Derbyshire
Safeguarding Adults
Board

ANNUAL REPORT 2024-2025

Introduction from the Independent Chair

Welcome to the Derbyshire Safeguarding Adults Board (DSAB) Annual Report for the period April 2024 to March 2025. This has been a time of change for the DSAB. My predecessor Andy Searle retired after being in post as DSAB Independent Chair for several years. On behalf of all DSAB colleagues I want to thank Andy for his commitment and professionalism in all he has done within the safeguarding adults' arena locally. I commenced in role as the new Independent Chair mid-January 2025 and spent a large part of the last months of the reporting period familiarising myself with DSAB structures and meeting key Partners.

In the last year as well as a change of Chair, DSAB underwent another significant change. In spring 2024, the joint Board arrangements with Derby City Safeguarding Adults Board reverted to individual Board areas following consultation with Partners across the City and County. Whilst both SABs will now focus on our own individual areas, we remain committed to working collaboratively on many linked workstreams. I saw this demonstrated early in my new role as DSAB Chair in the planning of a joint development session for the City and County SABs. We also had many constructive discussions with Derby colleagues regarding our refreshed strategic plans and priorities, which will cover the period April 2025 to 2027. Next year's annual report will illustrate the progress made against the new three-year plan for Derbyshire.

In 2024-2025 work focused on three priorities: Making Safeguarding Personal, Prevention, Quality Assurance and Performance. I have been assured that these priorities have been at the centre of the work of DSAB throughout the year along with a focus on the six principles of Adult Safeguarding: these being Empowerment, Protection, Prevention Partnership, Proportionality, and Accountability.

Safeguarding adult referrals across the county have continued to rise and the more focused approach now available through a single Board structure is enabling us to scrutinise data and other information in order that we can identify trends and challenges regarding all referrals and respond appropriately.

We have continued to facilitate Safeguarding Adult Reviews (SARs) to ensure the most serious incidents are examined leading to learning and good practice being identified and shared.

I have noted that supporting our Partners and the wider network of people working to safeguard adults in Derbyshire has been a strength during the last year. Several newsletters and learning briefs have been produced and other innovative ways used including an animation to ensure all colleagues can remain informed and aware of the very latest developments in the safeguarding adults landscape.

We are as always grateful to the Partners who commit their valuable time and energy to the DSAB. Personally, I am thankful for the warm welcome made to me as I start my DSAB journey. The support and assistance provided to me, in particular by my Core Business Group colleagues and from the DSAB Board Manager has been very much appreciated. Please take time to read this Annual Report as it evidences the huge amount of work over the last year completed by partner agencies across Derbyshire to enable people to make choices to stay safe and to live a life free from fear, harm, and abuse.

Amanda Clarke

Independent Chair, Derbyshire Safeguarding Adult Board

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Derbyshire demographic information

Derbyshire, centrally located in England and spanning **630,366 acres**, is a diverse county comprising both urban centres and rural landscapes. As of **2023**, the population stands at **811,449**, marking a **1.8% increase** since 2021. Projections suggest this will rise to **896,100 by 2043**.

In 2018, **22%** of residents were aged 65+, expected to reach **27% by 2043**. Since 2011, the number of people of retirement age has grown by **23% (32,800)**, outpacing the national increase of **20.1%**.

In 2017, Derbyshire had **347,200 households**, accounting for **17%** of East Midlands households. This is projected to grow by **9% (32,300 households)** by 2028, slightly above the national estimate of **8%**. There has been a notable rise in one-person households which are expected to reach **33% by 2043**:

The population is **51% female** and **49% male**. The 2021 Census introduced new data on gender identity and sexual orientation, with **0.29%** of residents aged 16+ identifying with a gender different from their sex at birth, below the national average of **0.55%**.

Over the past decade, there has been a **42% (10,800)** increase in non-UK born residents, exceeding the national rise of **33.6%**. In 2022, **6.3% (50,300)** of the population identified as being from Black and Minority Ethnic (BME) backgrounds.

Information source: Data Stories - Derbyshire Observatory

Governance and legislative context

The Care Act 2014 made the forming of a Safeguarding Adults Board (SAB) a statutory requirement of a local authority from April 2015. The Local Authority, Integrated Care Board (ICB) and Police are required to be statutory members of a SAB, but Derbyshire SAB, like many other SABs, has a larger membership of agencies (See Appendix 1). SABs are independent which enables them to provide effective scrutiny of local adult safeguarding arrangements. The effectiveness of a SAB is reliant on collaborative working between Board members and partner agencies and other local and regional boards. Agencies are placed under a duty by the Care Act 2014 to cooperate with the SAB.

