Nottinghamshire Safeguarding Adults Board

Stop abuse and neglect

NSAB

Annual Report

2024/25

CONTENTS

Message from the Independent Chair

It is my privilege to introduce the Nottinghamshire Safeguarding Adults Board (NSAB) Annual Report for 2024/25. This report reflects a year of continued commitment, challenge, and collaboration across our partnership, as we worked to safeguard adults and promote their wellbeing in increasingly complex and demanding circumstances.

Throughout the year, the Board remained focused on delivering the final year of our 2022–2025 strategic plan, with clear progress made across our five core themes: communication and engagement, lived experience, quality assurance, governance, and collaborative learning. Our work was shaped by a strong commitment to prevention, assurance, and engagement – principles that continue to underpin our approach.

I continue to meet quarterly with executive leads from our statutory partners, as well as with the chairs of the four subgroups that drive the work of the NSAB. These regular touchpoints help ensure our collective focus remains aligned with the Board's priorities and workstreams, while also reinforcing a strong governance framework that supports accountability across the partnership.

During 2024/25 we strengthened our engagement with diverse communities, including the voluntary sector, faith groups and prisons, and took steps to engage with people with lived experience in shaping safeguarding practice. Our developing partnership with Healthwatch and other advocacy organisations is helping us better understand the experiences of people who have been through safeguarding processes, and this will remain a key focus as we move into our next strategic cycle and begin working with our new three-year strategic plan for 2025–2028.

The Board continued to respond to emerging challenges, including the ongoing scrutiny of Nottinghamshire Healthcare NHS Foundation Trust, where we maintained a clear focus on safeguarding within the improvement journey. We also worked closely with the Integrated Care Board to improve oversight of independent hospitals and to promote an open culture across all settings, including prisons and private providers.

Our work on transitional safeguarding progressed significantly, with a dedicated development group focusing on strengthening multi-agency transitional safeguarding arrangements and guidance materials across Nottingham and Nottinghamshire children's and adults' services to support young people moving into adulthood. We also deepened our understanding of severe and multiple disadvantage, using data and learning from safeguarding adults reviews (SARs) to inform system-wide improvements.

The Board's commitment to learning and development remained strong, with a refreshed competency framework, a successful Safeguarding Adults Week, and a growing focus on accessible, multi-format training. We also continued to embed learning from local and national SARs, ensuring that our policies, procedures and practice reflect the latest insights and best practice.

As we look ahead to the implementation of our 2025–2028 strategy, we do so with a renewed sense of purpose and partnership. The challenges facing the safeguarding system are significant, but so too is the commitment of our partners. I am grateful to all those who contributed to the work of the Board in 2024/25; your dedication, insight and collaboration are what make this partnership effective.

If you would like this report in an alternative format or language, please contact the Business Support Team at **safeguarding1.adults@nottscc.gov.uk** or call **0115 977 4673**.

Scott MacKechnie
Independent Chair
Nottinghamshire Safeguarding Adults Board

Message from the Executive Group Statutory Members

During 2024/25, we strengthened our partnership approach by welcoming new members to the Board, implemented best practice for supporting safeguarding and homelessness, and ensured key partners in our social care system have a role in our arrangements.

Through our safeguarding adults reviews, we took steps to learn lessons to improve future practice and worked hard to involve family in our learning. We had a focus on mental health and sought assurance for safeguarding practice in our mental health services. This report demonstrates the impact the Board has had in a number of other key areas and I am assured as the Statutory Director for Adult Safeguarding that our partnership arrangements are both strong and proactive.

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

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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 Integrated Care Board 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

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Nottinghamshire Police remains steadfast in its commitment to delivering an outstanding service that protects and supports the most vulnerable members of our community. Safeguarding adults at risk of abuse, neglect or harm is a core part of our mission, and we recognise that meaningful progress is only possible through strong, collaborative partnerships.

Our joint efforts have been exemplified through the continued success of the 'Right Care, Right Person' initiative, which ensures individuals receive the most appropriate response from the right agency. By working closely with partners across the county, we refined our approach to incidents involving private hospitals, enabling quicker, more effective support for those in need.

We also strengthened our collective understanding through data sharing and intelligence-led approaches, delivering presentations on domestic abuse trends and liaising with the coroner's office to explore the circumstances surrounding deaths among people experiencing homelessness. These insights informed our safeguarding strategies and enhanced our ability to respond proactively.

Our contribution to safeguarding adults reviews further reinforced our commitment to learning and continuous improvement. I am proud to be part of a policing service that values partnership, transparency, and shared responsibility. Together, we are making real strides in protecting those most at risk and building a safer, more supportive society

Paul Lefford, 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 are:

- 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 (NHCFT) and Doncaster and 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.

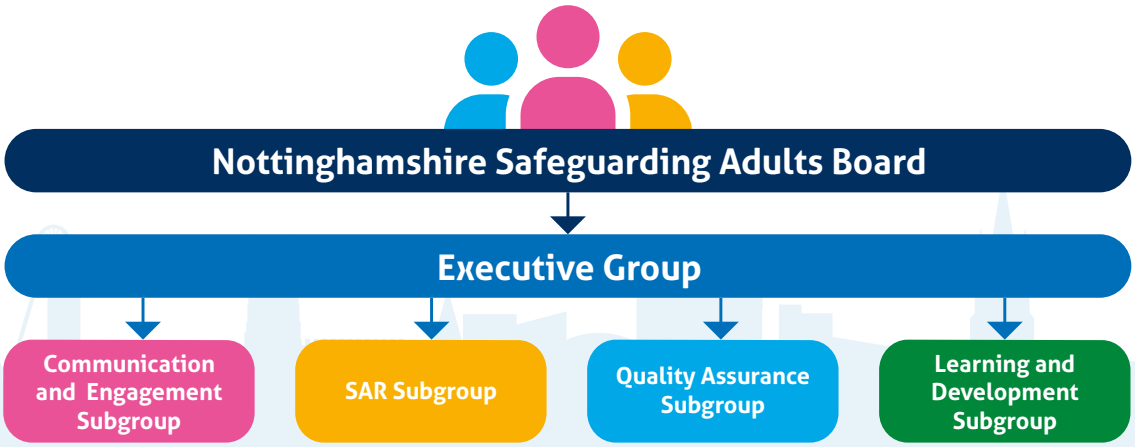
What we do

The three core duties of the Board are to:

- Publish an annual strategic plan
- Publish an annual report
- Undertake safeguarding adult 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.



The Board's strategic priorities

Prevention

We continue to operate the NSAB prevention strategy with an action plan detailing how we will work towards goals. During 2024/25, we updated and agreed the business plan, confirming key priorities around communication, lived experience, quality assurance, governance and partnership learning.

Some of the specific actions and achievements during the year included:

- The Communication and Engagement Subgroup began work to develop targeted outreach in Mansfield and Ashfield to address under-representation of Asian communities in safeguarding.
- The Communication and Engagement Subgroup also began planning to raise awareness of Care Act advocacy in Section 42 enquiries, informed by feedback from POhWER and Safeguarding Adults Collection (SAC) data.
- Following ministerial guidance, we reviewed and mapped local and national roles in responding to rough sleeping and homelessness and used insights from rough sleeper deaths to inform planning for harm reduction advice and outreach in temporary and supported housing.

