

Derby Safeguarding Adults Board

Annual Report 2024-2025



Introduction from the Independent Chair



Welcome to this Derby Safeguarding Adults Board (DSAB) annual report for 2024-25.

This annual report outlines the work undertaken to uphold the safety, dignity and rights of adults at risk of abuse or neglect in Derby. It details our commitment to

meeting our statutory requirements as detailed in the Care Act 2014 and assurance of the robust safeguarding arrangements that are embedded in the work of the board and its partners.

The report details how our partner agencies have delivered the strategic aims of the board together with highlighting key achievements over the year.

As we continue our work, I passionately believe that our strength as a board is in partnership. This will be essential as we constantly seek out new approaches to improve outcomes for adults at risk within our community

I sincerely hope you will find the time to read this report.

Best wishes,

Richard Proctor

Independent Chair, Derby Safeguarding Adults Board

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1. Demographic information of Derby



1.1 Demographic Information of Derby



The population of Derby in 2021 was estimated to be 261,400, an increase of 5.1% from around 248,800 in 2011. The population in Derby increased by a smaller percentage compared to the overall population in the East Midlands (7.7%). Key facts from the census include:

There were 105,700 households estimated in Derby (an increase from 102,300 in 2011).

20% of people in Derby were aged 15 years and under, 63.7% were aged 16 to 64 years and 16.4% were aged 65 years and over.

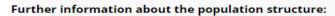
78.7% of Derby residents reported their country of birth as England (a decrease from 84.0% in 2011).

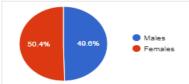


73.8% of people in Derby identified their ethnic group within the 'White' category (a decrease from 80.3% in 2011). 15.6% within the 'Asian, Asian British or Asian Welsh' category (an increase from 12.5% in 2011).

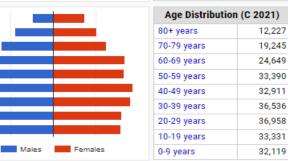
Median age in Derby

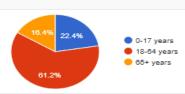
Between the last two censuses, the average (median) age of Derby increased by one year, from 36 to 37 years. Derby had a lower average (median) age than the East Midlands as a whole in 2021 (41 years) and a lower average (median) age than England (40 years).





Gender (C 2021)		
Males	129,512	
Females	131,854	





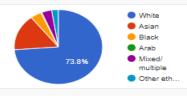




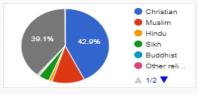


Country of Birth (C 2021)		
UK	210,170	
EU	19,668	
Europe (other)	1,473	
Middle East & Asia	21,633	
Africa	5,941	
Other country	2,479	

Age Groups (C 2021)



Ethnic Group (C 2021)			
White	192,871		
Asian	40,901		
Black	10,482		
Arab	1,032		
Mixed/multiple	9,562		
Other ethnic group	6,516		



Religion (C 2021)		
Christian	104,969	
Muslim	29,137	
Hindu	3,065	
Sikh	9,762	
Buddhist	828	
Jewish	150	
Other religion	1,297	
No religion	95,639	

2. Governance arrangements and legislative context

2.1 Governance arrangements and legislative context

The work of the Safeguarding Adults Boards (SABs) is directed by legislation, namely The Care Act 2014. The Care Act states that SABs must assure themselves that local safeguarding arrangements and partners are protecting adults in its area who:

- have needs for care and support (whether or not the local authority is meeting any of those needs) and;
- are experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs are unable to protect themselves from either the risk of, or experience of abuse or neglect.

Safeguarding Adults Boards have the following statutory duties:

- To produce and publish an Annual Report detailing the activity and effectiveness of the Board over the previous year.
- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute
- commission Safeguarding Adults Reviews (SARs) for any cases which meet the criteria for these in accordance with Section 44 of the Care Act.

The six principles of Safeguarding Adults are set out in the Care Act 2014 and each hold equal importance in the effective safeguarding of adults:

Empowerment	Citizens in Derby should be supported and encouraged to make their own decisions and informed consent.
Protection	Support and representation for those in greatest need.
Prevention	It is better to take action before harm occurs.
Proportionality	The least intrusive response to the risk presented.
Partnership	Services working with their communities to prevent, detect and report abuse and neglect.
Accountability	Transparency in safeguarding practice for Derby Citizens

In addition to their statutory functions the SABs have a wider preventative and developmental focus on safeguarding adults including

- To work together to oversee, monitor and coordinate systems and services in their duties of prevention of harm and protection of adults with care and support needs.
- To seek assurance that partners work together to safeguard adults in Derby in a way that supports them in making choices and having control about how they want to live.
- To develop multi-agency safeguarding adults policies and procedures and monitor their implementation.
- To provide multi-agency training in relation to safeguarding adults and be assured that staff in organisations access high quality training relevant to their role.
- To seek assurance, through the application of its quality assurance framework, that partners are applying MSP principles so that individuals are supported and feel empowered to make their own choices and decisions.
- To identify and highlight positive safeguarding adults practice and learning.
- To raise awareness of safeguarding to the general public to create a safer community.
- To be accountable and transparent to professionals and the public by making the function and work of the Board accessible to all.
- To respectfully challenge each other and provide assurance about performance of DSAB partners to safeguard adults with care and support needs.

3. Derby Safeguarding Adults Board (DSAB) 2024-25

derby **safeguarding adults** board

3.1 Derby Safeguarding Adults Board (DSAB)

3.1.1 DSAB Strategic Plan and Priorities:

The Derby Safeguarding Adults Board Strategic Plan 2024-24 has the three key priorities below to achieve its vision:

Quality Assurance	Making Safeguarding Personal	Prevention
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- Quality Assurance: The DSAB will strengthen and implement comprehensive systems of quality assurance to provide confidence that both the Board and its partner agencies have effective safeguarding arrangements in place. These systems will enable the Board to monitor, evaluate, and challenge practice, ensuring that adults at greatest risk in Derby are consistently protected and that safeguarding work meets statutory and local standards.
- Making Safeguarding Personal (MSP): The DSAB will continue to develop and embed approaches that place the adult at the centre of all safeguarding activity. This includes supporting partner organisations to establish and maintain processes that actively engage adults, or their chosen representatives, in meaningful discussions about how best to address individual safeguarding concerns, ensuring that their views, wishes, and outcomes shape decision-making and interventions.
- Prevention: The DSAB will develop and deliver proactive preventative strategies aimed at reducing the incidence of abuse, neglect, and exploitation within Derby. These strategies will focus on early identification of risks, awareness-raising across communities and organisations, and promoting a culture in which safeguarding is everyone's responsibility.

3.1.2 Vision of the Derby SAB for 2024-25:

"We will work together to enable people in Derby to make choices to stay safe and to live a life free from fear, harm and abuse". The DSAB is independently chaired by Richard Proctor, who has held this position since May 2024 following a formal appointment process. In his role as Independent Chair, Richard provides impartial oversight, constructive challenge, and strategic support to the Board, ensuring that it can effectively fulfil its objectives and uphold its statutory responsibilities.

The Board meets on a quarterly basis and operates within a framework of robust governance arrangements, both across partner agencies and internally. The Independent Chair plays a key role in fostering strong connections with other strategic boards and partnerships that impact adult safeguarding in Derby. These include the Derbyshire Safeguarding Adults Board, the Derby City and Derbyshire Safeguarding Children Partnership, the Health and Wellbeing Board, and the Derby City Prevent Strategy Board. These links support coordinated, multi-agency responses to safeguarding issues and promote a cohesive approach across local systems.

The DSAB is central to the strategic development of adult safeguarding in Derby. Its overarching objective is to provide assurance that local safeguarding arrangements are effective, that partner organisations fulfil their statutory duties, and that adults at risk in Derby City are supported and protected in accordance with the Care Act 2014. Through this work, the Board ensures that safeguarding remains a priority at both operational and strategic levels, promoting the safety, wellbeing, and rights of adults with care and support needs.

3.2 Resources and Funding for DSAB:

Derby SAB is funded by Derby City Council, Derby and Derbyshire ICB and Derbyshire Constabulary, Derbyshire Fire and Rescue Service and Derby Homes.

3.2.1 Derby SAB Budget Contributions 2024-25

Derby City Council	£100k
NHS Derby and Derbyshire ICB	£40k
Derbyshire Police	£40k
Derbyshire Fire and Rescue Service	£5k

Derby Homes £5k

Total Contributions £180k

Total Amount Spent £186k

Derby Safeguarding Adult Review (SAR) expenses are included within the above Derby SAB budget expenditure The total expenditure for safeguarding adult reviews during 2024-2025 was £11k.

3.3 Key DSAB achievements and progress 2024-2025

MCA Subgroup Newsletters

As part of ongoing efforts to strengthen awareness and application of the Mental Capacity Act (MCA) across all partner organisations, the Joint Derby and Derbyshire MCA Subgroup produced and disseminated two dedicated <u>newsletters</u> during 2024–25.

The MCA newsletters were introduced following lessons learned from Safeguarding Adult reviews and multi-agency case file audits, aiming to address inconsistencies and promote a more consistent and effective application of the MCA across practice.

These newsletters were specifically designed to support frontline practitioners by providing clear, practical information on the principles of the MCA and how they should be embedded in day-to-day practice. Each edition offered guidance, and updates on relevant policy or case law, helping staff to better understand their responsibilities when working with adults who may lack capacity to make certain decisions.

By producing the newsletters in an accessible and engaging format, the subgroup aimed to reinforce key messages around empowerment, decision-making, and the importance of acting in an individual's best interests. The newsletters also served as a valuable resource for highlighting good practice, addressing common areas of challenge, and signposting staff to further sources of training and support.

Through this work, the Joint MCA Subgroup contributed to building greater confidence and consistency across the workforce in applying the Act, ultimately

ensuring that the rights of adults in Derby and Derbyshire are respected, protected, and promoted.

Derby and Derbyshire SAB safeguarding adults practice guidance

The composite practice guidance document was updated by the Joint Policy and Procedures subgroup with the following new pieces of practice guidance:

Reviewed and updated guidance:

- Office of the Public Guardian
- Guidelines on notification of deaths to the coroner where there are safeguarding concerns
- Think Family staff guidance
- Missing persons (including the Herbert Protocol)
- Domestic abuse

Guidance removed:

 Guidelines for reporting accidents and assaults to adults with care and support needs

New guidance added:

- Falls and safeguarding
- Adolescent to Parent Violence and Abuse (APVA)
- Adults who disclose non recent abuse'
- Equality, diversity and inclusion and safeguarding adults
- Multiple Exclusion Homelessness toolkit

Derby and Derbyshire SAB Safeguarding Adults- What to Expect' Leaflet

The 'What to Expect' leaflet was reviewed and updated following feedback from carers, ensuring that it remains relevant, accessible, and responsive to the needs of those it is designed to support. This resource serves as a practical guide for adults aged 18 and over who have care and support needs, as well as for their carers, providing clear information about what they can anticipate when engaging with safeguarding processes and related services.

The leaflet aims to improve understanding of rights, responsibilities, and available support, helping individuals and their carers to navigate systems confidently and make informed decisions. By incorporating feedback from those with lived experience, the leaflet reflects real-life concerns and questions, ensuring that it addresses common uncertainties and provides reassurance where needed.

Ultimately, the 'What to Expect' leaflet contributes to greater transparency, empowerment, and confidence for adults and carers, supporting the Derby Safeguarding Adults Board's commitment to placing individuals at the centre of safeguarding practice.

Derby and Derbyshire SAB Multi-Agency Training

The delivery of high-quality, multi-agency safeguarding training continued to be a key priority for the DSAB during 2024–25. This training programme was designed to strengthen and support the wider workforce in carrying out their responsibilities to safeguard and promote the welfare of adults with care and support needs. By equipping staff with the knowledge, skills, and confidence required, the training helps to ensure that adults are supported to live their lives safely, with dignity, and free from the risk of harm, abuse, or neglect.