The appointment of a SAB Independent Chair is the responsibility of the local authority in consultation with statutory partners.

The Board has three statutory functions

Annual Report	Publication of an Annual Report detailing the activity of the Board over the previous year.
Strategic Plan	Production and publication of a plan setting out how the Board will meet its agreed strategic objectives.
Safeguarding Adult Reviews	Undertaking Safeguarding Adult Reviews (SARs) in accordance with Section 44 of The Care Act 2014

In addition to its statutory duties, SABs play a vital role in **preventative and developmental safeguarding** across Derbyshire. Their wider responsibilities include:

Policy and Practice Development

Regular review and enhancement of multi-agency safeguarding policies, procedures, and guidance to ensure consistency and effectiveness of safeguarding practice. Derbyshire and Derby City Safeguarding Adults Boards have joint safeguarding adults Policies and Procedures.

Training and Workforce Development

Ensuring that frontline staff and managers across partner organisations have access to high-quality, role-relevant training that positively influences safeguarding practice.

Embedding the Making Safeguarding Personal principles

Identifying and sharing examples of effective safeguarding where **Making Safeguarding Personal (MSP)** principles have been successfully applied.

Community Awareness

Raising public awareness about recognising and reporting abuse and neglect through accessible formats and multilingual resources.

Partnership Challenge

Constructively challenging partners to deliver high-quality safeguarding services

Collaboration

Working collaboratively with partner agencies and other strategic partnerships to improve wellbeing. These partnerships include;

- Derby Safeguarding Adults Board
- Derby and Derbyshire Safeguarding Children Partnership
- Derbyshire and Derby Health and Wellbeing Boards
- Derbyshire and Derby Safer Communities Boards
- National and Regional Safeguarding Adults Board Managers Networks
- National Independent Chairs Network

Safeguarding Principles

The Care Act 2014 sets out six principles that underpin all adult safeguarding work. Derbyshire SAB treats each principle as equally vital to effective safeguarding:

Empowerment: Supporting individuals to make informed decisions and give consent.

Prevention: Acting before harm occurs, embedding safeguarding into everyday practice.

Proportionality: Responding in the least intrusive way appropriate to the risk.

Protection: Providing support and representation for those in greatest need.

Partnership: Working collaboratively across services and communities to prevent, detect, and respond to abuse and neglect.

Accountability: Ensuring transparency and clarity in safeguarding practices

Strategic Plan and Priorities 2024-2025

The Derbyshire SAB Strategic Plan for 2024-2025 is centred around our vision and mission.

Our vision

The DSAB partnership will support and enable people in *Derbyshire* to make choices to stay safe and to live a life free from harm, abuse, and exploitation. We will work together to enable people in Derby and Derbyshire to make choices to stay safe and to live a life free from fear, harm, and abuse.

Our mission

The DSAB partnership will listen, learn, support, and challenge each other to achieve the best possible outcomes for people in Derbyshire by putting the person at the centre of everything we do throughout the safeguarding processes.

Our vision and mission include people who are placed or living out of county and our cross-border responsibilities in line with our policies and procedures.

Our strategic priorities

The Derbyshire SAB has agreed four strategic priorities for 2024-2025.

Making Safeguarding Personal (MSP)

We will work to ensure that the person is at the centre of every interaction. This means listening, engaging, and understanding what the person wants to achieve and agreeing, negotiating and recording their desired outcomes, working with them or their advocate to see how these can be realised, and asking whether their expectations have been met.

Prevention

We will continue to develop and implement preventative strategies that seek to reduce the prevalence of abuse and neglect in Derbyshire which will clearly demonstrate how success and impact will be measured.