Partnership working

- The Transitional Safeguarding Development Group was established as a joint initiative between the Nottingham City and Nottinghamshire County Safeguarding Adults Boards and the Children's Safeguarding Partnerships. The group brings together representatives from children's and adults' services, health, police, probation, youth justice, social care, the Integrated Care Board, and The Children's Society. It was formed in response to learning that highlighted risks during the transition from childhood to adulthood. Members developed a joint action plan with priorities including embedding transitional safeguarding into policies and procedures, improving pathways for criminal exploitation, and increasing engagement with young people and families. The group also produced a 7-minute briefing and amended training slides originally shared by Dez Holmes (from Research In Practice), which have since been adopted by partners to support a joined-up approach across children's and adults' services in Nottingham and Nottinghamshire.
- We strengthened links with the Making Every Adult Matter (MEAM) team, Public Health and housing to ensure learning aligned with broader system initiatives, particularly focused on people impacted by homelessness and severe and multiple disadvantage.
- The Communication and Engagement Subgroup worked together with the Carers Federation, Nottingham Deaf Society, Rough Sleeper Initiative, Healthwatch and other partners to enhance communications and share expertise.
- We worked with Lowdham Grange Prison to support safeguarding improvements following concerns. The Independent Chair visited the prison to receive assurance around safeguarding processes, and a collaborative group is being developed to review ongoing practice.

Right Care, Right Person update from Nottinghamshire Police

On 10 February 2025, following extensive planning and collaboration with health and care partners, Nottinghamshire Police launched the Right Care, Right Person (RCRP) operating approach.

RCRP ensures that people in crisis are supported by the most appropriate professionals – for example, health or social care teams rather than the police when no crime has taken place.

It is not about police withdrawal from health, mental health, or social care incidents; police will continue to deploy where appropriate, ensuring the right care is provided by the right agency at all times.

Partnership working

Key partners in the planning and development of RCRP were Nottinghamshire Integrated Care Board (ICB), East Midlands Ambulance Service (EMAS), local authorities and NHS trusts (mental and physical health).

Pre-launch engagement

- Partnership meetings took place over 18 months to plan implementation and assess impact.
- Tactical meetings were established for regular briefings and updates.
- The ICB led the review of police proposals and coordinated workstreams (e.g. EMAS led conveyance).

Ongoing collaboration

- There was regular contact and feedback sessions with partners.
- Concerns and feedback were actively addressed to ensure a collaborative approach and avoid shifting demand to other services.

Implementation and communication

- All partners were informed and their agreement was secured before RCRP went live.
- Multiple partner briefings and training sessions were delivered.
- RCRP policy and briefing notes were widely shared.
- Clear processes were developed for partners to challenge decisions in real time or post-incident.

Ongoing assurance and learning

Incident review

- Feedback sessions and real-time reviews for incidents are held; questions are asked and answered and concerns are raised and addressed.
- Regular dip-testing of incidents and independent scrutiny take place, especially where deaths are reported.

National learning

- Nottinghamshire Police take part in the national RCRP tactical group to share and learn from best practice.
- The Coroner's findings and Preventing Future Death reports are reviewed regularly to inform local policy and practice.

Safeguarding assurance

- Regular updates are provided to the Safeguarding Adults Board.

Nottinghamshire Police remain committed to partnership working, transparency, and continuous improvement in the delivery of RCRP, ensuring safeguarding remains at the heart of the approach.

Other work in the year

- We supported consistent approaches to Mental Capacity Act training across organisations, aiming to improve confidence in applying legislation and documenting decisions.
- We started work to align hoarding policies and protocols across agencies to ensure consistent support and intervention.
- We began using SharePoint to improve internal and external workflows, collaboration, and document management.
- We analysed website data to improve user experience and developed surveys to gather further feedback from practitioners and carers.
- We began engaging with patients and carers to improve understanding of seclusion and loneliness in mental health services, informed by lived experience feedback.
- We reviewed learning from care home closures to strengthen escalation processes and stabilise the market. The Board also developed a longitudinal view of the care market, which is regularly reported by the Quality and Market Management Team (QMMT) to the Quality Assurance subgroup to inform oversight of trends and pressures in care provision.

Engagement

Learning and development

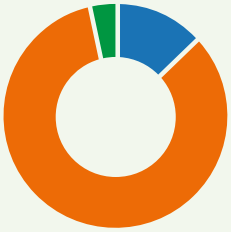
- We provided a variety of online and face-to-face training, including sessions on self-neglect, professional curiosity, transitional safeguarding, and lived experience.
- Between 1 April 2024 and 31 March 2025 we held eight 'understanding safeguarding concerns' training events with an average of 38.6 people attending each session.
- We also delivered two disclosure and barring workshops, with 29 people attending part 1 and 13 people attending part 2.
- We shared training resources and materials through various channels including written materials, online resources, and in-person sessions, to enhance and strengthen our safeguarding practices.
- Between 1 April 2024 and 31 March 2025 the training area of our website drew over 3,000 combined views, supporting our aim to make learning accessible and widely available.
- Our online safeguarding adults awareness training received the following:
    - Level 1: 720 views; 158 users
    - Level 2: 709 views; 154 users
    - Level 3: 641 views; 134 users
- Working with input from partners and wider professionals, the Learning and Development subgroup reviewed and updated the competency framework and learning pathway to align with national guidance, ensure inclusive language, and improve clarity, accessibility and inclusivity.
- Learning from national and local SARs informed improvements in training materials, particularly around mental capacity, executive functioning, self-neglect, and professional curiosity.
- The Transitional Safeguarding Development Group produced a 7-minute briefing on transitional safeguarding to raise awareness across agencies and planned further workshops for practitioners to improve understanding and application of transitional safeguarding principles.
- We worked to improve learning and development opportunities by reviewing data from feedback given by training participants and developing short, accessible learning formats, such as 7-minute briefings. We continue to discuss other options such as bite-sized video or talking heads-type resources, to reach a wider audience.
- During the year, our new and existing 7-minute briefings received engagement online as follows: (*please note clicks refer to when the document is viewed).
    - Autism: 26 users; 27 clicks
    - Chronologies: 18 users; 19 clicks
    - Cuckooing: 34 users; 40 clicks

- Effective Safeguarding Adults Referrals: 81 users; 97 clicks
- Exploitation: Perception vs Reality: 27 users; 28 clicks
- Mental Health Crisis and Suicide Prevention: 26 users; 27 clicks
- Making Safeguarding Personal: 81 users; 105 clicks
- Mate Crime: 26 users; 33 clicks
- Professional Curiosity: 44 users; 61 clicks
- Self-Neglect: 35 users; 38 clicks
- What is a Safeguarding Adults Review (SAR)?: 28 users; 33 clicks

- During Safeguarding Adults Week we put together workshops and presentations on topics including professional curiosity, transitional safeguarding, and safeguarding in sport. The sessions were attended by around 60 professionals, with particularly strong engagement in mental capacity, domestic abuse, and self-neglect. We also shared academic and practitioner case studies and strengthened links with sport and welfare officers through Sport England.
- The Professional Curiosity Task and Finish Group developed resources to promote trauma-informed practice and address barriers identified through a clinician survey.
- We piloted post-training impact assessments to evaluate how learning was embedded in practice and to refine future offers. These assessments evaluated what participants thought of the length of the training, the content, and the facilitator, as well as participants' level of knowledge before and after the training, and how they felt they could apply the learning. For example, the Understanding Safeguarding Concerns Training impact assessment identified that 97% of respondents thought the content of the training was very good or exceptional (see Figure 1), that the level of respondents' safeguarding knowledge had improved following the training (see Figure 2), and that 71% of respondents felt they could use the learning in the workplace all or most of the time (see Figure 3). This helped to identify that this training was working effectively overall.