Over the course of the year, DSAB delivered 108 safeguarding adult related training sessions, with a total of 1,432 delegates in attendance. Participants represented a wide range of agencies and professional backgrounds, reflecting the multi-agency nature of safeguarding work across Derby and Derbyshire. The sessions provided delegates with valuable insights into statutory safeguarding duties, expectations of professional practice, and key learning drawn from safeguarding adults reviews and other sources of best practice:

In addition to enhancing individual knowledge and competence, the training also played a vital role in strengthening shared understanding across agencies. By learning together, delegates were able to build stronger professional networks, improve communication, and develop a clearer, more consistent approach to safeguarding practice. This collaborative learning environment supports the Boards' overarching aim of embedding safeguarding as a collective responsibility across all sectors.

The DSAB received 291 evaluation responses from delegates who attended its webinars. Delegates were asked to provide feedback on their knowledge, confidence, and whether their practice would improve as a result of participating in the DSAB webinar.

- **Increased knowledge** 99% delegates reported improved understanding of safeguarding concepts and procedures.
- **Greater confidence** 90% delegates felt more confident in recognising and responding to safeguarding concerns.
- **Improved practice** 95.5% delegates reported that their practice will improve as a result of attending the DSAB webinar.

The continued high levels of engagement demonstrated the commitment of the local workforce to developing their safeguarding practice and reflect the importance of training as a driver for continuous improvement. DSAB will continue to review and adapt the training programme to ensure it remains responsive to emerging safeguarding themes, national policy developments, and the needs of local communities.

National Safeguarding Adults Week Webinars 18-22 November 2024

During the National Safeguarding Adults Awareness Week (NSAAW), Derby SAB, working jointly with Derbyshire Safeguarding Adults Board, delivered a programme of webinars. This series of learning events was developed to reflect and compliment the Ann Craft Trust's national theme of Working in Partnership.

The webinars provided an opportunity for a wide range of practitioners, partner organisations, and community representatives to come together and explore how safeguarding can be strengthened through proactive, collaborative approaches. Each session was designed to raise awareness of key safeguarding issues, highlight the importance of intervention, and promote the role that partnership working plays in preventing harm.

In addition to building knowledge, the webinars also sought to foster dialogue and encourage participants to share experiences and good practice. By creating this space for discussion, the Boards aimed to support the development of safer cultures within organisations, workplaces, and communities.

The webinars focused on the following subjects:

- MCA and Executive Functioning
- Making Safeguarding Personal how to work effectively with people you support
- Disclosure and Barring Service and Safeguarding Adults
- Professional Boundaries

- Trauma Informed Practice
- Understanding the Concept of Professional Curiosity
- Cybercrime and Online Safety
- County Lines and Exploitation

440 delegates were in attendance during the NSAAW, represented from agencies across Derby and Derbyshire and below highlights the feedback received on their knowledge and understanding, and whether their practice would improve as a result of participating in the NSAAW webinars:

- Increased knowledge and understanding 95% delegates reported improved knowledge and understanding of safeguarding concepts and procedures.
- **Improved practice** 96.5% delegates reported that their practice will improve as a result of attending the DSAB webinar.

'Our Safeguarding Adults Charter about Equality, Diversity and Inclusion'

The Derby SAB has taken steps to ensure that their commitment to Equality, Diversity and Inclusion (EDI) is clearly communicated and accessible to all. To achieve this, the Derby and Derbyshire SABs developed an 'Easy Read version of Our Safeguarding Adults Charter about Equality, Diversity and Inclusion'.

This charter has been designed using straightforward language and visual support so that it can be easily understood by a wide range of people, including those who may find standard written information difficult to engage with. It sets out, in a clear and practical way, what Equality, Diversity and Inclusion mean in the context of safeguarding adults and explains why these principles are essential to the work of DSAB and partners.

Importantly, the charter also outlines what individuals and communities can expect from the SABs. It describes how the Boards will uphold EDI values in their safeguarding role, what actions they are committed to taking, and how they will work to ensure that everyone's voice is heard and respected. In doing so, it provides a transparent statement of intent about the Boards' responsibility to promote fairness, challenge discrimination, and create an inclusive safeguarding environment.

By producing the Easy Read charter, the DSAB is reinforcing determination to make safeguarding accessible, inclusive, and meaningful for all adults, regardless of background, ability, or circumstance.

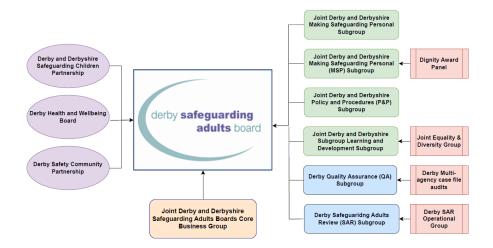
Self-assessment tool assurance form partners

During 2024-25, the Derby and Derbyshire SABs introduced the Self-Assessment Tool as a core mechanism for partner assurance. The tool was developed to provide all statutory and non-statutory partner agencies with a structured framework through which to assess the robustness of their safeguarding adults arrangements.

The Self-Assessment Tool enables organisations to evaluate their compliance with statutory duties, measure progress against safeguarding priorities, and evidence the systems and processes they have in place to protect adults at risk of harm or neglect. It also allows partners to identify areas where further development is required, ensuring that safeguarding remains a priority across both strategic and operational levels.

For the Boards, the information gained through the tool provides valuable assurance regarding the effectiveness and consistency of safeguarding practice across Derby and Derbyshire. It also facilitates constructive dialogue between partners, promotes transparency, and encourages the sharing of good practice. The outcome of this collective approach strengthens accountability, supports continuous improvement, and underpins the Boards' commitment to ensuring that safeguarding adults remains central to organisational culture and service delivery.

3.4 DSAB Subgroups:



The Board work programme is supported by its six sub-groups. Each subgroup comprising multi-agency representation across statutory and non-statutory services as well as health and social care organisations. Each subgroup is accountable to the Board in relation to achievements against the business plan and provides a highlight report for each Board meeting which focuses on the subgroups progress in respect of actions needed to implement the current Board Strategic Plan. The four key subgroups are:

3.4.1 Learning and Development (L&D) Subgroup



The Learning and Development (L&D) Subgroup is chaired by Gaz Smethem, Derbyshire Constabulary.

The Learning and Development (L&D) Subgroup is a joint function of the Derby and Derbyshire Safeguarding Adults Boards (SABs), established to ensure that staff across all partner agencies are equipped with the knowledge, skills, and confidence to deliver effective safeguarding practice. The subgroup's work has

focused on developing a consistent, multi-agency training offer, embedding Making Safeguarding Personal (MSP), and promoting quality assurance and learning from reviews.

Key Achievements

Making Safeguarding Personal (MSP)

- MSP principles were embedded across all training materials, including the Chairing Multi-Agency Meetings course and the Mental Capacity Act (MCA) training slides.
- Trauma-informed practice was a key focus this year. A training slide pack, led by Dave Ensor (DHCFT), was finalised and shared with partners. Agencies discussed implementation strategies (October 2024).

Quality Assurance and Performance

- Learning from Safeguarding Adult Reviews (SARs) and multi-agency audits was a standing item at each meeting. Agencies were encouraged to reflect on this learning and integrate it into their own training.
- Evaluation of DSAB training courses was routinely reviewed. A report compiled by the Derbyshire SAB Manager summarised attendee feedback, and Microsoft Teams Forms were used to assess the impact of webinars delivered during World Elder Abuse Awareness Day (WEAAD) and National Safeguarding Adults Week.
- EDI and safeguarding training slides were developed and finalised for use across agencies. Partners are currently confirming implementation plans.

Prevention and Collaboration

- The subgroup promoted a coordinated approach to training by asking partners to evaluate their existing packages and consider sharing them across agencies.
- Cross-cutting themes with child safeguarding and domestic homicide reviews were identified. Discussions are ongoing about delivering joint learning sessions to maximise resources and reduce duplication.
- Safeguarding Adults Week (18–22 November 2024) featured a range of webinars and training sessions delivered by partner agencies, which were well attended and positively received.

Engagement and Participation

- The subgroup met three times during the year, with a fourth meeting cancelled due to apologies. At the October 2024 meeting, the group acknowledged the contributions of former Vice Chair DI John Murphy and welcomed Karene Coleman as the new Vice Chair.
- Concerns were raised about limited multi-agency attendance at some training sessions, with attendance often limited to local authority staff. Agencies were reminded of the importance of participation, and barriers such as user profile creation were discussed.

Proposal to Disband the Subgroup

Following a review of the subgroup's Terms of Reference and the 2024–2025 action plan, it was identified that much of the L&D subgroup's work overlaps with other groups (e.g. SAR, MSP, PISG/QA subgroups, and Board office teams). The lack of a

dedicated training budget has also limited the subgroup's ability to deliver new initiatives.

No risks have been identified in disbanding the subgroup. Ongoing work has been mapped to other subgroups or Board teams, with minimal disruption anticipated. The following arrangements are proposed:

- Retain the subgroup's email distribution list to continue sharing learning and development updates.
- Convene Task and Finish groups as needed for specific training-related projects, chaired by Gareth Smethem.
- Gareth will continue to update the Board office on developments from the DDSCP Learning and Development Subgroup to support joint working and shared access to training.

This proposal will be presented to the Board on 10 July 2025, following a consultation period with subgroup members. No objections were raised.

3.4.2 Quality Assurance (QA) Subgroup



The Quality Assurance (QA) Subgroup is chaired by Andy Appleyard, Derby City Council.

The Quality Assurance Subgroup has continued in its work to ensure referrals submitted by partner agencies are appropriate, meet the thresholds for enquiries and enquiries are conducted effectively to achieve the best possible outcomes in line with people's views and personal aspirations.

Following the decision to revise the target percentage of referrals which met the threshold for investigation, ambitiously set in 2023/24, at 95%; the subgroup has seen continued improvement by all partner agencies in this area. This has been a key achievement in 2024/25 and will continue to be a specific area of focus for the subgroup as we move into 2025/26.

The development of a robust data set has proved challenging, but work has progressed in this area and subsequently we are moving towards an improved position enabling the group to gain a deeper understanding of the frequency and

prevalence of specific types of referrals which will be the platform for the development of greater prevention activities.

Multi agency cases files audits have been targeted towards specific themes including self, neglect, domestic abuse in older adults, transitions (18 to 24) from Children to Adult Services and financial abuse. These are repeated themes which enabled the subgroup to assess the level of learning and improvement from previous



audits within partner agencies. Learning LOOPs have been used to disseminate further learning and recommendations. Multi agency cases files audits in 2025/26 will focus on the most frequently reported referral types, to enhance our understanding of the factors driving these referrals.

The subgroup continues to obtain assurance from partner agencies regarding safeguarding adults processes and partners provide relevant feedback on referrals that do not meet the threshold for an enquiry. Processes and protocols have been shared amongst subgroup partners to improve practice and demonstrates the collaborative working fostered with the subgroup.

Safeguarding activity reports and KPIs for the Board are reviewed ad discussed at each subgroup meeting as part of the standard agenda. Any learning from multiagency reviews both locally and nationally such as SARs, DHRs and learning reviews are analysed, assessed and shared with partner agencies when appropriate.

Attendance at the subgroup remains high, deputies attend the meeting when required and in person meetings have taken place to further develop the working relationships between subgroup members.

We are ambitious for the subgroup in 2025/26, and I would like to take this opportunity to thanks colleagues for their ongoing work and commitment to the work we do in the subgroup.

Some of the key things achieved in 2024-25 were, which were highlighted during the April development session:

 Continued assurances obtained from partner agencies re: safeguarding adult processes.