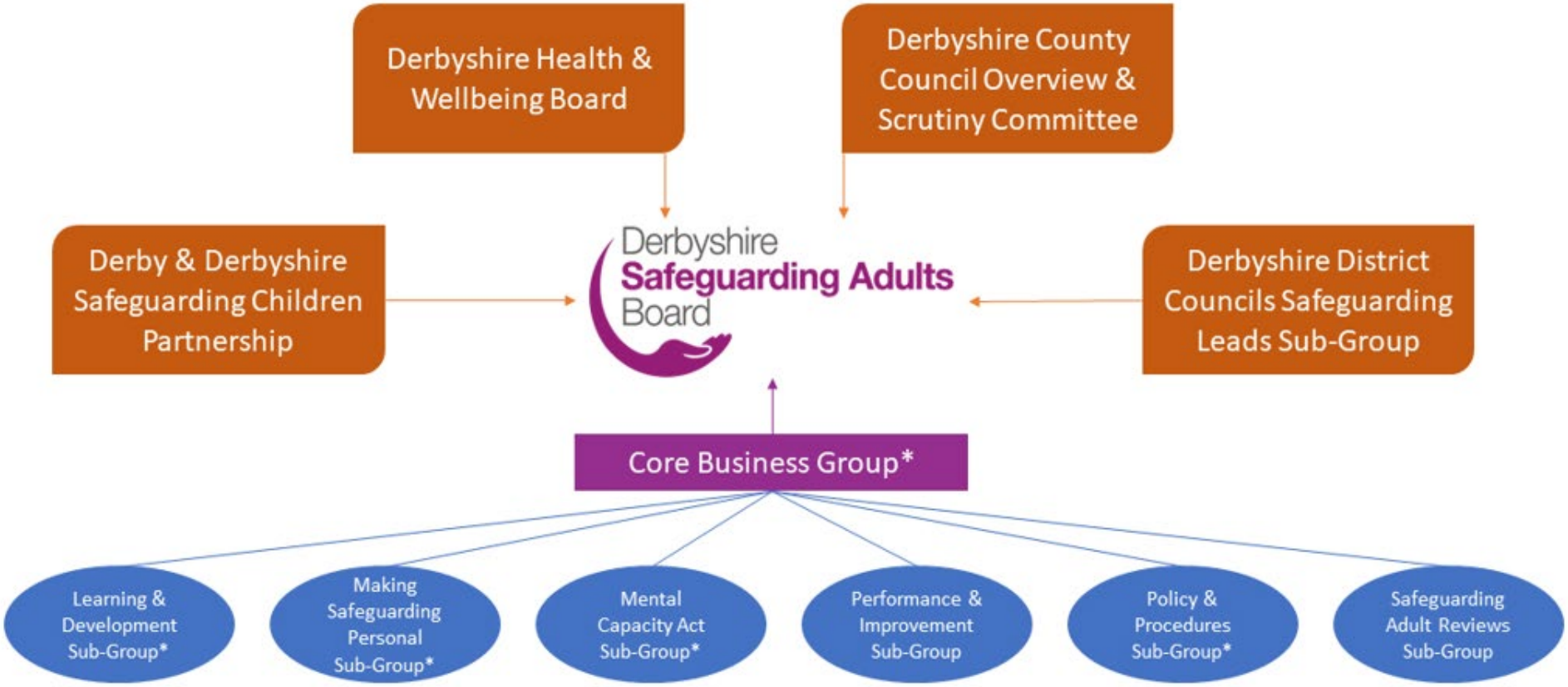
Performance

We will work with Board partners to ensure that the Board and all safeguarding adults processes are effective and compliant with relevant legislation and best practice guidelines.

Quality Assurance

We will develop and implement systems to seek assurance that all partners have robust processes and arrangements in place to safeguard adults at risk in Derbyshire and that learning from Safeguarding Adult Review and other quality assurance processes is implemented.

Derbyshire Safeguarding Adults Board Structure Chart



* Indicates a joint sub-group with Derby City

Subgroups and working groups

The Derbyshire SAB operates through a structured framework of subgroups and working groups to deliver its strategic priorities effectively. Each subgroup maintains a dedicated action plan to demonstrate how its work supports the DSAB's strategic priorities. Subgroup chairs provide quarterly updates to the Board for oversight and assurance.