Figure 1: Training content

I thought the content in the training was



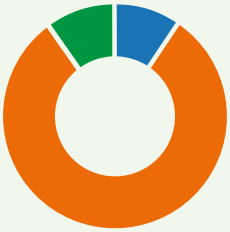
Exceptional	4
Very good	26
Average	1
Poor	0
Very poor	0

Figure 2: Safeguarding knowledge before and after training

My level of knowledge prior to the training was

Exceptional	2
Very good	11
Average	15
Poor	3
Very poor	0

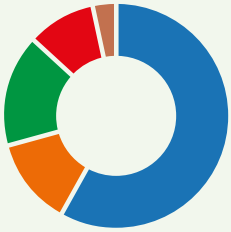
My level of knowledge following the training is



Exceptional	3
Very good	25
Average	3
Poor	0
Very poor	0

Figure 3: Applying the learning

In my workplace I can apply this learning



All the time	18
Most of the time	4
Sometimes	5
Not often	3
Never	0
Other	1

Publicity

- Safeguarding Adults Week in November 2024 was a key focus for publicity and we used the opportunity to promote resources and toolkits including presentations and case studies through our website, bulletins and partner channels, with a particular focus on trauma-informed care and professional curiosity.
- We improved communications around the Complex Persons Panel and modern slavery services, using slide decks, events, and e-bulletins to raise awareness with the aim of increasing referrals into those services.
- We updated and approved the communications strategy, aligning city and county priorities and supporting our new three-year strategy for 2025-28. We worked on this project together with people with lived experience and also produced an easy-read version.

- The Communication and Engagement Subgroup supported the development of a 'Voice of Lived Experience' survey to begin to understand how we can be more accessible to our communities.
- We are developing a carers animation with input from the Carers Federation to highlight the role of carers in safeguarding and promote support services. The animation is being produced in partnership with West Nottinghamshire College as a free resource and is due to be delivered during the 2025/26 financial year.
- The CHARLIE-P fire safety campaign was launched in summer 2024 using existing resources from Nottinghamshire Fire & Rescue Service, with briefing materials shared widely across the partnership. The campaign generated increased referrals and continued to engage partners through early 2025, with further promotion planned.
- The Making Safeguarding Personal (MSP) toolkit and materials were actively promoted during the year. The Communication and Engagement Subgroup explored developing alternative, more engaging formats for MSP messages to improve uptake, such as short videos demonstrating good and poor practice, podcasts featuring real-life experiences, and role play scenarios to help practitioners understand how to have MSP-focused conversations and embed its principles into practice. The ideas were agreed in principle and will be further developed during 2025/26.
- We progressed work in the open cultures space, fostering environments where staff feel able to speak up and share concerns, and where the organisation learns from incidents, including agreeing to commission a culture review at a private hospital in Nottinghamshire. This review is due to take place during the 2025/26 reporting period.
- Analytics for the year show steady engagement with key safeguarding resources and news updates on the NSAB website. The homepage remained the most visited page, with over 31,000 views, while the news section as a whole ranked second. Individual news stories, including updates on police access to property and safeguarding adults referrer training dates, attracted significant traffic, reflecting our ongoing work to share timely information with partners and the public. Core safeguarding resources also featured prominently among the most-visited pages, with high engagement on the procedures, training, resources, reviews and reports sections.

Partnership and development events

- Partner organisations highlighted their work at development events, fostering knowledge-sharing across agencies.
- Safeguarding Adults Week was planned and delivered with our input, including professional curiosity and exploitation in modern slavery as key topics.

- We held a partnership event in May which focused on severe and multiple disadvantages, with featured contributions from Public Health and the Second National SAR Analysis.
- Members of the Transitional Safeguarding Development Group contributed to and aligned with the County/City Child Exploitation Transformation Project, ensuring that transitional safeguarding is considered within wider exploitation workstreams.
- Nottinghamshire Police restructured their exploitation pathways by integrating coordinators into the children's exploitation hub, allowing better information sharing and response to criminal exploitation of children who are transitioning to adulthood.

Network engagement

- Engagement with lived experience representatives informed training priorities and improved sensitivity when working with individuals who have experienced trauma.
- Wider engagement with probation, prisons, and housing services addressed risks during transitional periods and promoted reintegration.
- The Communication and Engagement Subgroup welcomed new members from Nottinghamshire Police and Doncaster and Bassetlaw Teaching Hospitals, enhancing its reach and communications expertise.
- The Transitional Safeguarding Development Group introduced a 'lived experience' standing agenda item, for partners to discuss any initiative in their organisation that has captured the voice of lived experience. Some of the topics discussed include high intensity users and support for carers.
- We continue to raise awareness of both the Slavery Exploitation Risk Assessment Conference (SERAC) and Complex Case Panels, supporting a more coordinated response to hidden exploitation risks for young people transitioning to adulthood.

Slavery Exploitation Risk Assessment Conference

The Slavery Exploitation Risk Assessment Conference (SERAC) is a multi-agency safeguarding forum that brings organisations together to protect people at risk of modern slavery, human trafficking and exploitation. Originally developed within Nottingham City boundaries, the service has now expanded into Nottinghamshire County, enabling broader access to coordinated safeguarding support.

We have actively helped promote SERAC across the county by raising awareness among partner agencies and encouraging referrals, including through partnership events and subgroup meetings.

SERAC complements other multi-agency forums such as Complex Case Panels, offering a targeted response to hidden risks of exploitation in adults – not limited to transitional safeguarding. We continue to work with our partners to strengthen referral pathways into SERAC and make sure it aligns with wider safeguarding priorities.

Assurance

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

- We reviewed and strengthened our membership and external links to ensure broad representation across the safeguarding system. This included engagement with the Voluntary, Community and Social Enterprise (VCSE) Alliance, faith organisations (including the Dioceses of the Church of England and Roman Catholic Church), prisons (such as Lowdham), SERCO, academia, carers, coroners, and Sport England. Further work is planned to expand engagement with other prisons and faith groups, and to strengthen links with coroners following guidance issued by the national Safeguarding Adults Board Chairs network.
- We developed and ratified a new communications and engagement strategy aligned to the overarching Board strategy for 2025-28. This included reviewing and aligning the strategy with the Nottingham City SAB and enhancing the use of local data (including census and safeguarding data) to inform communications. The Carers Federation now attends the Communication and Engagement Subgroup.

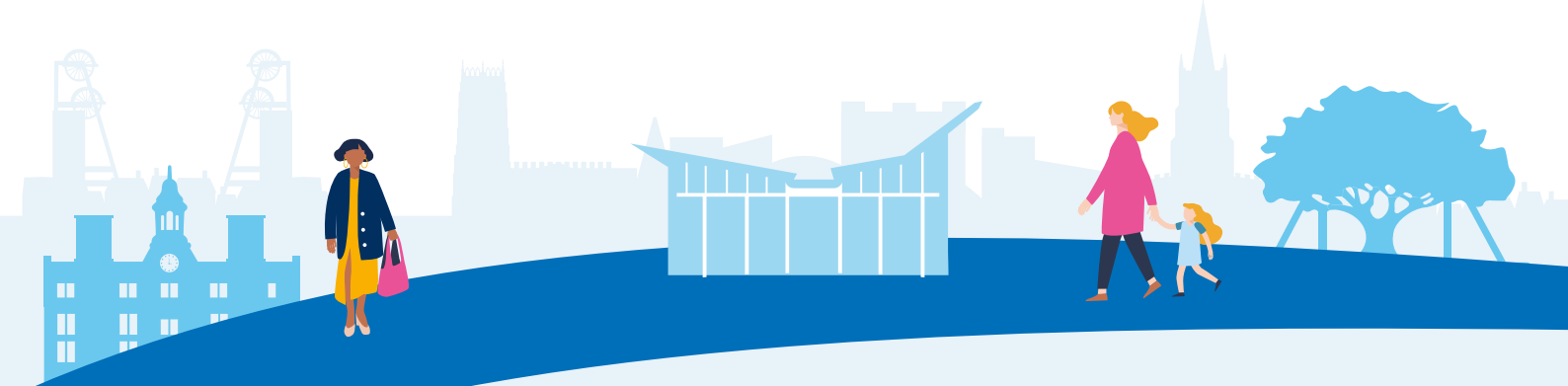
Theme 2:
To increase participation of people with lived experience in shaping services

- We continued to build on the work of the Co-production Task and Finish Group, identifying opportunities to involve people with lived experience of safeguarding in shaping services. Initial steps included collaborating with people with lived experiences in producing easy-read procedures, involving a young carer in a recent SAR.
- The Board hosted a project with Healthwatch to gather feedback from consenting adults with lived experience of safeguarding, specifically their experiences of Section 42 enquiries, and to identify those willing to support future Board work. This project involved two linked surveys:
    - the first gathering experiences following Section 42 enquiries,
    - the second identifying those willing to engage further with the Board.
- Healthwatch acted as a consultant for the project, and the findings of the first survey were shared with the Adult Social Care safeguarding lead to inform future practice. Follow-up with participants of the second survey will take place during the 2025/26 reporting period.

