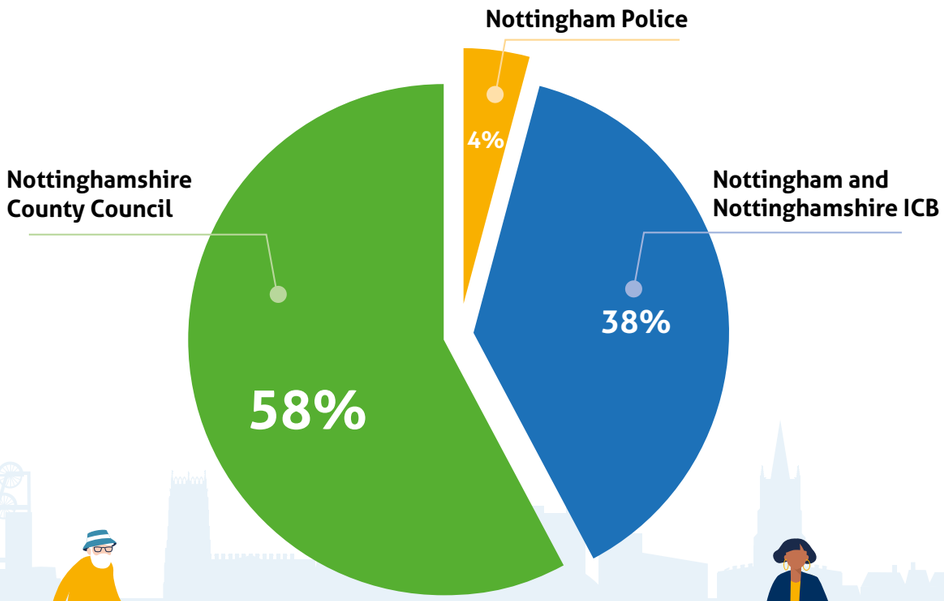
The non-statutory SAR was commissioned in 2023 following concerns raised regarding the death of an individual following admittance to a mental health hospital. While the case did not meet the criteria for a SAR, a significant amount of work took place with the provider. In January 2024, representatives from the hospital attended a SAR subgroup meeting where they provided information and assurance regarding the work undertaken as a result of the case. We continue to work closely with the provider and have commissioned work around closed/open cultures in response to both this incident and other incidents that have gained national media attention.

Learning from SARs

We have incorporated learning from SARs into a comprehensive training offering. Individual courses can be found at **Learning and development (nottinghamshire.gov.uk)** and **Resources (nottinghamshire.gov.uk).**

Funding

The total budget for 2023/24 was £269,635. This was split as shown in the graph below.



How can I report a safeguarding concern?

If you have been abused or neglected, or know someone who has, please report this to Nottinghamshire County Council on **0300 500 80 80.**

You could also report this to someone you trust such as the police, a family member, or your doctor or social worker.

If you believe that you or the person you are concerned about is in immediate danger, call emergency services on **999** or, to report a crime, call **101.**

What if I want to report something out of hours?

If your concern is an emergency, but you do not think that it requires police intervention and it is out of normal business hours, please contact the Emergency Duty Team on **0300 456 4546.**

The team is available:

Saturday and Sunday 24 hours

Monday - Friday 5:00pm-8:30am

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.

Report in confidence:

Online at **https://www.nottinghamshire.gov.uk/care/safeguarding/adult-safeguarding-hub/members-of-the-public-report-abuse**

or if your enquiry is urgent, call **0300 500 8080.**

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