The groups supporting the DSAB during 2024-2025 are:

- **Safeguarding Adult Review (SAR) Sub-Group**
  Oversees the commissioning and management of SARs in line with statutory duties (S.44 of the Care Act 2014).
- **Performance and Improvement Sub-Group (PISG)**
  Monitors and analyses performance data, oversees audit activity, and leads assurance exercises to promote continuous improvement.
- **Core Business Group (CBG)**
  Coordinates the delivery of the Board's core functions.
- **Learning and Development Sub-Group (L&D)**
  Develops and promotes safeguarding training and learning opportunities.
- **Mental Capacity Act Sub-Group (MCA)**
  Supports implementation and awareness of the Mental Capacity Act across partner organisations.
- **Policy and Procedures Sub-Group (P&P)**
  Ensures safeguarding policies and procedures are current, consistent, and effective.
- **Making Safeguarding Personal (MSP) Sub-Group**
  Seeks to embed person-centred approaches in safeguarding practice.
- **Multiagency Adult Risk Management (MARM) Working Group**
  Has a quality assurance focus on both strategic and operational matters related to the MARM process.
- **Financial Abuse Working Group**
  Focuses on prevention, detection, and awareness raising in relation to financial abuse and scams.
- **Equality, Diversity and Inclusion Working Group**
  Promotes inclusive safeguarding practices.

Derbyshire SAB Budget

Derbyshire SAB is funded by its statutory partners; Derbyshire County Council, Derbyshire Police, and Derby and Derbyshire ICB.

Derbyshire SAB Budget Contributions 2024-2025

Derbyshire County Council Adult Care	£50,749.02
Derby and Derbyshire ICB	£50, 749.02
Derbyshire Police	£50,749.02

Total Contributions	**£152,247.06**
Total Amount Spent	**£147,021.39**

Safeguarding Adult Reviews (SAR) expenses

SAR expenses are not included within the main Derbyshire SAB budget expenditure and are instead split three ways between the three statutory partners of the Derbyshire SAB when a SAR is completed. The total expenditure for safeguarding adult reviews during 2024-2025 was **£23,796.00**

Multiagency Adult Risk Management (MARM) hoarding grant

The MARM hoarding grant is used to provide practical support for people who are being supported via the MARM process. This grant is funded by Derbyshire County Council Adult Social Care, Derbyshire Fire and Rescue Service, and Derby and Derbyshire ICB.

MARM Hoarding grant 2024-2025	
Total Contributions	**£15,000**
Total Amount Spent	**£15,000**

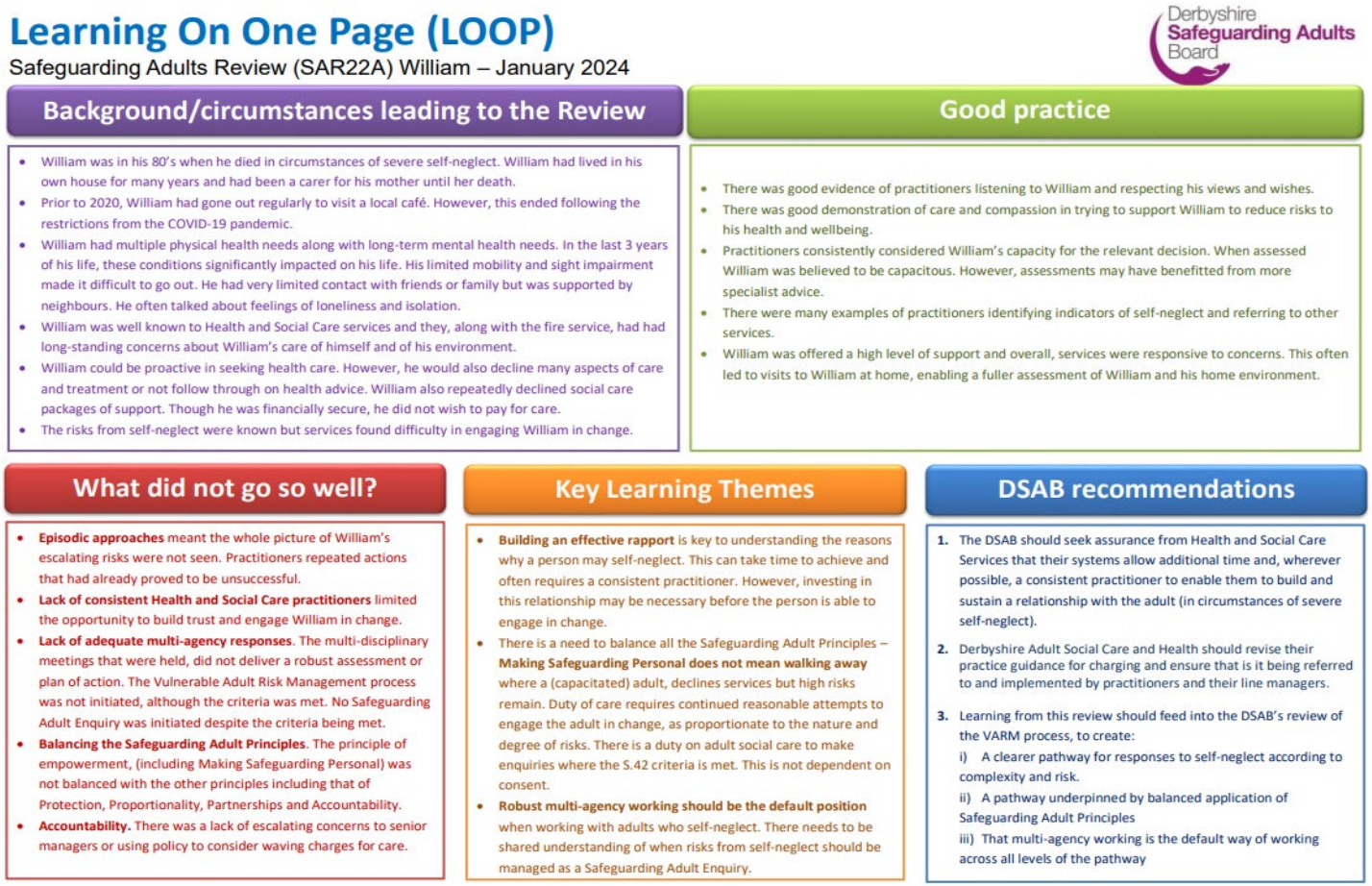
Safeguarding Adult Reviews published 2024-2025