- Learnings from multi-agency learning reviews locally and nationally, such as SARs, DHRs and learning reviews are reviewed and analysed for dissemination to partner agencies.
- Safeguarding activity reports and KPIs for the Board are reviewed and discussed at each QA Subgroup.
- Partners continue to provide feedback on cases referred that did not meet the Safeguarding Statutory Criteria.
- Undertaken multi-agency case file audits to cover themes such as selfneglect, domestic abuse in older adults, transition (18-24) and financial abuse.
 These are repeated themes to review if learning from previous audits has had an impact on agency practices. LOOPs have been used to disseminate any learning and recommendations.
- PiPoT Policy is under review following the implementation in October 2023 and feedback obtained from partners.

3.4.3 Mental Capacity Act Subgroup



The Mental Capacity Act (MCA) Subgroup is chaired by Emily Freeman, Derby City Council

The MCA Subgroup serves as a joint committee for both Derby and Derbyshire Safeguarding Adults Boards. It benefits from strong support and active participation by key statutory and non-statutory partners, with consistently good attendance. The subgroup's primary role is to promote and safeguard decision-making within

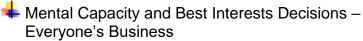
a legal framework. It empowers individuals to make their own decisions whenever possible while protecting those who lack the capacity to do so.

Meeting quarterly, the MCA Subgroup regularly reviews the Subgroup Action Plan, which aligns with the four priorities of the Derby and Derbyshire SABs: Making Safeguarding Personal, Quality Assurance, Performance, and Prevention.

Work Undertaken by the MCA Subgroup in 2024–25:

Newsletter Publication:

Successfully published three editions of the MCA Subgroup Newsletter (Issues 7, 8, and 9), which were circulated across partner organisations. These are available on the <u>DSAB website</u>. Key themes included:





- 4 39 Essex Chambers: Mental Capacity Act Resource Centre
- Capacity and the Impact of Trauma on Decision-Making
- Lasting Power of Attorney and Advance Decision to Refuse Treatment
- Law Society Guidance
- ♣ National Safeguarding Adults Awareness Week 2024

Transition and MCA:

Established a Task and Finish Group to explore and develop information for professionals on the application of the Mental Capacity Act during transition periods. This work is expected to be completed in the next financial year.

Practice Updates:

Regularly shared relevant case law and practice updates with partners to support continued professional development.

Review of Learning from Reviews:

Reviewed learning from local and national SARs, DHRs, and FFRs where the MCA was referenced, to share relevant findings with partners.

Partner Assurance:

Collected assurance from partners regarding their use and understanding of the MCA and DoLS within their organisations, including delivery of MCArelated training, via targeted surveys.

• Publications:

Published information leaflets on Lasting Power of Attorney and Advance Decision to Refuse Treatment to support awareness and understanding.

Feedback and Insight:

Considered feedback provided by advocacy services to inform subgroup discussions and developments.

Sharing Good Practice:

Partners continued to share examples of good practice, tools, and resources, and engaged in collective scrutiny of MCA and DoLS implementation across agencies.

Audit Feedback:

Considered internal audit findings from partner agencies on the application of DoLS.

While the MCA Subgroup continues to play a key role in supporting the work of both the Derby and Derbyshire SABs, there is growing recognition that MCA considerations should be embedded across all subgroups, rather than being confined to the MCA Subgroup alone. As the MCA is a golden thread running through all adult safeguarding activity, it is hoped that, moving forward, the work and learning from the MCA Subgroup will be more widely shared and integrated into the work of other subgroups across the Boards.

3.4.4 Safeguarding Adults Review (SAR) Subgroup



The Safeguarding Adults Review (SAR) Subgroup is chaired by Andy Smith, Derby City Council.

The Safeguarding Adults Review (SAR) Subgroup plays a key role in reviewing referrals to assess whether they meet the criteria for a SAR as outlined in the Care Act 2014. These reviews are a statutory requirement and aim to ensure that lessons are learned when an adult with care and support needs dies or experiences serious

harm due to abuse or neglect, and there is concern about how agencies worked together.

To support the implementation of learning, a dedicated SAR Operational Group has also been established. This group monitors and evaluates progress against action plans resulting from SARs and other relevant reviews. It ensures that key learning, both local and national, is effectively disseminated to professionals across all statutory and partner agencies.

During the 2024-25 period:

- **Derby SAR01** recommendations were monitored by the SAR Operational Group and were formally signed off in December 2024.
- **Derby SAR02** has one outstanding action remaining. The full action plan is expected to be signed off in the next financial year.
- **Derby SAR03** was commissioned in March 2024 and is currently in progress. The Independent Reviewer continues to work closely with the family to ensure their voice is heard and reflected in the final report.
- **Derby SAR04**, which also commissioned in March 2024, was signed off by the Board in March 2025. This SAR used a System Findings (SAR-SF)

methodology, focusing on broader system learning from organisational and structural influences. While the report was signed off, the SAR Operational Group is reviewing the associated questions and will propose SMART recommendations for the Board's consideration. The Independent Reviewer has engaged with the family throughout the review.

 Derby SAR05 was accepted by the SAR Subgroup in July 2024 and is being commissioned to an Independent Reviewer.

In 2024-25, one new referral was received but did not meet SAR criteria. It was recommended as a Fatal Fire Review and referred to Derbyshire Fire and Rescue Service.

It has been agreed that going forward, SARs commissioned to Independent Reviewers will be allocated across the three statutory partners.

The National Analysis of Safeguarding Adult Reviews (SARs): April 2019 – March 2023:

The National Analysis of Safeguarding Adult Reviews (SARs): April 2019 – March 2023 was published in summer 2024. This report included a review of Derby SAR01, which had been formally signed off in May 2021.

The analysis aimed to identify key priorities for sector-led improvement based on learning from SARs completed during this four-year period, which notably encompassed the COVID-19 pandemic.

Following the publication of this report, Safeguarding Adults Board Managers, Chairs, and Independent Reviewers, from across the country, have joined forces to drive progress through four key workstreams:

- Workstream 1 Developing the Evidence-Base across Four Domains
- Workstream 2 A Summit on Adult Safeguarding
- Workstream 3 Improving and Measuring the Impact of SARs
- Workstream 4 Reviewing the Care Act 2014 (ten years on)

DSAB is keen to learn from the insights and recommendations within this analysis and is committed to embedding the lessons into local practice to strengthen safeguarding outcomes for adults in Derby.

Further details about the National Analysis of Safeguarding Adult Reviews: April 2019 – March 2023 are available on the <u>Local Government Association</u> website.

3.4.5 Making Safeguarding Personal (MSP) Subgroup



The Derby City Safeguarding Adult Board's Making Safeguarding Personal (MSP) Subgroup is chaired by Bill Nicol, Derby and Derbyshire NHS Integrated Board. The MSP Subgroup became a joint Derby and Derbyshire Safeguarding Adults Boards (SABs) group in May 2024.

The primary focus of the MSP Subgroup is to raise awareness of adult safeguarding across both Derby and Derbyshire and to ensure that the voices and experiences of adults involved in safeguarding processes are used to shape practice and strengthen multi-agency collaboration.

The Subgroup is responsible for overseeing the SABs' strategic objective of embedding the inclusion of adults at risk throughout every stage of the safeguarding process. It is essential that adults receive appropriate and accessible information, enabling them to make informed decisions throughout their safeguarding journey. Wherever possible,



their views should be actively sought, respected, and prioritised. Information must be provided in various formats and from multiple sources to meet diverse needs.

Over the past year, the MSP Subgroup has remained active and made significant progress. Evidence from case file audits and the SABs' Key Performance Indicators shows improved engagement with adults and their families during safeguarding processes. These findings indicate that efforts are being made to understand and respond to the needs and desired outcomes of adults at risk.

MSP continues to be a central theme in the SABs' multi-agency training programme. In addition, steps have been taken to increase public awareness of safeguarding and the "What to Expect" leaflet. This leaflet was reviewed and updated following feedback from adults and carers.

Partner agencies also continued to use the adult safeguarding presentation to raise awareness among service user groups. Work is underway to broaden engagement

with community groups to improve understanding of safeguarding, what constitutes abuse or neglect, and how to access support for those at risk.

The subgroup developed the 'Our Safeguarding Adults Charter on Equality, Diversity, and Inclusion', which is expected to be formally adopted at the Joint SABs Development Day in April 2025.

The Communication Strategy was also updated and is now a joint Derby and Derbyshire SAB strategy. Its aim is to ensure that safeguarding information is communicated clearly, consistently, and effectively to the appropriate audiences using the most suitable channels at the right time.

The MSP Subgroup also led Derby SABs Dignity Action Day event and helped to raise awareness of the Dignity in Care agenda across the Derby and Derbyshire partnership.

Making Safeguarding Personal remains a vital and sensitive aspect of safeguarding practice. While there is still progress to be made, the Subgroup's work continues to positively influence how we understand and respond to the needs of adults at risk, supporting our commitment to keeping people safe from abuse and neglect.

3.4.6 Policies and Procedures (P&P) Subgroup



The Policy and Procedures (P&P) Subgroup is a joint subgroup with Derbyshire Safeguarding Adult Board, and is chaired by Zoe Rodger-Fox, Chesterfield Royal Hospital.

I would like to start this annual update with a Thank you to Jane Graham (Deputy Chair) along with the board manages and administrators for their ongoing support of myself and this subgroup.

This is a joint subgroup supporting the policies and procedures work of both the Derby and Derbyshire safeguarding adults board and is well attended and supported by a breadth of agencies across the city and county. Those who attend contributing not only to the meeting but take on a number of task and finish groups during the

year and without the hard work of all members the subgroup the subgroup and work produced would not be in the positive position that it is current in.

The purpose of the Joint Policies and Procedures Subgroup is to establish and review multi-agency policies and procedures and practice guidance in relation to safeguarding adults to ensure that staff are equipped to respond to safeguarding adults concerns and promote the welfare of adults with care and support needs with the aim to:

- support both SABs in meeting the requirements of national guidance/legislation and standards in service provision to safeguard adults who are in need of care and support
- identify, develop, review and promote multi-agency safeguarding adults policy, procedures and practice guidance.
- Existing guidance will not be reviewed unless there is a requirement due to;
 - o A change in legislation or statutory guidance
 - The review date has arrived
 - A formal request is made via the Board or a SAB subgroup that an amendment is
 - o required due to a factual inaccuracy.
 - Learning from a SAR/learning review/DHR/CSPR requires a change to be made to existing guidance
- promote a consistent approach to safeguarding adults across Derby and Derbyshire.
- Embed the principles of Making Safeguarding Personal within safeguarding policy and practice guidance

The Chair and deputy chair continued in role for the year with agreement from the sub-group, they are both from health services across Derbyshire and the terms of reference has been reviewed and updated where appropriate.

There has been a complete review of the monitoring process of all policy and procedure and learning was adopted following benchmarking with another SAB with the group now having review dates archive and review processes for all documents and records of this.

All policy and procedures are developed with a focus on the citizen to support the making safeguarding personal agenda and is consulted on across a range of agencies.

The subgroup has continued with the progress that has been made over the last six years with all pieces of work currently require being worked on or completed. There have been five new pieces of guidance produced this year, and the group have also made close link with the DDSCP policy and procedure subgroup with an additional two pieces of joint guidance promoting a think family approach across the city and county.

Additionally, four pieces of work have been archived as no longer require or being added to alternative sections to support in ease of access for practitioners.

	2019-21	2020-21	2021-22	2022-23	2023-24	2024-25
RED – Document needed and not yet started	10	6	4	2	0	0
AMBER – Document being worked on or awaiting sign off	11	6	4	5	5	8
GREEN – Document in Place	26	42	51	56	57	54
BLUE – Archived	N/A	N/A	N/A	N/A	3	7

2.4 Safeguarding Adults in Practice

The case of Mary and her husband Bill.