Theme 3:
Quality assurance and performance monitoring

- We worked with commissioning partners to strengthen assurance processes relating to care homes and specialist services and have been sighted on risk factors within this sector, enabling a partnership approach to tracking and mitigating where risks are identified.
- Risk levels within Living Well care homes (people aged 18-64) showed a positive trend over the reporting period, with the proportion of low-risk services increasing from 34% to 47%. High-risk services decreased by 50%, and very high-risk services decreased by 20%, reflecting strengthened assurance processes and targeted interventions by commissioning partners.
- Throughout 2024/25, Ageing Well care homes experienced a gradual shift in risk profile. The proportion of services rated as low priority declined slightly from 53% in Q1 and Q2 to 47% by Q4, while high and very high-risk ratings increased, particularly in the final quarter. High-risk services rose from 4% to 11%, and very high-risk services from 7% to 11%, indicating growing concerns around governance, staffing, and financial viability. These trends reflect the pressures within the sector and underscore the importance of continued oversight and targeted support from commissioning partners and the Board.
- The Transitional Safeguarding Development Group reviewed national learning from SARs and Child Safeguarding Practice Reviews (CSPRs), applying it locally to improve oversight of transitional safeguarding practice and identify gaps in support at key transition points. Achievements during 2024/25 include:
    - Developing a 7-minute briefing, now live on the Board's website, to raise staff awareness of transitional safeguarding.
    - Producing training slides that have been adopted by partner organisations to ensure a consistent approach and incorporated into their training offers.
    - Ensuring that transitional safeguarding policies are now adopted across both adults' and children's services in Nottinghamshire, providing a consistent framework for supporting young people through key transitions.
    - Exploration work started to develop a Maturity Matrix, which partner organisations will use to self-assess their transitional safeguarding practice, supporting the development of targeted resources. This will be featured in next year's annual report.
    - Beginning work on improving data capture to enable a more data-led approach, with further updates to be provided in next year's annual report.

- We continued to build our understanding of the challenges facing adults experiencing severe and multiple disadvantage. This included analysing data on homelessness and safeguarding concerns, developing an action plan linked to the N22 and M22 SARs, and engaging with regional and national networks to inform future practice.
- Partnership work with the Domestic Abuse Board supported the Violence Against Women and Girls initiative. We agreed a refreshed approach to learning from domestic abuse-related deaths and put improved reporting and escalation mechanisms in place. Sufficient assurance enabled this item to be removed from the risk register.
- We reviewed progress against the open cultures action plan and extended its scope to include prisons and private hospitals. This included analysis of whistleblowing and complaints data, securing funding for a culture review, and initiating stronger relationships with prison settings, with improving safeguarding practice in these settings identified as a focus for the year ahead.
- We continued to receive updates regarding the improvement journey of the NHCFT from the ICB.
- An audit assessing the effectiveness of multi-agency communication during Section 42 enquiries (linked to the K19 SAR) confirmed improvements in timeliness, clear ownership of actions, and appropriate agency involvement. The audit also highlighted opportunities to refine the audit tool, to better enable the auditor to capture proportionate agency communication, encompassing all forms of contact from emails and phone calls to formal multi-agency meetings. The audit was overseen by the Quality Assurance subgroup and will be repeated in 2025/26 to monitor progress and sustain quality.
- The Non-Safeguarding Notification Pathway was introduced within the Quality and Market Management Team (QMMT) to provide a dedicated route for raising non-safeguarding concerns through the appropriate channels. Robust processes are in place to ensure that any issues identified as safeguarding concerns are promptly redirected to the correct team. The number of referrals from QMMT to the safeguarding pathway is reported to the Board's Quality Assurance Subgroup, strengthening oversight. This pathway has enhanced collaboration between the QMMT and the Multi-agency Safeguarding Hub (MASH) and supports broader monitoring of care quality.
- We improved the Board's Performance Assurance Tool analysis to better capture quantitative and qualitative assurance, including positive examples and case studies of good practice.
- SAR L20 was independently reviewed by an external consultant during the reporting period, providing valuable challenge to our processes and supporting improvements in impact assessment. This external scrutiny reflects the Board's commitment to openness and continuous learning.



Theme 4:
Governance, structure and support functions

- We reviewed our safeguarding concerns procedures against Local Government Association guidance. Legal amendments were completed and informed the updated procedures. Work was also started on updating the SAR procedures.
- We strengthened collaboration and accountability across the adult safeguarding system by working closely with other statutory boards and promoting shared safeguarding messages. This included hosting a partnership event to consider the national SAR analysis.
- Governance was strengthened through improved oversight of NHCFT's Section 48 improvement plan and ongoing homicide review, with regular updates from the ICB providing assurance to Board members on progress.

Person in a Position of Trust (PiPoT)

At Nottingham University Hospitals (NUH), the PiPoT process is now well embedded, with an increase in staff allegations being managed through safeguarding procedures. This reflects greater awareness and engagement from care group leads, supported by the Head of Employee Relations. Allegations have related to domestic abuse, neglect of patients, financial abuse, and assault, with several cases subject to police investigation. Additional training is being delivered to international medical and nursing staff to address cultural differences in safeguarding practice. A 15% increase in safeguarding input into staff allegations was recorded across the 2024–2025 period, reflecting continued growth in awareness and reporting.

At Doncaster and Bassetlaw Teaching Hospitals (DBTH), a standalone PiPoT policy is now in place, with a rise in cases also demonstrating increased divisional awareness. The process is coordinated by the Safeguarding Team and chaired by the Head or Deputy Head of Safeguarding, with representation from Divisional Leads, the Associate Medical Director, and HR. All PiPoT activity is reported quarterly, with oversight from the Deputy Chief Nurse.

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

- We reviewed recommendations from local and second national SAR analysis and recommendations to incorporate them into policies and procedures. We developed an action plan with Nottingham City Safeguarding Adults Board and continue to take part in national discussions around implementation of recommendations.
- We created a survey to gather feedback from frontline workers, managers and strategic leads to identify challenges faced by colleagues, evaluate training, and collect suggestions for areas we could prioritise in the next three-year strategy, set to run from 2025 to 2028. The survey received 141 responses and revealed high awareness of the board and its strategy. Its findings highlighted useful information to aid the development of the 2025-28 strategy including: neglect and self-neglect; severe and multiple disadvantages; raising awareness and education; and promoting staff wellbeing.
- We initiated a review of the self-neglect toolkit and training following learning from the national SAR analysis and local reviews. The COM-B model, a framework that identifies the Capability, Opportunity, and Motivation needed to change behaviour, was recommended to support practice improvements in this area.
- Learning from the rough sleeper deaths thematic analysis, helped raise awareness of key risks and priorities, emphasising the importance of earlier identification of those at risk, closer links with prisons and probation, and more robust engagement with supported housing providers.
- Collaborative learning opportunities such as Mental Capacity Act (MCA) forums enabled agencies to share guidance, templates, and best practice, supporting a more consistent approach across the wider partnership.