During 2024-2025 two Safeguarding Adult Reviews were completed and published on the Derbyshire SAB website in relation to William (SAR22A) and Karolina (SAR23B).

SAR22A 'William' publication

In May 2024, learning resources including a Learning Brief, Learning On One Page, and an animation were published and shared across the partnership following the completion of the Safeguarding Adults Review in relation to 'William'.

William, a White British man died in his eighties following a fall at his home. Prior to his death, William had been living in circumstances of self-neglect. Three recommendations were made in this SAR, and work completed to embed the learning included the launch of a new self neglect toolkit for front line staff and managers across all agencies to support them to achieve the best possible outcomes when working with adults who are at risk of harm due to self-neglect.



Learning On One Page (LOOP)

Safeguarding Adults Review (SAR22A) William – January 2024

Derbyshire Safeguarding Adults Board

Background/circumstances leading to the Review

- William was in his 80's when he died in circumstances of severe self-neglect. William had lived in his own house for many years and had been a carer for his mother until her death.
- Prior to 2020, William had gone out regularly to visit a local café. However, this ended following the restrictions from the COVID-19 pandemic.
- William had multiple physical health needs along with long-term mental health needs. In the last 3 years of his life, these conditions significantly impacted on his life. His limited mobility and sight impairment made it difficult to go out. He had very limited contact with friends or family but was supported by neighbours. He often talked about feelings of loneliness and isolation.
- William was well known to Health and Social Care services and they, along with the fire service, had had long-standing concerns about William's care of himself and of his environment.
- William could be proactive in seeking health care. However, he would also decline many aspects of care and treatment or not follow through on health advice. William also repeatedly declined social care packages of support. Though he was financially secure, he did not wish to pay for care.
- The risks from self-neglect were known but services found difficulty in engaging William in change.

Good practice

- There was good evidence of practitioners listening to William and respecting his views and wishes.
- There was good demonstration of care and compassion in trying to support William to reduce risks to his health and wellbeing.
- Practitioners consistently considered William's capacity for the relevant decision. When assessed William was believed to be capacitous. However, assessments may have benefitted from more specialist advice.
- There were many examples of practitioners identifying indicators of self-neglect and referring to other services.
- William was offered a high level of support and overall, services were responsive to concerns. This often led to visits to William at home, enabling a fuller assessment of William and his home environment.

What did not go so well?

- **Episodic approaches** meant the whole picture of William's escalating risks were not seen. Practitioners repeated actions that had already proved to be unsuccessful.
- **Lack of consistent Health and Social Care practitioners** limited the opportunity to build trust and engage William in change.
- **Lack of adequate multi-agency responses**. The multi-disciplinary meetings that were held, did not deliver a robust assessment or plan of action. The Vulnerable Adult Risk Management process was not initiated, although the criteria was met. No Safeguarding Adult Enquiry was initiated despite the criteria being met.
- **Balancing the Safeguarding Adult Principles**. The principle of empowerment, (including Making Safeguarding Personal) was not balanced with the other principles including that of Protection, Proportionality, Partnerships and Accountability.
- **Accountability.** There was a lack of escalating concerns to senior managers or using policy to consider waving charges for care.