A referral came in initially from the GP for Bill, expressing that he had been making attempts to harm himself. The referral did not meet safeguarding criteria. However, the GP also included a line that Bill had commented that he "wished to take his wife with him". A check of the Adult Social Care (ASC) record revealed that Mary was fully funded by Continuing Health Care (CHC), bedbound with advanced dementia.

A safeguarding contact was raised for Mary and allocated to a worker on the same day. The allocated worker contacted various agencies: Community Mental Health Team (CMHT), GP, CHC as well as family. It was found that Mary has a large package of care at home funded by CHC, and that Bill has a small package of care managed by the local authority. However, there was still a period of time whereby Mary and Bill were left alone, therefore there was still a significant risk.

The CMH Crisis Team advised that they had been working with Bill following his attempts to harm himself, and that had been going well. This was felt to be positive. Mary and Bill have two sons: one of which was local but estranged due to Bill's behaviour, and the other who lived far away and was unable to come to Derby to support the couple. Both sons have a Lasting Power of Attorney for health and finances for their parents, and did not want Mary to move to an alternative setting (i.e. a care home) due to the disruption this would cause her.

An urgent initial enquiry meeting was convened CMHT, CHC, locality ASC, Police all present. Everyone agreed that the risks to Mary from Bill were significant. It was noted that there had been previous safeguarding concerns raised regarding Mary making allegations that she believed Bill was going to "kill her" years ago when Mary was still able to communicate. The meeting agreed that a Mental Health Assessment (MHA) for Bill may be appropriate, and agencies would await the outcome of that.

In the meantime, a meeting was convened between management in the Safeguarding Adults Team, and legal to discuss the best way forward. It was felt that as family had LPA and were objecting to Mary going into a placement away from the home, the safest and least restrictive option heading into the weekend would be to request an increase in care calls to make 24-hour care at home. This would reduce the opportunity for Bill to harm Mary.

Another urgent strategy meeting was held with all key partners involved. Bill did not meet the criteria for detention under the MHA. The extra care had been in place all weekend and Mary was safe and well.

There was further meeting working with CHC, ASC and CMHT during the same week to further assess the situation, while the couple continued to receive the additional support from carers and the Crisis Team. It was agreed by family and professionals that it was in Mary's best interest to go into a care home as a place of safety, and family were looking at identifying one close to Bill so he could visit.

This case demonstrates the strengths of the Multi-agency Safeguarding Hub in a multidisciplinary approach to a crisis to get a positive and safe outcome for the couple.

4. Activity Reports



4.1 Activity Reports:

4.1.1 Safeguarding Adults 2024-25 Data

The 2024-25 Safeguarding Adults Collection (SAC) records details about safeguarding activity for adults aged 18 and over and was amended in line with the changes brought about by the Care Act 2014.

Here is an explanation of some of the terminology used in the following data reports:

- Safeguarding Concerns: This means cases where a sign of suspected abuse or neglect is reported to the council or identified by the council. Derby City Council have captured information about concerns that were raised during 2024-25, that is the date the concern was raised with the council falls within the reporting year, regardless of the date the incident took place.
- Safeguarding Enquiries: This means the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult to a more formal multi-agency plan or course of action.
- Section 42 Safeguarding Enquiries: The enquiries where an adult meets all of the section 42 criteria.
- Other Safeguarding Enquiries: The enquiries where an adult does not meet all of the section 42 criteria but the council considers it necessary and proportionate to have a safeguarding enquiry.

The next two pages will highlight the total number of safeguarding referrals received 2024-25 with the following breakdown:

- Number of safeguarding referrals received during 2024-25
- Safeguarding enquiries started and concluded during 2024-25

Total Number of Safeguarding Referrals received in Derby during 2024-25

Age and Gender

Total Number of Safeguarding Referrals Received in 2024-25

6141

People between 18-64 received the most referrals amounting to 53%. This is the same as 2023-24.

55% of referrals were in relation to women were

whilst 45% were in relation to men.

The average population of females in Derby 50.5%

17%

Total Percentage increase in Referrals from 2023-24

Total Number of Section 42 Safeguarding Enquiries

5257

Ethnicity

2023-24	2024-25	Ethnicity
74%	68%	White / White British
2%	2%	Mixed / Multiple
5%	6%	Asian / Asian British
3%	4%	Black / African / Caribbean / Black British
1%	1%	Other Ethnic Group
15%	19%	Undeclared / Not Known

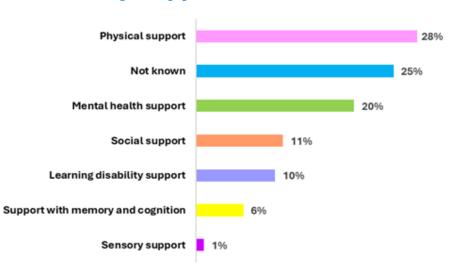
The average population of Derby who are White/White British is

73.8%

White/White British is the

largest ethnicity group for safeguarding referrals with 68%. The percentage, a decrease of 6% from the previous year

Primary Support Reasons



Referral Source

Majority of referrals were made by care homes 18.6%

1.6% of referrals were self-referrals or referrals from members of the public.

Safeguarding Enquiries concluded in Derby during 2024-25

Location of Abuse

53% of Safeguarding Enquiries concluded were where alleged abuse took place in the individuals own home. This is an increase of 2% from 2023-24.





20% of concluded referrals were where abuse took place in a care home (nursing or residential), which is a 4% decrease from 2023-24 whilst 9% were in a hospital setting.

Advocacy



22% of people who lacked mental capacity during the safeguarding process were supported by an advocate.

Making Safeguarding Personal

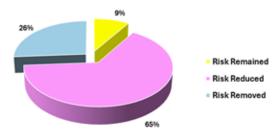
74.5% of people were asked of their desired outcomes, of which 82.4% expressed their desired outcomes.

Of those who expressed their desired outcomes, 96.5% people said they fel listened to a lot or quite a bit during the safeguarding process.

Type of Abuse

2023-24	2024-25	Type of Abuse
26%	23%	Neglect and Acts of Omission
17%	19%	Physical Abuse
14%	14%	Psychological Abuse
14%	14%	Financial or Material Abuse
10%	13%	Self-Neglect
8%	9%	Domestic Abuse
5%	4%	Sexual Abuse
3%	2%	Organisational Abuse
1%	1%	Sexual Exploitation
>1%	1%	Discriminatory Abuse
>1%	<1%	Modern Slavery

Result of action Taken



Outcomes

91% felt that following the completion of the Safeguarding Enquiries, the risk was removed or reduced. This is a

decrease of 2.5% increase in comparison to 2023-24.

4.1.2 Feedback from people with lived experiences

Thank you for taking my concerns seriously

I am glad an investigation into my concerns were completed and acted on them and made sure my relative is safe in

A lot of work was done to ensure my safeguarding concerns were raised. It has had a positive effect on the care my relative is receiving now the concerns have been addressed

Thank you for the feedback as to the actions taken to keep my relative safe. It is good to know their voice is heard

We were happy that the safeguarding incident had been investigated and that changes had been put in place to ensure our relatives safety

I am glad it was raised and that actions were put in place to maintain my safety

4.1.3 Deprivation of Liberty Safeguards (DoLS) Data – 2024-25

The Deprivation of Liberty Safeguards, often referred to as DOLS came into effect in 2009. They are part of the legal framework set out in the Mental Capacity Act 2005 to safeguard the rights of people who lack the mental capacity to make decisions for themselves.

The European Court of Human Rights established in principle that 'no one should be deprived of their liberty unless it is prescribed by law'. The Deprivation of Liberty Safeguards were subsequently introduced to ensure, that in circumstances where a hospital or care home believe it will be necessary to deprive a person of their liberty in order to deliver a particular care plan, that any deprivation of liberty:

- is in the person's best interests
- is necessary and proportionate to prevent harm
- is with representation and rights of appeal
- is reviewed, monitored and continues no longer than necessary

What amounts to a deprivation of liberty depends on the specific circumstances of each individual case. As a result, there is no single definition or a standard checklist that can be used. However, in March 2014, a landmark Supreme Court judgement set out an 'acid test' for determining whether a person is being deprived of their liberty. The judgment states that the person is being deprived of their liberty if a person:

- lacks capacity to consent to their care and treatment and
- is under continuous supervision and control and
- is not free to leave

During 2024-25, Derby City Council received: 1318 applications for DoLS.

5. Statements from Partners



5.1 Statements from Partners:

Derby City Council (DCC)

Placing people at the heart of everything we do remains our core approach in Adult Social Care. We are continually improving how we identify individuals' desired outcomes from safeguarding enquiries, work to achieve those outcomes, and reduce or eliminate the risks they face through our interventions.

The volume of safeguarding referrals Derby City Council (DCC) receives continues to grow year on year. In 2024-25, a total of 6141 safeguarding adults' concerns were received. This led to 3698 Section 42 Enquires. An increase in referrals over 844 or 16.8% from the previous year.

We recognise we are an outlier, receiving significantly higher numbers of referrals than other East Midlands authorities and our comparative authorities, in proportion to our size, demographics and socio-economic challenges. Subsequently a key focus for the Council is to work with Derby Safeguarding Adults Board partners to ensure the referrals we receive meet the criteria for an enquiry and the most appropriate action is taken to support vulnerable adults within the city.

One of the key priorities of the Derby Safeguarding Adults Board relates to prevention, which is also a key element of our refreshed Adult Social Care strategy. We have therefore worked to develop our insight potential to ensure we are aware of the types of risks people are exposed to, the settings in which these risks have an impact on a vulnerable adult as well as the profile of the individual themselves. This information is shaping the way we take forward our prevention activities and with the intention of enabling us to reduce the number of people who become a victim of abuse.

The Council continues to host the Derby Safeguarding Adults Board functions and actively participates in the work of its subgroups. The Multi-Agency Safeguarding Hub, which enhances partnership working and co-locates colleagues from the Derbyshire Constabulary, NHS, Children's and Adult's Social Care and Probation Services remains our preferred approach and set up.

The Council actively supports and promotes events led by the Board, including hosting the Annual Dignity in Action event 2025 at the Council House. The Board also delivers webinars, which are widely shared with Council staff. Notably, 28.7% of attendees on Board training sessions were Council employees.

Additionally, the Council leads and chairs the multi-agency case file audits, ensuring that any learning is shared both across the partnership and within the Council. These efforts help strengthen safeguarding practice, promote consistent learning, and improve outcomes for adults at risk across Derby.

Through the reshaping of our Adult Social Care Services, we will continue to improve our overall performance. Building upon our neighbourhood approach and deploying more of our resources in the areas with the greatest level of need, will enable us to respond to concerns more quickly, reducing risks supporting people to live the life of their choosing.

Derbyshire Police

Protecting the vulnerable is central to our policing purpose and is a continual thread through the Chief Constable's and Police and Crime Commissioner's (PCC) priorities. Performance in this area is governed at the highest levels within the organisation, through the Victims, Crime and Vulnerability Governance Board and Performance Assurance Boards, both chaired by members of the Police Executive Team.

Derbyshire Constabulary continues to improve information-sharing processes with partners to ensure the right organisation is able to provide bespoke care tailored to an individual's needs.

This year, the Force actively participated in National Safeguarding Adults Week, reinforcing our commitment to raising awareness and promoting best practice across the partnership.

Over the last two years, the Safeguarding and Coordination Hub (SCH) has delivered vulnerability training to nearly 1,300 frontline officers and staff. Training was split into seven topic areas, including an introduction to vulnerability and safeguarding, and a dedicated module on vulnerable adults. This has ensured our frontline teams have the right skills to spot early signs of vulnerability and take appropriate safeguarding action.