What the Board will be focussing on in 2025/26

Engagement

- We will lead and support partners to take a 'back to basics' approach to adult safeguarding, ensuring public and professional awareness, training and organisational processes are as effective as possible.
- We will continue to improve the way we engage with adults with lived experience of adult safeguarding, enabling them to inform and contribute to our statutory responsibilities and strategic goals.
- We will signpost to or directly provide adult safeguarding training to non-statutory home care and care home providers that have been identified as needing support and improvement.
- We will embed the communication and engagement strategy into our work and strengthen external, internal, and lived experience campaigns to raise awareness, improve collaboration, and promote key safeguarding messages to the public and professionals.

Prevention

- We will seek assurance from partners about how they support the wellbeing and resilience of frontline staff carrying out adult safeguarding responsibilities and share good practice across the system.
- We will lead and support work, including through the severe and multiple disadvantage working group, to improve system pathways and help partner workforces safeguard adults who experience severe and multiple disadvantage.
- We will complete a review and update of procedures to produce a shared set of procedures that reflect current best adult safeguarding practice.
- We will continue to work with partners through the transitional safeguarding development group to improve pathways and responses for young people moving into adulthood and between or out of services, reducing the risk and severity of harm during these transitions.

Assurance

- We will support and seek assurance from health and social care commissioners and providers that adult safeguarding processes are effectively embedded in care home and home care services, reducing the likelihood and severity of neglect and self-neglect.
- We will appraise the preferred local authority model under the local government reforms to ensure it does not adversely impact effective adult safeguarding practice.
- We will complete the 'open culture' project by commissioning a patient survey to assess whether reported improvements in safeguarding and whistleblowing at local independent mental health hospitals are improving inpatient care.
- We will continue to seek assurance on quality and safety challenges across the partnership – including from local police and mental health organisations – ensuring that identified performance issues affecting safeguarding are successfully addressed.
- We will fulfil our statutory responsibilities by undertaking and learning from local SARs, other statutory reviews, and national guidance, and we will implement the recommendations in the 'Making Connections' SAR report to reduce the risk and severity of harm from similar incidents in the future.

Case studies

Borough Council

A safeguarding referral was made from customer services after they received a phone call from a vulnerable older woman. Mary (not her real name) had recently discharged herself from hospital and moved back into a house she owned.

The Community Safety and Safeguarding Officer spoke to Mary and learned that although she owned the house, she hadn't lived there for many years. Her daughter had moved into her house, while Mary had been living in a static caravan with her partner until his recent death.

The house had fallen into a state of disrepair, was full of hoarded items, and had no heating or usable kitchen. It was also home to three dogs. When she moved back in, Mary was living in a downstairs room with no access to a bathroom. Her mobility issues meant she couldn't wash she could not wash or care for herself. She was also partially-sighted and couldn't move around her room without high risk of tripping, and as a result she was effectively restricted to her bed. Her daughter, who had previously experienced alcohol dependency and had a history of poor mental health, had not allowed Mary to hire a skip and clear some of her belongings.

When Mary got in touch, the relationship with her daughter had completely broken down and they weren't speaking to each other. Even so, Mary felt guilty about asking for support because she didn't want to cause issues for her daughter.

Mary had spoken to adult social care before and it was agreed that she needed a care package and occupational therapy assessment. However, she was so embarrassed about the state of the property that she refused. She wanted a safe home for herself, but didn't want to sell the property she owned and make her daughter homeless.

In speaking with the Community Safety and Safeguarding Officer Mary accepted that she had no real quality of life and separate MASH referrals would need to be made for her and her daughter. She also agreed that her situation could be disussed at the district based Complex Needs Panel.

The MASH team worked with both mother and daughter to build trust and reach a solution underpinned by the six statutory safeguarding principles. In time, Mary was supported to sell her property and move into a residential care home that could better meet her needs, and the daughter was allocated her own rented property and accepted help in getting her benefits and finances back in order.

With Mary now in a financial position to live in the care home long-term, and her daughter settled in her own accommodation and managing her finances, it was recognised that the safeguarding enquiry could be concluded and that input from the Complex Needs Panel was no longer required.

Adult Social Care

Nottinghamshire Police submitted a Public Protection Notice (PPN) after attending the address of a 70-year-old male who phoned them to report a break-in by his neighbour. The man, Mr A, alleged that the neighbour had entered his house, switched off his fridge, resulting in food spoilage, and used a scanner to block his TV signal and disable his security camera. The police reported that the address was in a state of disarray with clothing and other items – such as multiple car batteries – everywhere, stating that they believed Mr A was self-neglecting.

The concern was allocated to a MASH social worker who asked the police, mental health services and the local housing department if they had any additional information of relevance. The police confirmed that they did not believe a crime had been committed and would not be taking any further action, whilst the housing department confirmed that Mr A had signed a 'no-contact' agreement with the neighbour three years ago due to poor relations.

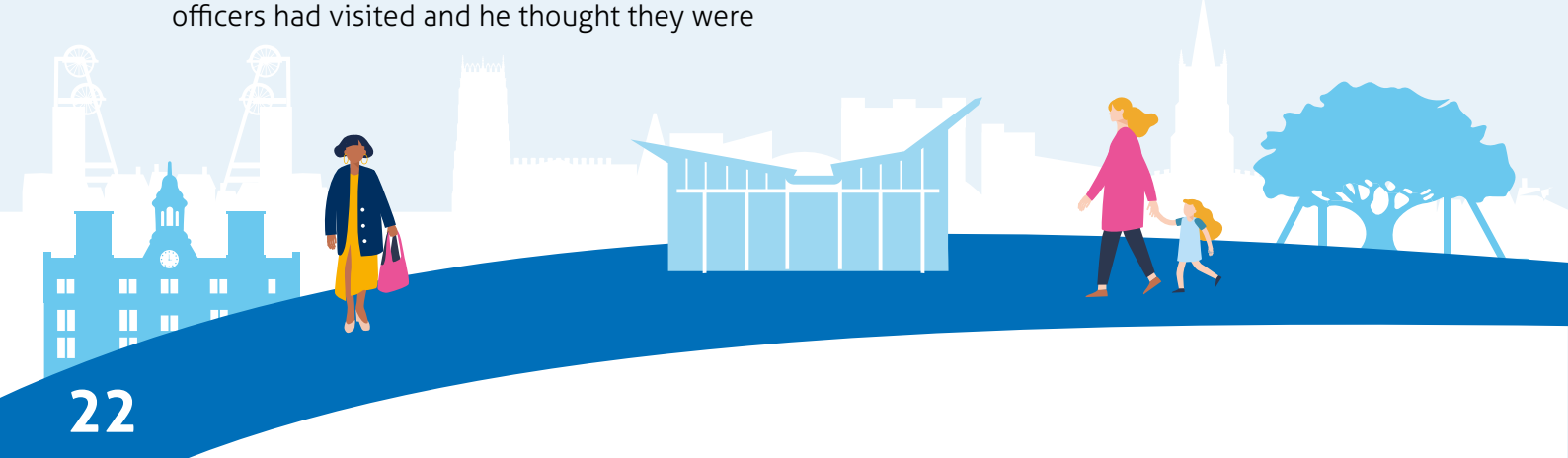
The social worker rang Mr A and explained that the police had raised a safeguarding concern because they were worried about his wellbeing, before listening to his concerns. Mr A admitted that he was unsure how his neighbour had entered as there were no signs of a break-in and his neighbour did not have a key, commenting that he regularly changed the locks for safety reasons.

Mr A explained that he was struggling to manage at home, especially now he had reduced mobility, and recognised that it was very cluttered. He reported that his tenancy officers had visited and he thought they were going to refer him for support to declutter his home, but this had not yet happened.

Mr A acknowledged that he had struggled with his mental health in the past, commenting that his mood could go up or down and that he had previously been on medication for anxiety. Whilst he thought his mental health was now okay, he admitted that his cluttered home was causing him worry, because he may be putting his tenancy at risk. He confirmed that he was not currently receiving any support for his mental health but that he was due to see his GP shortly about a physical health issue.