Key Learning Themes

- **Building an effective rapport** is key to understanding the reasons why a person may self-neglect. This can take time to achieve and often requires a consistent practitioner. However, investing in this relationship may be necessary before the person is able to engage in change.
- There is a need to balance all the Safeguarding Adult Principles – **Making Safeguarding Personal does not mean walking away** where a (capacitated) adult, declines services but high risks remain. Duty of care requires continued reasonable attempts to engage the adult in change, as proportionate to the nature and degree of risks. There is a duty on adult social care to make enquiries where the S.42 criteria is met. This is not dependent on consent.
- **Robust multi-agency working should be the default position** when working with adults who self-neglect. There needs to be shared understanding of when risks from self-neglect should be managed as a Safeguarding Adult Enquiry.

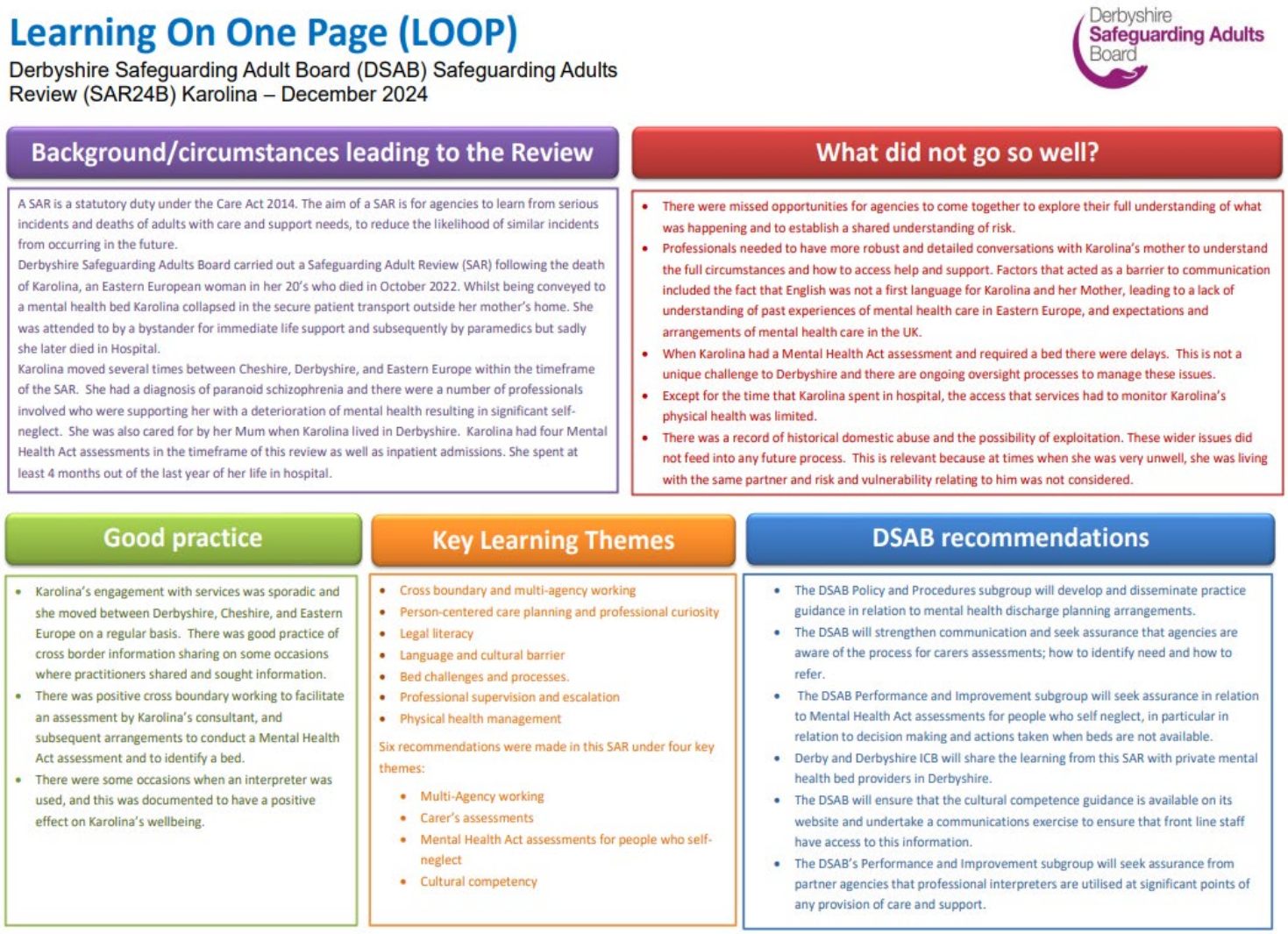
DSAB recommendations

1. The DSAB should seek assurance from Health and Social Care Services that their systems allow additional time and, wherever possible, a consistent practitioner to enable them to build and sustain a relationship with the adult (in circumstances of severe self-neglect).
2. Derbyshire Adult Social Care and Health should revise their practice guidance for charging and ensure that is it being referred to and implemented by practitioners and their line managers.
3. Learning from this review should feed into the DSAB's review of the VARM process, to create:
   i) A clearer pathway for responses to self-neglect according to complexity and risk.
   ii) A pathway underpinned by balanced application of Safeguarding Adult Principles
   iii) That multi-agency working is the default way of working across all levels of the pathway

SAR23B ‘Karolina’ publication

In February 2025, a Learning Brief and a Learning On One Page (LOOP) were published and shared across the partnership following the completion of the Safeguarding Adults Review in relation to ‘Karolina’. Karolina was an Eastern European woman who died in her twenties whilst being conveyed to a mental health bed. Karolina had a diagnosis of paranoid schizophrenia and had been living in circumstances of self neglect following a deterioration in her mental health.

Six recommendations were made in the SAR, and work undertaken to embed the learning has included the development of guidance for staff in relation to equality, diversity and inclusion and cultural competency.



Learning On One Page (LOOP)

Derbyshire Safeguarding Adult Board (DSAB) Safeguarding Adults Review (SAR24B) Karolina – December 2024

Derbyshire Safeguarding Adults Board

Background/circumstances leading to the Review

A SAR is a statutory duty under the Care Act 2014. The aim of a SAR is for agencies to learn from serious incidents and deaths of adults with care and support needs, to reduce the likelihood of similar incidents from occurring in the future.