Derbyshire Constabulary has robust policies in place to manage allegations against Persons in Positions of Trust (PIPOT). Recent changes to the PIPOT procedure have been publicised internally to ensure staff are well informed and compliant with guidance. Allegations involving staff who may pose a risk to vulnerable people are managed by the Professional Standards Department and/or specialist investigators. The Constabulary upholds the Police Code of Ethics, ensuring that those who fall below expected standards are dealt with swiftly to maintain high quality services and public confidence.

Derbyshire Constabulary is committed to continuous learning and improvement. We continue to review and strengthen our safeguarding referral processes to partners through internal quality assurance checks, joint reviews and sharing learning with our staff for continuous improvement. Staff are encouraged to attend free training

courses provided by the Safeguarding Adults Board, which support professional development and reinforce a shared understanding of safeguarding responsibilities.

Looking ahead, Derbyshire Constabulary remains committed to the Safeguarding Adults Partnership's priorities: *Making Safeguarding Personal, Quality Assurance and Performance, and Prevention.* We will continue to invest in training, strengthen our data-led decision-making, and work collaboratively with partners to ensure adults at risk are protected, empowered, and supported.

NHS Derby and Derbyshire Integrated Care Board

The NHS Derby and Derbyshire Integrated Care Board (DDICB) Safeguarding Adult Team work in partnership with healthcare providers across the NHS to ensure that providers are meeting their statutory requirements in keeping adults at risk safe from abusive behaviour and practice.

2024-15 update:

Making Safeguarding Personal - Making Safeguarding Personal (MSP) is a key component in safeguarding practice. The ICBs Assistant Director is Chairperson of the Safeguarding Adult Board's MSP Committee and ensures that the ICB have an active role in overseeing this important work on behalf of the SAB. MSP is also a core element of the ICBs staff training programme. The ICB also collate information on current levels of MSP practice from their Safeguarding Adult Assurance Framework (SAAF) activity. A version of this is completed and assessed by all NHS care settings.

Quality Assurance - This is the primary focus of the ICBs safeguarding adult activity. Assurance and performance are monitored via the SAAF process and by attendance at NHS Trusts internal Safeguarding Boards and Committees. DDICB also provide clinical supervision to Provider Trusts safeguarding adult staff and maintain an overview of challenges, trends, and developments.

Performance - DDICB contribute to the SAB's case file audit committee and ensure that learning is disseminated across Primary Care. The DDICB also coordinate a network of GP Safeguarding Adult Leads and they contribute to our understanding via bespoke training events and lunchtime "drop in" sessions where any issues regarding performance, challenges, and outcomes can be discussed and explored.

Prevention - The DDICB are not patient facing but the importance of preventative intervention is elaborated upon in all training events and assurance assessments. Staff are positively encouraged to report and concern which may in dictate that a patient, or their family member is at risk of harm.

DDICB have introduced a PIPOT policy, and this is coordinated in accordance with SAB guidance through the human Resources Department. It is likely that the efficacy of this policy will be reviewed during 2025-26.

This has been a productive year for DDICB. We continue to be active and effective members of both SABs and their respective supporting architecture. We are members of every SAB subcommittee and contribute to a wide, and diverse range of safeguarding workstreams including Prevent, MAPPA, Domestic Abuse, Homicide & Learning Reviews etc. We continue to provide a varied staff training programme which had over 400 attendees during 2024-25. The DDICB enjoy a positive profile at both a local, and a regional level.

Department for Work and Pensions

DWP's Advanced Customer Support and Safeguarding Initiatives (2024–25)

Throughout 2024–25, the Department for Work and Pensions (DWP) has focused on enhancing support for its most vulnerable customers through Customer Experience Advanced Customer Support designed to ensure that all service lines are equipped with the necessary tools, strategies, and processes to respond to the needs of customers at every stage of their journey.

Advanced Customer Support (ACS)

ACS plays a central role in identifying and addressing barriers that prevent customers from accessing services. Its mission is to ensure that individuals who face significant challenges or risks receive timely and appropriate support. By empowering DWP staff to act decisively and compassionately, ACS aims to prevent situations from escalating into crises.

DWP staff are trained to recognize and respond to the needs of vulnerable individuals. They are supported by a comprehensive suite of guidance materials and referral pathways. When more specialized assistance is needed, a national network of Advanced Customer Support Senior Leaders (ACSSLs) is available. These leaders work closely with local and national partners to provide expert advice and connect customers with the right support services.

Additionally, the DWP Visiting Service, comprising around 600 Visiting Officers, offers in-person support to customers who are unable to access services through other means. This ensures that no one is left behind due to accessibility issues.

Supporting Customers at Risk of Harm

Mental health challenges are a common concern among DWP customers. To address this, the department has implemented structured processes for identifying and supporting individuals who may be at risk of self-harm or suicide. Whether the interaction occurs in person or over the phone, staff are trained to respond appropriately.

A key component of this response is the Six Point Plan (6PP), which outlines the steps staff should take when a customer expresses intent to harm themselves. While

DWP does not have a statutory duty of care, it embraces the principle that safeguarding is a shared responsibility. The department actively promotes signposting to professional services and organizations that can provide specialized support.

To further strengthen safeguarding efforts, DWP collaborates with partner organizations to access and share free training resources. This helps build staff confidence and understanding in dealing with complex safeguarding issues. The department takes pride in its collaborative, multi-agency approach to supporting vulnerable individuals.

Serious Case Panel (SCP)

The Serious Case Panel (SCP) serves as the highest level of governance for safeguarding within DWP. Chaired by a Non-Executive Director and including senior leaders such as the Permanent Secretary and Chief Medical Advisor, the SCP review's themes from serious cases, including Internal Process Reviews. Its goal is to ensure that lessons are learned and that support for vulnerable customers is continually enhanced. The panel is accountable to Ministers and the Work & Pensions Select Committee. More details can be found on the GOV.UK website.

Partnership with Safeguarding Adults Boards (SABs)

DWP works closely with Safeguarding Adults Boards (SABs) to identify learning opportunities through Safeguarding Adult Reviews (SARs), in line with national protocols. Even small improvements can significantly impact customers, particularly those with additional needs navigating complex systems.

The department is committed to strengthening its relationship with SABs and expanding its safeguarding protocols to include both Section 42 and Section 44 of the Care Act 2014. By participating in SARs, DWP ensures that insights from past cases inform future practices, helping to prevent similar incidents.

In summary, DWP's efforts through ACS, the SCP, and partnerships with SABs reflect a strong commitment to safeguarding and supporting vulnerable individuals. These initiatives aim to create a more responsive, compassionate, and effective service for those who need it most.

Although the Department for Work and Pensions (DWP) does not have a statutory duty to safeguard, we are committed to acting responsibly when concerns arise. If we become aware of, or are informed about, allegations involving individuals working with adults, we follow established procedures to ensure these concerns are reported through the appropriate channels.

In Derbyshire, any allegations that fall under the Person in a Position of Trust (PIPOT) framework are referred directly to me. Upon receiving such a referral, I take the necessary and appropriate steps in line with safeguarding protocols to ensure the matter is addressed effectively and responsibly.

DWP has published their first <u>annual report</u> which set out how we have delivered for customers, improved processes for identifying customers with additional needs, strengthened the capability of our people and steps taken to embed learning, particularly from serious cases.

Derby City Council - Community Safety Partnership

The Crime and Disorder Act 1998 established Community Safety Partnership (CSP's) to:

- bring together local partners
- formulate and implement strategies and plans to tackle crime, disorder, antisocial behaviour, substance misuse and re-offending in their communities.
- Identify strategic community safety problems

Additional statutory requirements:

- Domestic Abuse
- Modern Slavery
- Prevent Duty
- Public Sector Equality Duty Community Cohesion
- Serious Violence
- Victim Support Serious Violence, Domestic and Sexual Abuse

Derby Homes

Derby Homes remains strongly committed to safeguarding and promoting the wellbeing of adults at risk, including those with care and support needs, individuals facing homelessness or rough sleeping, and others made vulnerable by their circumstances. Safeguarding is a shared responsibility, and we continue to embed a culture of continuous improvement, learning, and strength-based practice.

To enhance our safeguarding framework, we appointed a dedicated Safeguarding and Compliance Manager with a background in social work. This role has strengthened leadership and accountability across services and supports our ongoing alignment with the Board's strategic priorities. We also continue to implement our safeguarding framework from the previous review, consolidating improvements and learning.

Our Safeguarding Champions model has been reviewed and refreshed. Champions are now better supported through one-to-one engagement, updated terms of reference, and a revised expression of interest process. They provide safeguarding advice within their teams, attend quarterly meetings, and ensure key messages and updates are shared throughout the organisation.

We also maintain networks of trained Workplace Domestic Abuse Champions and Mental Health First Aiders, who support staff safety and wellbeing. Domestic abuse policies are under review to ensure our approach remains robust and responsive.

Derby Homes continues to meet three key safeguarding KPIs: concerns are discussed with the adult at referral, consent is obtained, and mental capacity is considered. One KPI-ensuring referrals meet threshold criteria-is an area of focus. To address this, we are finalising a guidance document covering the threshold criteria, consent, and mental capacity to build confidence and clarity among staff.

To support ongoing improvement and assurance, we are finalising a new Peer Review Process. This will help embed reflective learning and celebrate best practice.

In 2024-2025, our organisational campaign, 'Safeguarding – The Big Picture', focused on contextual safeguarding and place-based risk. This helped strengthen coordination and multi-agency working. Our 2025-2026 campaign, 'Back to Basics', will reinforce foundational knowledge through training and policy updates, particularly

around Categories of Abuse, the Care Act 2014, Making Safeguarding Personal, and Mental Capacity.

Partnership working remains central. We continue to fund a dedicated Social Worker to support rough sleepers and facilitate a Multi-Agency Rough Sleeper Hub with local partners, ensuring joined-up interventions and shared risk management. We also work closely with the Council's Head of Safeguarding to review complex cases and extract learning.

Following the Ministerial letter to Safeguarding Adults Board regarding rough sleeping, Derby Homes has formalised the Rough Sleeper Response Manager's involvement in SAB meetings, enhancing strategic alignment. We are also embedding a trauma-informed approach across rough sleeper services-adapting engagement methods, reviewing environments, and providing staff training to improve trust and responsiveness.

Derby Homes is proud to remain DAHA accredited, demonstrating our sustained commitment to improving responses to domestic abuse. We continue to collaborate with other housing providers working towards the same accreditation, sharing learning and approaches.

All staff receive regular safeguarding training, enabling them to identify, respond to, and escalate concerns effectively. This includes recognising the complex intersections of risk for those with multiple needs, such as housing insecurity and poor mental health.

We contribute actively to key Safeguarding Adults Board subgroups, including Policy and Procedures, Mental Capacity Act, Learning and Development, Making Safeguarding Personal, and Quality Assurance-reinforcing our commitment to collaboration and improvement.

Lastly, we provide full assurance that we recognise, and report concerns appropriately concerning PIPOT (Managing Allegations Against People in Position of Trust).

Derbyshire Community Health Services (DCHS) NHS Foundation Trust

Making Safeguarding Personal - The Safeguarding Service advocates making safeguarding personal through the provision of advice/support, training and supervision. Staff are advised and encouraged to have conversations with the people of Derby City and Derbyshire that they are providing care for and/or where there is a safeguarding referral; to give the person the opportunity to voice their needs/wants, reflecting the safeguarding personal agenda.

Safeguarding supervision enables the Named Nurses and Specialist Practitioners for both adults and children to explore and reflect with staff what daily life is like for the patient/service user, their current level of need/support and how to make a safeguarding journey personal.

Quality Assurance - DCHS is a proactive member of both the Derby SAB and the Derbyshire SAB, prioritising attendance at the Board Meetings and sub-groups. The DCHS Named Nurse Safeguarding Adults, chairs the Derbyshire SAB Multi-agency Audit Group.