A discussion took place about what options were open to Mr A and it was agreed that the social worker would make a referral to Notts Fire & Rescue for a 'safe and well' visit to assess the potential fire risk his house posed, and another to Adult Social Care for an assessment of his social care needs, focussing on his ability to manage his home and engage more with his local community, something Mr A said he would like to do.

In respect of Mr A's mental health, he agreed to discuss his feelings of anxiety and low mood with his GP at his forthcoming appointment. He was also agreeable to the social worker contacting his GP and his local housing department to update them and, in respect of his house, to ask whether any practical support was available. A safeguarding plan was drawn up and shared with Mr A, detailing all the agreed actions, and a review date scheduled for the community social worker to revisit this with Mr A once they began their involvement with him.



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).

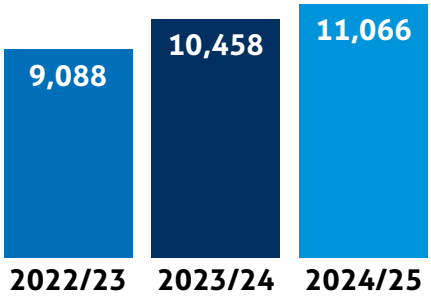
The following data consists of:

1. All safeguarding concerns and enquiries that were started between 1 April 2024 and 31 March 2025.

2. All safeguarding enquiries that were completed between 1 April 2024 and 31 March 2025. This includes referrals and enquiries which started in previous years.

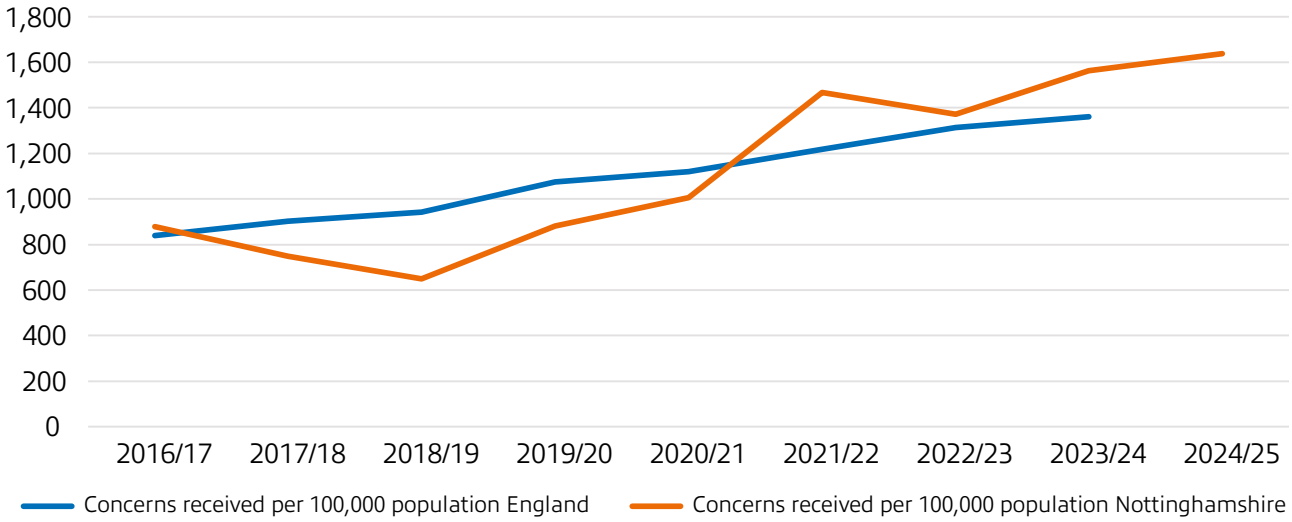
Note: Some of the totals reported below exceed the number of people supported because some people were involved in multiple enquiries during the year and experienced more than one type of abuse.

Figure 4:
Safeguarding concerns received in Nottinghamshire by year



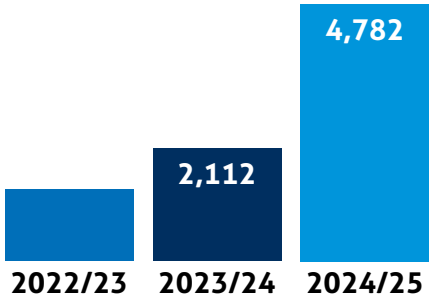
The number of concerns received in 2024/25 increased to over 11,000 for the first time – a 6% increase on the previous year.

Figure 5:
Safeguarding concerns received during 2024/25



The total number of safeguarding concerns received per 100,000 people in Nottinghamshire between 1 April 2024 and 31 March 2025 was 1,638, which is an increase of 4.7% from 2023/24 (1,564). The number of concerns received during the year per 100,000 population in England was not available at the time of publication.

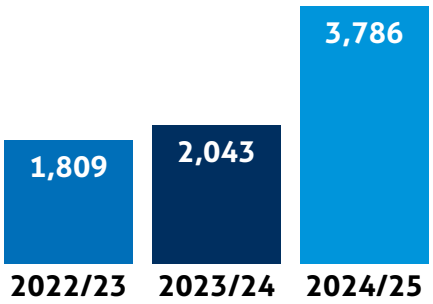
Figure 6:
Safeguarding enquiries started in Nottinghamshire by year



The number of enquiries started in the reporting period increased to 4,782. That is a 126% increase on enquiries compared to the previous year.

There was a drop in numbers from 2021/22 (3,756) to both subsequent years (1,368 in 2022/23 and 2,112 in 2023/24), which can in large 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 now been rectified and the 2024/25 reporting period, as expected, has shown a sharp increase back to, and above, the number of enquiries started in the 2021/22 reporting period.

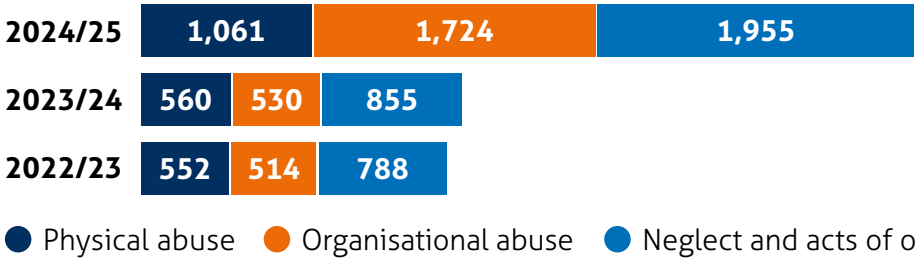
Figure 7:
Safeguarding enquiries concluded in Nottinghamshire by year



The number of enquiries concluded in the year increased by 85%, from 2,043 in 2023/24 to 3,786 in 2024/25. As with the previous chart, these figures should be seen in the context of the recording practice noted above. The subsequent increase, following on from the rectification mentioned above, is in line with our expectations that this year's reporting would show a return to numbers similar to, if not exceeding, those from 2021/22.

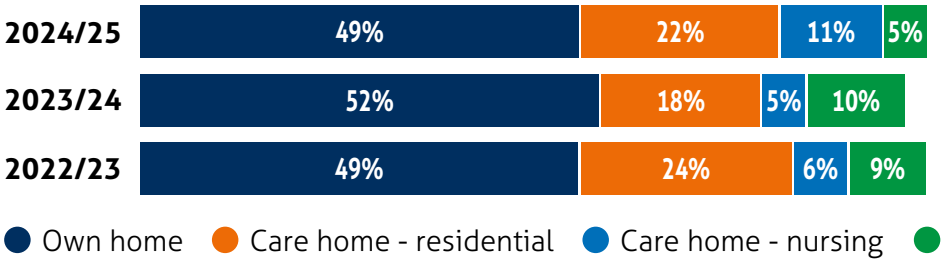
Note that these figures are the numbers of enquiries concluded in the reporting year, regardless of when they were started, so include some enquiries that were started before the reporting period.