Derbyshire Safeguarding Adults Board carried out a Safeguarding Adult Review (SAR) following the death of Karolina, an Eastern European woman in her 20’s who died in October 2022. Whilst being conveyed to a mental health bed Karolina collapsed in the secure patient transport outside her mother’s home. She was attended to by a bystander for immediate life support and subsequently by paramedics but sadly she later died in Hospital.

Karolina moved several times between Cheshire, Derbyshire, and Eastern Europe within the timeframe of the SAR. She had a diagnosis of paranoid schizophrenia and there were a number of professionals involved who were supporting her with a deterioration of mental health resulting in significant self-neglect. She was also cared for by her Mum when Karolina lived in Derbyshire. Karolina had four Mental Health Act assessments in the timeframe of this review as well as inpatient admissions. She spent at least 4 months out of the last year of her life in hospital.

What did not go so well?

- There were missed opportunities for agencies to come together to explore their full understanding of what was happening and to establish a shared understanding of risk.
- Professionals needed to have more robust and detailed conversations with Karolina’s mother to understand the full circumstances and how to access help and support. Factors that acted as a barrier to communication included the fact that English was not a first language for Karolina and her Mother, leading to a lack of understanding of past experiences of mental health care in Eastern Europe, and expectations and arrangements of mental health care in the UK.
- When Karolina had a Mental Health Act assessment and required a bed there were delays. This is not a unique challenge to Derbyshire and there are ongoing oversight processes to manage these issues.
- Except for the time that Karolina spent in hospital, the access that services had to monitor Karolina’s physical health was limited.
- There was a record of historical domestic abuse and the possibility of exploitation. These wider issues did not feed into any future process. This is relevant because at times when she was very unwell, she was living with the same partner and risk and vulnerability relating to him was not considered.

Good practice

- Karolina’s engagement with services was sporadic and she moved between Derbyshire, Cheshire, and Eastern Europe on a regular basis. There was good practice of cross border information sharing on some occasions where practitioners shared and sought information.
- There was positive cross boundary working to facilitate an assessment by Karolina’s consultant, and subsequent arrangements to conduct a Mental Health Act assessment and to identify a bed.
- There were some occasions when an interpreter was used, and this was documented to have a positive effect on Karolina’s wellbeing.