DCHS has demonstrated compliance with the Safeguarding Adult Assurance
Framework (SAAF), Section 11 Audit and the Markers of Good Practice, Looked
After Children Audit. DCHS is required to provide assurance that it is meeting its
safeguarding adult and children statutory requirements to the Integrated Care Board.

The DCHS Safeguarding Governance Group (SGG) provides assurance to the Quality Services Committee (QSC) and the DCHS Board. The Group meets bimonthly and provides assurance to QSC that DCHS is meeting its statutory safeguarding duty and is compliant with the Care Act 2014 and Section 11 of the Children Act 2004.

The audit schedule for 2024-2025 included the quality of referrals to adult social care, including making safeguarding personal, MCA and Deprivation of Liberty Safeguards.

Prevention - The Safeguarding Service provides advice/support to staff: this includes discussions regarding care and support/safety plans to prevent harm when

either someone makes an unwise decision and/or they don't have capacity and how to make a safeguarding referral to Social Care to enable the people that DCHS staff have contact with to be safeguarded and protected from harm.

Safeguarding supervision is recognised by DCHS as an important element of the safety culture. It provides professional advice and support to practitioners who are involved in the day-to-day work with adults and their families including promoting good standards of practice and contributes to improving outcomes for adults at risk and their families. DCHS has identified which staff groups require safeguarding adult supervision.

DCHS attends meetings where there are concerns regarding abuse, harm, domestic abuse and radicalization, as part of information sharing across agencies and includes contributing to safety plans; to reduce risk and enable access to appropriate support.

Learning from Safeguarding Adult Reviews, Domestic Homicide Reviews, Fatal Fires and Child Safeguarding Practice Reviews is actioned and disseminated throughout DCHS, to support minimizing harm and abuse.

DCHS has a Person in Position of Trust (PIPOT) policy which supports the organisation to review and investigate PIPOT concerns. PIPOT Data and outcomes are included in the DCHS Safeguarding Service Annual Report. The DCHS Safeguarding Governance Group (SGG) provides assurance to the Quality Services Committee (QSC) and the DCHS Board for PIPOT concerns.

Derbyshire Fire and Rescue Service

Making Safeguarding Personal - Safeguarding Managers actively promote MSP within the Service and ensure any referrals received by our employees that the person's wishes are at the heart of the referral.

Quality Assurance - DFRS have shared information this year on learning from SAR 04 and have given assurance on how we manage our referrals.

Performance - We ensure all Safeguarding concerns are dealt with centrally to avoid referrals that do not meet the criteria are being sent to the right pathway.

Prevention - Work with partners to share any learning from fatal fires. Ensured Learning Loops are discussed at Internal Safeguarding Meetings.

Derbyshire Fire and Rescue Service (DFRS) remain committed to the safeguarding of adults and has continued to contribute to the Board's key strategic objectives throughout 2024/25. DFRS attend and contribute to several of the subgroups including Quality Assurance, Serious Adult Reviews and MARM working group.

To support the delivery of the Safeguarding agenda we have this year published our PIPOT procedure and added this to the recruitment page of our website. Alongside this we have embarked on Safer Recruitment training for all employees and added guidance on our internal toolkits providing advice and guidance on how to spot signs of anyone who may be wishing to join the Service solely to access adults and children at risk. Furthermore, all our employees have undertaken Enhanced DBS checks providing that extra layer of assurance for partners and communities we serve.

Derbyshire Fire and Rescue Service have collaborated with Derby City Adults Board this year to support a Serious Adults Review (SAR) and actively discuss Learning Loops from other SARs within our internal safeguarding board meetings. DFRS remains dedicated to learning from incidents of abuse and disseminating throughout the organization to promote and support continual professional development.

DFRS maintains Information Sharing Agreements with several agencies to ensure that any concerns relating to fire are shared and addressed promptly. This resulted in over 5,000 safe and well checks last year.

DFRS have recently received their His Majesty Inspectorate of Constabulary and Fire and Rescue Service Report and are delighted to be recognized as 'Good' at responding to safeguarding concerns.

We have a PIPOT procedure now in place that ensures any allegations against a member of our staff and contractors will be dealt with in accordance with our Safeguarding and PIPOT policy.

Derbyshire Healthcare Foundation Trust (DHCFT)

Derbyshire Healthcare (DHCFT) is a provider of NHS mental health, learning disabilities and substance misuse (drug and alcohol) services in Derby City and Derbyshire County. We also provide a wide range of children's health services, and we run the East Midlands Gambling Harms Service. We employ 3,000 people delivering services from a number of community bases across the whole of Derbyshire and from our new inpatient units in Derby and Chesterfield. Across the County and the City, we serve a combined population of approximately one million people.

DHCFT has a strategic vision "We make a positive difference in everything we do"
Our strong values of caring, inclusivity, ambitious (high quality services) belonging
and collaboration, ensure we have a culture that embeds a person-centered
approach ensuring our patients are listened to, involved in decisions about them and
have their choices respected. Our safeguarding adult training ensures that our staff
understand and embrace the 6 principles of making safeguarding personal to
promote a preventative and safe environments where our patients can recover. We
continue to work with our services to ensure safeguarding is a golden thread
throughout our Organisation.

DHCFT demonstrates safeguarding compliance with completion of the Safeguarding Adult Assurance Framework (SAAF). We demonstrate commitment to the delivery of high standards and reporting in line with our statutory requirements and our safeguarding duties as outlined in Section 11 and SAAF and Markers of Good Practice. The Safeguarding Team reports to the Quality and Safeguarding Committee for DHCFT to offer continued assurance we are meeting our safeguarding priorities. DHCFT is a proactive member of both the Derby SAB and the Derbyshire SAB, prioritising attendance at the Board Meetings and sub-groups. DHCFT are involved in multi-agency audits and case reviews to identify strengths and areas for improvement. Learning from safeguarding incidents has been used to update policies and training.

The Safeguarding Team provides advice/support training and supervision to reflect and promote high standards of care, understanding of thresholds and escalation. We encourage our staff to be professionally curious to improve outcomes for our work

with children, families and adults in our care. Our Safeguarding Team is integrated across children and adults and transition, capturing all aspects. Think Family is integral to our safeguarding work and ethos. Safeguarding training for children and adults is separate but covers impact of both adult and child as a cross fertilisation.

DHCFT monitor and track our safeguarding mandatory training. We focus our safeguarding work on the Local Authority KPIs and have as a result have ongoing focussed work to improve our safeguarding referrals.

DHCFT works collaboratively with our system partners to identify risks. We are actively involved in Domestic Abuse Related Death Reviews, Safeguarding Adult Reviews, Fatal Fire Reviews and Child Safeguarding Practice Learning Reviews We work with our Organisation to implement learning from these by dissemination throughout the Organisation by inclusion in our monthly safeguarding information document, focussed work if required and within our training.

DHCFT has a Managing Allegations Against Staff, Carers and Volunteers Person in a Position of Trust (PiPoT) Policy and Procedure in place. This Policy is based on the Derby and Derbyshire Safeguarding Children Board and Derby and Derbyshire Safeguarding Adult Board (DSCB/DSAB's) Framework for dealing with allegations of abuse made against Trust employees, workers or volunteers in respect of children, young people and adults at risk.

DHU Healthcare

DHU Health Care is an active member of both the Derbyshire and Derby Safeguarding Adult Boards and has continued to contribute to the Board's Strategic key strategic objectives. Throughout 2024/25 DHU has proactively contributed to the boards supporting subgroups including the subgroups for Quality Assurance, SAR Operational Sub-group & Performance and Improvement.

To support the delivery of the safeguarding agenda within DHU there is a clear governance and accountability framework in place. The framework provides assurance to our commissioners that Safeguarding is a priority throughout the organisation.

Making Safeguarding Personal (MSP) – The DHU Safeguarding Team advocates making safeguarding personal. This can be demonstrated through the provision of advice, support and supervision for staff and the bespoke 'think family' training provided by the team. The bespoke training has been developed to reflect our service provision whilst meeting guidance outlined within the intercollegiate documents. The training is enhanced by a suite of easy read factsheets on our internal intranet, this is inclusive of information regarding MSP.

Quality Assurance - DHU Health Care demonstrates safeguarding compliance with completion of the Safeguarding Adult Assurance Framework (SAAF) and Section 11 Audit.

These quality assurance assessments provide opportunity to demonstrate good practice and ensures DHU are compliant in all aspects of safeguarding against specific key standards of Safeguarding inclusive of the SAB's key strategic objectives.

Safeguarding sits within the portfolio of Director of Nursing & Quality and forms part of the Quality Strategy. There are established links from the frontline to Board of Directors with clear reporting mechanisms in place via structured internal governance committees.

Performance - Safeguarding audits form a core part of the DHU safeguarding quality assurance programme and are delivered in accordance with the DHU Audit

Strategy. Audits are designed not only to monitor compliance but also to drive continuous quality improvement. Audit outcomes are aligned to key performance indicators (KPIs) and the safeguarding board expectations.

The safeguarding leads have enhanced audit processes by incorporating trend analysis and thematic reviews, supporting proactive identification of risks and system-wide learning.

Prevention - The DHU safeguarding leads are active members of the DHU Health Care Patient & Public Involvement Committee & the Clinical Quality and Patient Safety Committee ensuring Safeguarding is a consideration with all agenda items.

DHU have a robust referral system in place to refer safeguarding and low-level care concerns for adults with care and support requirements. These early help referrals provide opportunity to ensure that an individual receives the right support, thus reducing risk by enabling access to appropriate support. This demonstrates DHU commitment to interagency working to enable people in Derby & Derbyshire to live a life free from fear, harm and abuse.

DHU contributes to Domestic homicide reviews and Safeguarding adult reviews. Any learning identified within these statutory reviews are disseminated throughout the organization to promote and aid understanding and consequently improvements to service provision.

The DHU Safeguarding procedure details the organisations responsibilities regarding managing allegations against staff. All cases of concern are managed within the We do share information of concern in accordance with Safeguarding Adult Board policy. All cases requiring notification to the DBS or professional bodies are also managed in line with policy.

Diocese of Derby

The Diocese of Derby has safeguarding responsibility for over 300 churches across the diocese. Our churches are not only places of worship, but they are also an important part of the community delivering services such as children's activities, food banks, warms spaces, cafes and providing pastoral support, with a focus on reducing isolation and supporting the most vulnerable in our communities.

The Diocese support parishes to ensure preventative measures are in place to worker towards safer churches. We continue to support our volunteer Parish Safeguarding Officers who support our work in individual parishes. We respond to safeguarding referrals and liaise closely with local services to ensure a 'think family' approach is taken. The Diocese work with those who may pose a risk when worshipping in church, completing risk assessments and implementing safety plans.

Our emphasis is on creating a culture of curiosity, transparency and accountability. We continue to deliver a full programme of training for our staff and volunteers, in line with national guidance, which we track for compliance. The Diocese have our external audit June 2026-June 2027. The purpose of this audit is to make sure dioceses, cathedrals and palaces are doing all they can to create environments where everyone feels safe, valued and respected.

Making Safeguarding Personal - We are embedding Making Safeguarding Personal into our safeguarding casework, ensuring that adults at risk are actively involved in decisions about their safety and support. We have strengthened our survivor engagement approach by introducing feedback loops and support pathways that prioritise the lived experiences of those affected by abuse.

Quality Assurance - We work to the National Safeguarding Quality Standards which we are embedding in parishes to ensure consistency across the diocese. Our case work is quality assured by the National Safeguarding Team Regional Lead to identify areas for improvement and ensure compliance with national and local policies and procedures.

Performance - We collate performance data which is shared with our trustees and at the Diocesan Safeguarding Advisory Panel (DSAP). Additionally, we complete

annual returns to the National Church to ensure they have oversight and scrutiny of the work we undertake.