Figure 8:
Type of abuse by year



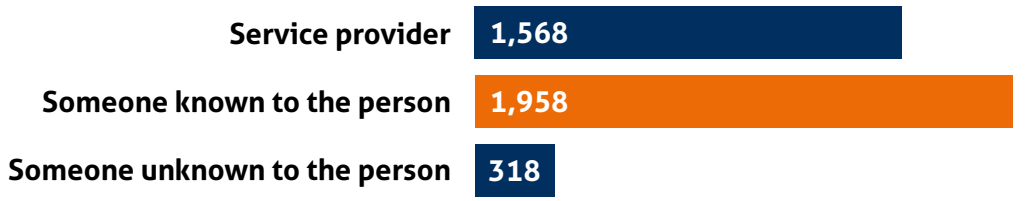
The three most common types of abuse remain neglect, organisational abuse and physical abuse, in that order. This order has changed from 2023/24, when neglect was the most common type of abuse, followed by physical and organisational. Figures for 2024/25 show a significant increase in all cases of abuse compared to the previous year. This increase can be explained by the change in recording practice outlined earlier in the report. During 2022/23 and 2023/24, safeguarding enquiries undertaken by the adult MASH team were not consistently recorded as s.42-part 2 enquiries due to technical constraints, despite adults continuing to be supported by Adult Social Care. This issue has now been resolved, and the 2024/25 data reflects a more accurate and complete picture of safeguarding activity, resulting in the sharp increase in recorded cases across all abuse types.

Figure 9:
Location of abuse by year



The four most common locations of abuse in 2024/25 were 'own home', 'residential care home', 'nursing care home' and 'in the community' in that order. This is in line with the national picture. Comparing Nottinghamshire figures from previous years, the percentages for 'own home' and 'residential care home' have changed only slightly, while the percentage of instances reported as taking place in a nursing care home has increased and the percentage taking place in the community has decreased.

Figure 10:
Source of risk in 2024/25



The sources of risk reported upon during 2024/25 were the same as in the previous year: 'someone known to the individual'; 'service provider'; and 'someone unknown to the individual'. However, the number of incidents where the source of risk was 'someone unknown to the individual' reduced from 360 in 2023/24 to 318 in 2024/25, whilst the number of incidents in which the source of risk was 'service provider' increased from 635 in 2023/24 to 1,568 in 2024/25. Although the reason for this increase is not clear, it could reflect the increase in care provision, both residential and in the community, commissioned on behalf of adults by the local authority. 'Someone known to the individual' remained the largest single source of risk.

Figure 11:
Primary support reason in 2024/25

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.

Primary support reasons recorded in 2024/25 were as shown in the pie chart below.

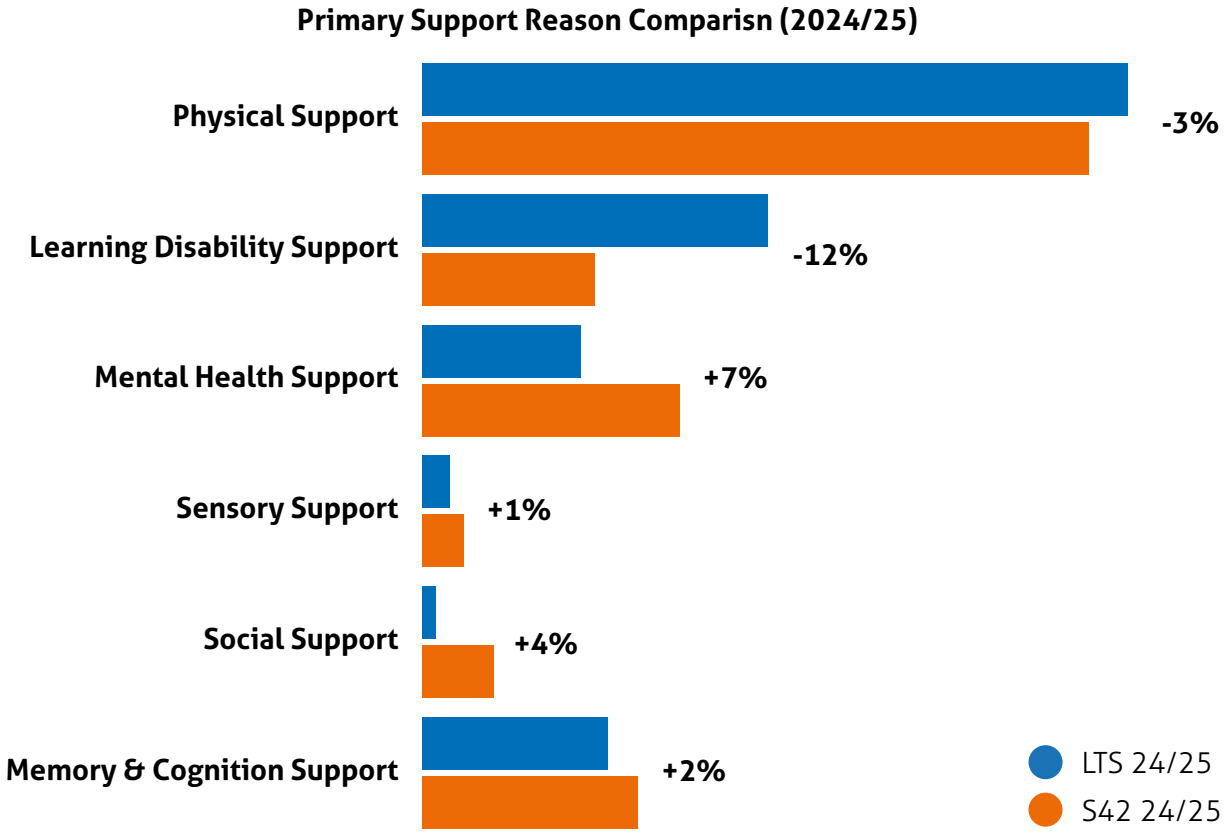
Physical support	1,635	Learning disability support	440
Sensory support	91	Mental health support	630
Support with memory & cognition	542	Social support	192
		Not known	540

Figure 12:
Comparison of primary support reasons

The chart below shows the distribution of primary support reasons for individuals receiving long-term services (LTS) compared with those involved in Section 42 safeguarding enquiries (S42) during the 2024/25 period.

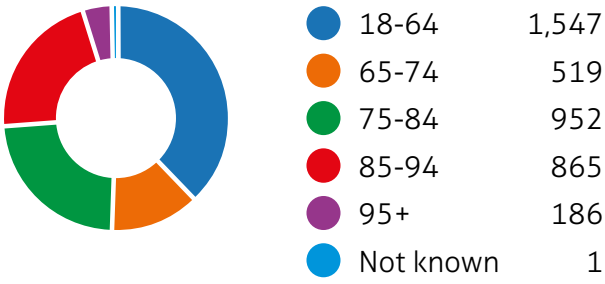
LTS refers to adults receiving ongoing care and support under the Care Act, with primary support reasons recorded as part of their care plans.

Section 42 enquiries (S42) are formal safeguarding investigations triggered when an adult is experiencing or at risk of abuse or neglect and is unable to protect themselves.



The comparison data would appear to suggest an overrepresentation in the area of mental health and adult safeguarding and an underrepresentation in the learning/intellectual disability adult safeguarding area, which the Board will explore further in the coming year.

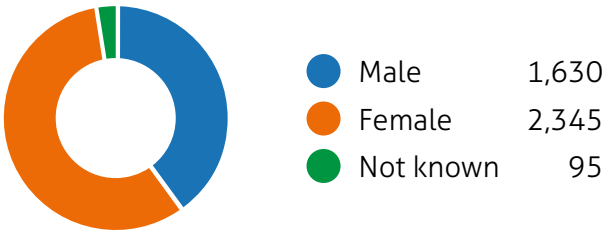
Figure 13:
Age of people subject to safeguarding enquiries in 2024/25



The total number of safeguarding enquiries in 2024/25 was higher than in the previous year and the majority of enquiries (2,522) concerned adults aged 65 or above (939 in 2023/24), with 1,547 enquiries concerning adults aged 18 to 64 (837 in 2023/24).