Prevention - There is a commitment to focus on prevention and early identification in the diocese. We have a robust training schedule which we monitor for compliance. When completing risk assessments, we work closely with statutory services.

The Diocese recognises its responsibility to respond appropriately to any concerns or allegations involving individuals in positions of trust, whether paid, voluntary, or ministerial, who may pose a risk to adults with care and support needs. Our approach is rooted in the principles of transparency, accountability, and risk management, and reflects the statutory guidance.

Key Assurance Measures:

- Internal PIPOT Process: All safeguarding concerns involving PIPOT are escalated to the Diocesan Safeguarding Officer (DSO), who liaises directly with the relevant statutory partners as appropriate to the case.
- Training and Awareness: Safeguarding staff, clergy, lay ministers, leaders, and volunteers receive training on recognising and reporting concerns involving people in positions of trust. This is nationally agreed training.
- Information Sharing Protocols: We follow robust protocols for sharing information with statutory agencies, ensuring confidentiality and safeguarding are prioritised.
- Monitoring and Review: All PIPOT cases are subject to regular review and oversight by the Diocesan Safeguarding Management Group.

The Diocese remains committed to safeguarding adults and children and ensuring that individuals in positions of trust are held to the highest standards of conduct and accountability.

East Midlands Ambulance Service (EMAS)

East Midlands Ambulance Service NHS Trust (EMAS) continues to prioritise safeguarding as an essential part of providing high quality care. EMAS has a "Think Family" approach to safeguarding ensuring all patients, staff, and members of the public is treated with dignity and respect, and all staff recognise that safeguarding is 'everyone's businesses.

EMAS as a Trust must continue to be vigilant about the evolving safeguarding agenda. Early identification and effective information sharing is key to ensuring EMAS remains compliant and reacts appropriately to safeguarding and protecting our patients. Alongside education delivery, the Trust has an active communication plan, governance framework and strong leadership to ensure the safeguarding agenda continues to be integral to patient safety and high-quality care at EMAS and that we continue to meet our statutory duties.

EMAS is represented at Derby Safeguarding Adult by the EMAS DSM-Q of the area. The EMAS Safeguarding team will attend on behalf of the DSM-Q if they are unable to attend or find a suitable divisional deputy. Information from the local boards is an agenda item at the EMAS Quality Forum with a view to considering themes across the East Midlands.

He below demonstrates some of EMAS's Key Achievements in 2024-25:

- Completed Section 11 audit tool- full compliance submission.
- Reviewed suite of safeguarding polices to ensure they are all up to date with national guidance.
- Created Bespoke Safeguarding eLearning package for 2024-2025 Essential Education.
- Created a Memorandum of understanding between EMAS and Universities regarding responsibilities in relation to allegations.
- Implemented a screening process for all CQC referrals.
- Implemented a new screening process of all referrals relating to adult mental health.
- Collaboration with OHID to create a new bi-monthly quality improvement meeting regarding the illicit drugs and alcohol pathway.
- Delivered specialist safeguarding training to student paramedics at De Montfort University (potential future work force following placement with EMAS).
- Recruited to both Safeguarding Specialist Practitioner Roles (Adults and Children).

- Reviewed collegiate responsibilities and safe staffing which resulted in amendment of job descriptions and banding in the senior safeguarding team.
- Amended the safeguarding referral section on siren to capture NHS England Ambulance Data sets.
- Created a pilot pathway in LLR to allow crews to raise referrals where there are concerns regarding mould in properties.
- Recognised for quality of work relating to Domestic Abuse, in particular praise for our Domestic Abuse Policies and pathway. Strengthened processes in EOC for non-clinical staff to escalate immediate safeguarding concerns to the clinical hub.
- Created a new multi-agency training video for child death these included colleagues from EOC, Operations, safeguarding and external partners (Police, Paediatrician, Child Death team, Community Health, and Acute Hospital).
- Engagement with the newly created Regional Safeguarding Improvement Group.
- Implemented a new process to ensure that all IR1s relating to sexual safety are reviewed by the safeguarding team to ensure appropriate support for staff.
- Delivered a number of bespoke safeguarding training sessions across the divisions in response to learning identified
- Full compliance with NHS England Data Collection Framework (Prevent and SCAT).

All EMAS staff remain engaged with the agenda and the Safeguarding Team are looking forward to the new financial year. It is a priority that the Safeguarding Team to continue to develop and maintain the engagement of staff, rise to the challenge of continued service improvement and ensuring that safeguarding remains an integral part of all service delivery. There is ongoing work required to ensure that the learning regarding the safeguarding agenda and quality of referrals is embedded.

The aim for the 2025-2026 work plan (see appendix 1) continues to strengthen the current agenda, adapting to the ever-changing landscape of health and social care alongside the needs of EMAS as an organisation.

The safeguarding work plan is fluid and there is recognition that so, planned work for 2024-2025 has been carried over. Additional work may also be added to the plan in line with national learning. The work plan will be adapted should the needs of the service require the Safeguarding Team to support in additional agendas.

EMAS has managing allegations procedures with the Designated Officer (DO) as the Head of Safeguarding. This role has been delegated to the Head of Safeguarding by Director of Quality.

The role of the DO is to coordinate and oversee individual cases on behalf of the Trust and inform and work closely internally with divisional managers and the HR Business Partner, and externally with HRBP, Police, Social Care and Local Authority Designated Officer (LADO)/ Person in Position of Trust (PiPOT) Guardian.

All managing allegations cases are presented to the Trusts Confidential Incident Review Group (CIRG). CIRG takes place weekly (case dependent), chaired by the Head of Safeguarding.

Confidential Incident Review Group (CIRG) is a forum to support multi-disciplinary and inter-team discussions for the management of allegations under Employee Relation process, Managing Allegation processes and whether the case requires notifying as a Patient Safety Incident Investigation (PSII).

Members of CIRG are responsible for ensuring the managing allegations process is adhered to, appropriate management of each case is individualised and ensure cross over between other organisational processes are aligned to prevent duplication.

Any concerns shared with the Designated Officer deemed not to meet threshold for Managing Allegations process are passed back to PALS and Division/HR management

Healthwatch, Derby

Healthwatch Derby have supported DSAB in sharing safeguarding initiatives and strategies across our networks and continue to help raise wider awareness of safeguarding plans.

Probation Service

There continues to be a renewed emphasis with our operational staff on the importance of safeguarding and this is reflected within the new requirements of professional registration.

Related training events including a Safeguarding Adults classroom event are prerequisites to Practitioners being able to register.

Safeguarding discussions are also an integral feature of supervision sessions between the probation practitioner and the senior probation officer. Alongside, this our MAPPA protocols mandate consideration of Adult safeguarding issues within all formal meetings and our assessment tool OASys also gives specific consideration to adult safeguarding issues.

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

All of the assurance and QA tools used in the Probation Service include guidance and require reference and assessment of Adult Safeguarding issues. All high risk of serious harm assessments are quality assured and counter signed by a Senior Probation Officer, all assessments identifying an individual as posing a very high risk of harm are countersigned by the Head of Service. Management oversight of cases of interest/safeguarding concerns/MAPPA are discussed in supervision sessions with staff and we promote the Touchpoints Model which is guidance for managers on where case discussion is required.

Internal assurance is provided by our national audit team, external audits are undertaken by HMIP, and we have case audits completed by our quality team.

Whilst we do not have performance measures and / or indicators regarding adult safeguarding there are expectations in relation to safeguarding and risk management planning which would be picked up by the quality assurance process described in the above paragraph.

We monitor attendance of staff at training events by recording all training on the "My learning" system. This can be viewed by their line manager. Feedback is required after all training offered and followed up in discussions within their supervision with their line managers.

A dashboard has been developed to allow line managers to monitor completion of all training including mandatory safeguarding training. At the close of the 24/25 year all staff were up to date with mandatory training including safeguarding.

Learning from local and national SARs and Domestic Homicide Reviews (DHRs) is implemented via attendance by senior managers and learning is devolved to staff via the middle manager group and through feedback to individual practitioners via the DHR process and our own Serious Further Offence process.

- Attendance at Board Level Head/Deputy Head
- Attendance at Safeguarding Adult Reviews Deputy Head
- Attendance at Subgroups being reviewed but provisionally Deputy Head/Senior Probation Officer (Safeguarding Lead)

We have a local lead and a specialist divisional team working with TACT and Prevent cases. Safeguarding is a feature of all of our assessments on PoPs. Our organisation is aware of and compliant with s.42 to s.46 of the 2014 Care Act, as well as Chapter 14 of the Statutory Guidance, both of which detail organisational responsibilities regarding adult safeguarding. We also have a formal process of our responsibility for identifying and referring incidents of potentially concerning practice which may meet Safeguarding Adult Review (SAR) criteria to your local Safeguarding Adults Board.

We have national policies and procedures with regards to the following:

- Safeguarding adults and making a referral
- Whistleblowing & management of allegations against staff
- Complaints
- Staff supervision
- Information sharing
- MCA/DoLS including 'best Interest' and consent
- Prevent
- Risk assessment & management
- Domestic abuse

In addition, our offender personality disorder project completes case formulations prepared for offender managers to assist them in working in the best way with people who may be more difficult to engage. Policies and procedures for the National Probation Service are reviewed at a national level.

Our organisational recruitment policy and procedure includes a requirement to obtain at least two references; undertake DBS checks and confirm professional registration is still current. Staff are expected to adhere to a code of conduct for any professional body they might be a member of. The NPS ensures that all staff are aware of their personal responsibility to report safeguarding concerns as well as ensuring that poor practice is identified and improved. Our 'new starter' induction programme ensures that staff and volunteers are made aware of their adult safeguarding responsibilities. All staff are required to undertaken mandatory training which is in e-learning and face to face classroom events. Reflective practice sessions are offered to all staff with service user roles.

Equalities are promoted both in terms of our staff group and in relation to our work with our service users. This includes mandatory training events.

Actions from PIPOT processes are shared with PDU Heads to take forward and address via staff supervision and management. No relevant actions have been reported. Out of work conduct is a key aspect of the Civil Service Code of Conduct and features in training and briefing of all staff.

University Hospitals of Derby and Burton NHS Foundation Trust (UDBH)

Making Safeguarding Personal - The Safeguarding Adult Team supported and raised awareness to frontline staff who were encouraged to speak with the patient, gained consent to make a safeguarding referral wherever possible, managing the risk and balancing autonomy with their duty of care, and ensuring all practicable steps were undertaken. Making safeguarding personal was reiterated within level 3 safeguarding training, reflected in the increasing safeguarding referrals received, supported by safety planning, documentation of evidence which includes communication & handovers within departments and quality assured by the Safeguarding Adult Team.

Additionally, UHDB developed a 1-year role for a Clinical Educator to deliver domestic abuse and sexual violence training across the Trust, a suite of awareness raising tools have been developed and disseminated to the emergency pathway, wards and outpatient areas. An Independent Domestic Violence Advisor from Glow, holding a UHDB Honorary contract, supports the health & well-being service with advice and guidance for individual staff victims of domestic abuse and provides a consultation service.

Quality Assurance - UHDB completed 247 safeguarding referrals to Derby City MASH, 88.26 % met the safeguarding criteria, 27 referrals did not meet the criteria. Similarly, 6 monthly safeguarding audits of referrals were undertaken and demonstrated good compliance with thresholds, appropriate management of cases where threshold not met and sharing of information regarding and referral to community health safeguarding teams.

360 Assurance identified significant assurance in the Trust MCA processes and policy. The MCA educator team project concluded in June 2024, the responsibilities of the team were amalgamated in the Safeguarding Adults Team, alongside successfully recruiting two members from the MCA to the Adult Team.

The Safeguarding Adult Team continued to increase visibility across all 5 sites at UHDB to offer guidance, support and advice regarding safeguarding, MCA assessments, best interest and DoLS, to frontline staff within inpatient and outpatient

areas. 24/25 has demonstrated a substantial increase of 334 urgent DoLS authorisations, which were quality assured by the Safeguarding Adult Team.

Urgent Dols authorisations

- Year 23/24 = 1092
- Year 24/25 = 1426

E-learning was redeveloped, which was included in the induction required training and 2 face-to-face sessions offered twice monthly. Quarterly MCA audit continued which were reported into the Trust Safeguarding Group, MCA and Consent Steering Group.

Performance - Safeguarding Adult Team continued to respond to Section 42 (Care Act 2014) enquiries, when this event / incident was alleged to have happened in the hospital which UHDB describe as a "referral against the Trust". We have responded to 81 section 42 enquiries received across all local authorities within the year.

Themes commonly include hospital acquired tissue viability issues, unexplained bruising, discharge and information sharing concerns. Information is disseminated to senior divisional and leads to cascade to appropriate teams, information is shared within internal governance.

The Team will implement quarterly thematic review of section 42 referrals in 2025-26 and support the Discharge Improvement project with relevant information from the section 42 referrals.

Prevention - Level 3 safeguarding (adults and children's) is mandatory for all patients facing clinical staff and was a full day face to face training session (or available via eLearning specifically commissioned for UHDB). With over 13,000 staff at UHDB, training compliance across the Trust is a significant issue. Compliance with safeguarding training is as follows; Level 1 - 94%, Level 2 - 75%, Level 3 (which also includes level 1 & 2 competencies) is - 89%.

UHDB responded to 7 SAR scoping requests from local and regional Safeguarding Adult Boards, and we have been required to undertake 1 Individual Management Reviews (IMRs). Completed 3 submissions to the SAR subgroup to request consideration for undertaking a SAR.

UHDB responded to 18 scoping requests for DARDR and no IMR's have been requested to be undertaken. UHDB also responded to 2 scoping requests for Fatal Fire Learning Reviews - 1 were not known to UHDB, and 1 SAR was then referred to as a Fatal Fire Learning Review.

The Trust has a policy regarding managing allegations against staff. All cases of concern are managed within the Oversight of Professional Standards Group (Nursing and midwifery registrants, AHPs and others) and the Responsible Officers Forum for medical staff. We do share information of concern in accordance with Safeguarding Adult Board policy. All cases requiring notification to the DBS or professional bodies are also managed in line with policy.

University of Derby (UoD)

The University of Derby is committed to ensuring that safeguarding is experienced as a supportive and empowering process rather than a purely procedural one. Making safeguarding everyone's responsibility and person centered is central to our approach, ensuring that students, staff and all members of our community are listened to, involved in decisions about their support, and able to shape outcomes that matter to them.

We have strengthened our student-centred processes through the Support to Participate in University Life (SuPUL) procedure, which ensures interventions are built around each individual's circumstances. This approach not only supports students but enables them to remain engaged with their studies and broader university life.

Student voice is integral to this work. Through surveys, workshops, and coproduction activities, students have identified both areas of strength and areas where they feel less safe, such as public spaces around campus. Their feedback has directly shaped preventative measures and reinforced our belief that safeguarding must be collaborative.

We also recognise that certain groups face distinct challenges. For example, young men have highlighted barriers to seeking support for mental health difficulties. In response, we have introduced dedicated wellbeing initiatives that reflect the diverse needs of our community, helping ensure that safeguarding remains responsive and personal.

Robust governance and assurance structures underpin safeguarding at the University of Derby. The Safeguarding Committee provides oversight of policy, practice, and training, reporting into our senior governance bodies to ensure accountability. This model allows safeguarding to remain both strategically aligned and operationally embedded.

Training and professional development also play a key role in assuring quality. A refreshed e-learning module, accessible to all staff, has been widely completed, while new face-to-face training has offered deeper engagement with the realities of managing disclosures. Staff have reported greater confidence and clarity in applying

safeguarding procedures, showing that quality assurance is not simply about compliance but about embedding culture and confidence across the organisation.

Our Local Safeguarding Officer (LoSO) model has continued to provide visible leadership across campuses, ensuring that expertise is accessible where it is most needed. This distributed approach reinforces safeguarding as everyone's responsibility, supported by trained colleagues with enhanced skills.

The University continues to see a rise in safeguarding activity, reflecting both the growing complexity of student life and the increased awareness and confidence of students and staff in raising concerns. While the scale of reporting has increased, this is viewed positively: it demonstrates that safeguarding is visible, accessible, and trusted within our community.

The most frequently encountered issues relate to mental health, wellbeing, and relationships. These are consistent with national higher education trends but also highlight the importance of local context, particularly for students who may be living away from home for the first time. Our role is not only to respond to crises but also to provide the reassurance that students are not navigating these challenges alone.

Our performance is measured not simply by volumes of reports but by the impact of our interventions. Many students who have engaged with safeguarding processes continue successfully in their studies, which underlines the value of timely, compassionate, and effective support. For staff, performance is also about having the right tools, knowledge, and networks to respond confidently, something that our training and governance processes continue to reinforce.

Prevention remains at the heart of our safeguarding strategy. We believe that the most effective safeguarding happens before a concern reaches crisis point. Across 2023/24, we have developed a range of initiatives that strengthen early identification and proactive support. Our digital monitoring systems allow us to identify emerging risks quickly, while awareness campaigns have embedded safeguarding messages into induction programmes and ongoing communications. These initiatives not only provide information but also encourage students to see safeguarding as part of everyday life at university.

Preventative work also extends into our partnerships. The University collaborates

with statutory and voluntary agencies across Derby and Derbyshire, ensuring that students can access specialist support when needed. This partnership approach allows us to respond holistically to issues such as domestic abuse, substance misuse, and exploitation.

Staff training is another preventative measure. By equipping staff with the skills to notice early signs of distress and the confidence to respond, we create an environment where safeguarding concerns are less likely to escalate. Our culture emphasises curiosity, care, and communication, ensuring that prevention is woven into every interaction.

Safeguarding at the University of Derby is about nurturing a culture where every student and member of staff feels safe, supported, and able to thrive. By strengthening our quality assurance, measuring impact as well as activity, and focusing on prevention, we are confident that our approach reflects both the priorities of the Boards and the lived realities of our community.

5.2 Concluding Statement: Derby SAB Business Manager – Sana Farah



As we bring this annual report to a close, it is important to pause and reflect on the journey that Derby Safeguarding Adults Board has travelled over the past year. Safeguarding requires persistence, openness, and the courage to confront the challenges we face. This year has shown us that when agencies, communities, and individuals come together with a shared purpose, we can make a real and lasting difference to the safety and wellbeing of adults at risk.

The report has highlighted both the progress made and the challenges that remain. Safeguarding cannot be the responsibility of any single organisation. It is built on partnership, on listening to each other, sharing learning, and holding ourselves to account. It is also built on prevention, ensuring that we are not only responding when harm occurs, but actively creating the conditions where people are supported earlier, where risks are reduced, and where lives can be lived with dignity, safety, and independence.

Looking forward, the Board remains committed to building on this foundation. Our priorities will continue to be informed by the voices of people, by evidence of what works, and by a commitment to equality, diversity, and inclusion.

On behalf of the Board, we would like to extend our sincere thanks to everyone who has played a part in safeguarding adults across Derby during 2024–25. From frontline workers and volunteers to partner agencies and community groups, your dedication, care, and commitment have been vital in helping to protect those most at risk. Safeguarding cannot be achieved in isolation; it relies on the strength of our partnerships, the willingness to learn from one another, and the shared belief that every adult has the right to live free from harm. By working together, we continue to build safer, more supportive communities where adults can live with dignity, independence, and security.

"DSAB is committed to promoting equality. The DSAB aspires to remove the barriers of institutional discrimination and oppression in Safeguarding Adults practice across the city.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. Safeguarding Adults is everybody's business. Everybody is different and diversity will be celebrated and respected. Everybody will be treated fairly, with accessible information, advice and support to help stay safe and maintain control of their lives."

If you have any comments or feedback, or if you would like a copy of this report in large print, or in an alternative language or format, please contact us:

Contact Derby SAB

DSAB@derby.gov.uk

Derby Safeguarding Adults Board website

Appendix 1: Derby SAB Board Membership 2024-2025

1. Derby SAB Independent Chair

Richard Proctor Independent Chai	Derby Safeguarding Adults Board
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2. Derby SAB Vice-Chair

3. Derby SAB Board office staff

Sana Farah	Derby Safeguarding Adults Board Manager	Derby Safeguarding Adults Board					
Milo Bennett	Derby Safeguarding Adults Board Administrator	Derby Safeguarding Adults Board					

4. Derby SAB Board members statutory partners – Derby City Council Adult Social Care, Derbyshire Constabulary, Derby and Derbyshire Integrated Care Board

Andy Smith	Strategic Director	Derby City Council Adult Social Care and Health	Deputy – Andy Appleyard
Dean Howells	Chief Nurse	Derby and Derbyshire Integrated Care Board	Deputy – Tracy Burton, Bill Nicol, Michelle Grant
Christopher Marriott	Detective Superintendent, Head of Public Protection	Derbyshire Constabulary	

5. Derby SAB Board non-statutory members but part of the wider partnership of the Board

Louise Barlow	Head of Operations	East Midlands Ambulance Service
Carl Tring-Willis	Head of Housing Management	Derby Homes
Tumi Band	Director of Nursing and Patient Experience	Derbyshire Healthcare NHS Foundation Trust
Clive Stanbrook	Area Manager for Community Safety	Derbyshire Fire and Rescue Service
Cllr Alison Martin	Councillor	Derby City Council
Elaine Summers	Head of Safeguarding	Derbyshire Community Healthcare Service
Lisa Marriott	Head of Safeguarding	Diocese of Derby
James Moore	Chief Executive Officer - Healthwatch	Healthwatch, Derby
Jane O'Daly-Miller	Head of Safeguarding and Vulnerable People	University Hospitals of Derby and Burton NHS Trust
Joe Rhodes-Orwin	Head of Delivery, Policy & Strategy	Derbyshire Office of the Police and Crime Commissioner
Julie Tomlinson	Lead Nurse Safeguarding Adults	DHU Health Care CIC
Karen Hartley	Advanced Customer Support Senior Leader	Department for Work and Pensions
Bob Bearne	Probation Service Officer	The Probation Service
Sarah Duncanson	Inspection Manager	Care Quality Commission
Sarah Davis	Registered Manager	DeCA
Purjinder Gill	Service Manager	Community Safety, Derby City Council
Sarah Richardson	Head of Student Services	University Of Derby

Appendix 2: DSAB meeting attendance monitoring form 2024-2025

Key	
	Attended
Α	Apologies received
	Did Not Attend

Date of Board meeting	Derby City Council Adult Social Care & Health (DCC ASCH)	Derby and Derbyshire Integrated Care Board (DDICB)	Derbyshire Constabulary	Care Quality Commission (CQC)	DerbyCarers Association (DeCA)	Derby Homes	Department of Working Pensions (DWP)	Derby City Council Community Safety Partnership	Derbyshire Community Health Services Foundation Trust (DCHS)	Derbyshire Fire and Rescue (DFRS)	Derbyshire Healthcare NHS Foundation Trust (DHCFT)		DHU Health Care Commnity Interest Company (DHU CIC)	East Midlands Ambulance Service NHS Trust (EMAS)	Healthwatch Derby	Office of the Police & Crime Commissioner (OPCC)	Probation Service	University Hospitals of Derby & Burton NHS Foundation Trust (UHDB)	University of Derby (UoD)
23/05/2024					N/A	Α										А			
24/07/2024					N/A			Α		Α									
29/10/2024					N/A		А	А				Post vacant							
10/03/2025					А								А						

































2024-25 Annual Report

Derby Safeguarding Adults Board

01332 642961

October 2025

DSAB@derby.gov.uk

http://www.derbysab.org.uk/