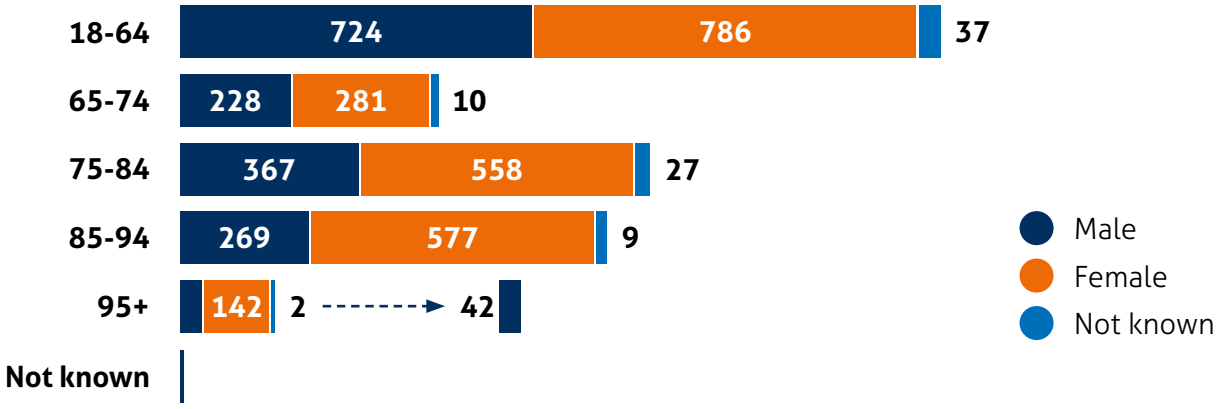
The largest cohort of adults aged over 65 experiencing abuse remained those aged 75 to 84, and the second largest cohort remained those aged 85 to 94, with the picture for the third and fourth largest cohorts also broadly replicating the ratios from the previous year.

Figure 14:
Gender of people subject to safeguarding enquiries in 2024/25



Figures regarding the gender split of safeguarding concerns in the county remained exactly the same in 2024/25 as in 2023/24: females accounted for 58%, males accounted for 40%, and 'gender unknown' remained at 2%.

Figure 15:
Number of safeguarding enquiries started in 2024/25 by age and gender of people involved



This is the second year that we have reported on the age and gender of adults involved in safeguarding enquiries. We are continuing to observe 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 2024/25, the percentage of people who were asked about their preferred outcomes was 82% – an increase of five percentage points on the previous year, and slightly above the national average of 81%. A mechanism has been introduced to capture the reasons why the person was not asked about their preferred outcomes. This captures reasons such as capacity considerations or alternative sources of information.
- The percentage of outcomes that were either fully or partially achieved increased to 97% from 95% the previous year. The national average was 95%.
- The indicator results for 'risk removed or reduced' increased to 93% from the previous year's figure of 82%. This was slightly above the national average of 91%.
- The number of people without capacity being supported to be involved in their safeguarding assessment increased to 84% in 2024/25 from 79% in 2023/24. The national average was 83%.

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 robust procedure recognising the Social Care Institute for Excellence (SCIE) quality markers has been developed and ratified with both NSAB and Nottingham City Safeguarding Adults Board (NCSAB). To provide a best practice framework for delivering statutory section 44 duty, delivering safeguarding adults reviews, as required.

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 also reviewed and updated SAR templates and procedures to ensure consistency and clarity, and contributed to the development of a refreshed safeguarding adults at risk pathway.

Referrals

In 2024/25, the NSAB received three SAR referrals:

- Two referrals raised concerns about coercive control within regulated care settings, particularly in supported housing and care homes. Neither met the criteria for a mandatory SAR; however, they highlighted the need to strengthen recognition and understanding of coercive control in such environments. Together, these referrals informed the commissioning of a non-mandatory thematic review to assess how well previous SAR recommendations on coercive control had been embedded into practice and to identify further improvements.
- Another referral related to a young adult in supported housing who disengaged from services and experienced a significant incident. It was discussed in detail and although it did not meet the criteria for a SAR, it did identify important learning points about how agencies and supported housing providers could work more effectively to maintain engagement and safety in supported housing, which will inform future guidance and training.

Completed SARs

Non-statutory SAR: Priory Hospital

A non-mandatory SAR was commissioned previously following the death of an individual in a mental health hospital. During 2024/25, the subgroup continued to monitor progress, including securing funding for a culture review of the hospital, which is intended to finalise the non-statutory SAR and support ongoing improvements.

Learning from SARs

Learning from SARs continues to inform the Board's wider work, including training and development.

The subgroup reviewed recommendations from the Second National SAR Analysis and incorporated them into local policy and procedures. It also contributed to a joint City/County task group to strengthen SAR processes and align them with national best practice.

Specific examples of learning embedded during 2024/25 include:

- Updating the SAR report and executive summary templates to improve consistency, transparency, and accessibility while maintaining sensitivity to families.
- Embedding learning about coercive control, executive functioning, and mental capacity into multi-agency training programmes and briefings.
- Feeding learning into the updated safeguarding adults at risk pathway to ensure better responses at transition points and for people experiencing severe and multiple disadvantage.
- Using feedback from a young carer involved in SAR M22 to inform how the Board assesses the impact of action plans and supports carers more effectively.

ADASS review

In late 2024, NSAB commissioned an independent review offered by 'Partners in Care' to review the efficacy of our SAR Assurance Tool.

The consultants gathered views and experiences from Nottinghamshire County Council (NCC) staff and partners, focusing on how the Council discharges its SAR-related responsibilities.

The review found that while the SAR Impact Record tool has strong potential to strengthen learning and accountability, its effectiveness depends on clear processes, consistent application, and strong leadership commitment.

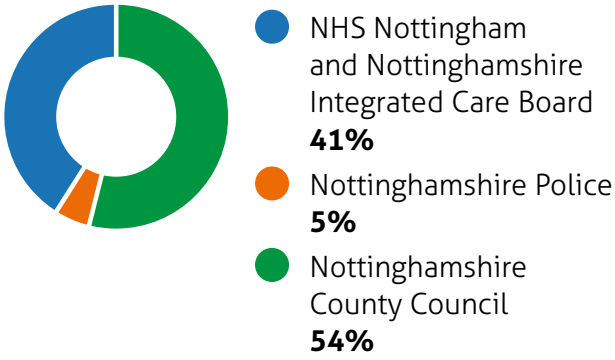
Key themes included ensuring the tool is embedded into practice, linking it to wider organisational learning, and maintaining transparency in tracking and evidencing changes resulting from SAR recommendations.

The review report includes recommendations to help NSAB and NCC maximise the value of the tool, embed learning across the system, and ultimately improve safeguarding outcomes for adults at risk.

Following the report, new procedures are being introduced which will include as standard completion of the Impact Tool 6-12 months after the action plan has been completed.

Funding

The total budget for 2024/25 was £251,116. 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 round-the-clock at weekends, from 5pm Friday until 8:30am Monday, and overnight on Monday, Tuesday, Wednesday and Thursday, from 5pm to 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

Department for Work & Pensions

Bassetlaw District Council North Nottinghamshire

Gedling Borough Council

Mansfield District Council

Probation Service East Midlands

Nottinghamshire County Council

POhWER

Rushcliffe Borough Council

Care Quality Commission

DSP/85196

Report in confidence: Online at www.nottinghamshire.gov.uk/care/safeguarding/reporting-abuse or if your enquiry is urgent call **0300 500 80 80**

Nottinghamshire Safeguarding Adults Board

Stop abuse and neglect