Key Learning Themes

- Cross boundary and multi-agency working
- Person-centered care planning and professional curiosity
- Legal literacy
- Language and cultural barrier
- Bed challenges and processes.
- Professional supervision and escalation
- Physical health management

Six recommendations were made in this SAR under four key themes:

- Multi-Agency working
- Carer’s assessments
- Mental Health Act assessments for people who self-neglect
- Cultural competency

DSAB recommendations

- The DSAB Policy and Procedures subgroup will develop and disseminate practice guidance in relation to mental health discharge planning arrangements.
- The DSAB will strengthen communication and seek assurance that agencies are aware of the process for carers assessments; how to identify need and how to refer.
- The DSAB Performance and Improvement subgroup will seek assurance in relation to Mental Health Act assessments for people who self neglect, in particular in relation to decision making and actions taken when beds are not available.
- Derby and Derbyshire ICB will share the learning from this SAR with private mental health bed providers in Derbyshire.
- The DSAB will ensure that the cultural competence guidance is available on its website and undertake a communications exercise to ensure that front line staff have access to this information.
- The DSAB’s Performance and Improvement subgroup will seek assurance from partner agencies that professional interpreters are utilised at significant points of any provision of care and support.

The Board will continue to monitor progress made following the learning points identified in both Safeguarding Adult Reviews until all work has been completed

Derbyshire SAB achievements and progress 2024-2025

SAB Self Assessment tool pilot December 2024

Category and standard *(Please select one of the rag ratings for each question-either Green, Amber, or Red by marking a X in the relevant box) and then use the 'work to be done' section to add a free text summary of the current position of your organisation)*	Evidence to support that the organisation completely meets ideal service/standard	Nearly meets ideal service/standard, clear improvement plan	Does not meet ideal service/standard and no clear improvement plan	Work to be done to achieve ideal service/standard; or explanation why the agency is unable to complete the standard	Not applicable to the organisation (type N/A)

The Self Assessment aims to provide all SAB organisations across Derby and Derbyshire with a framework to assess, monitor and/or improve their Safeguarding arrangements and in turn will support both the Derbyshire and Derby City SABs in assessing the effectiveness of safeguarding practice. A shorter version was developed for agencies who complete a SAAF audit to avoid duplication. Responses are being reviewed in the new financial year with a view to the self assessment taking place every two years moving forward.

Newsletters

Five Derbyshire SAB newsletters were produced and published on the Derbyshire SAB website. Two MCA newsletters were also produced by the Joint Derby and Derbyshire MCA subgroup to support frontline staff with understanding and applying the principles of the Mental Capacity Act.

Reviewed and updated practice guidance

The Policy and Procedures subgroup reviewed and updated, or creating new guidance on the following subjects.

Reviewed and updated practice 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

New practice guidance

- 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

Derbyshire and Derby SAB Self Neglect Toolkit

The Derby and Derbyshire SAB self-neglect toolkit and case closure checklist was launched in November 2024. It was produced following learning identified in a Safeguarding Adult Review (SAR22A) to support practitioners working with people due to self-neglect concerns. The self-neglect toolkit case closure checklist aims to ensure that agencies have explored all opportunities to safeguard the person, and helps practitioners to understand how working with other agencies can improve outcomes for people who self-neglect.

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

Updates were made to the Safeguarding Adults What to Expect leaflet to ensure it is also accessible and useful for carers following feedback from carers groups in Derbyshire. The leaflet provides an explanation of the safeguarding process in a clear and straightforward way. It is something the person or their carer can 'own', use to write down their thoughts and desired outcomes in relation to the safeguarding process, and refer to at any point during the safeguarding process.

New safeguarding adults electronic referral form

On the 25th July 2024, the Derbyshire safeguarding adults electronic referral form was launched. The form is for referrals from professionals only. The electronic referral form can be saved at the point of submission by the referrer to allow referring agencies to store a copy of the safeguarding adult referral on their own recording systems. Although the word document option for submitting referrals is still available we encourage referrers to use the electronic version of the form as it is designed to be much more user friendly and will also assist with improving data capture and data quality.

Trader News - a newsletter for tradespeople focusing on safeguarding members of the public

Trader News was published and shared with the District Councils Safeguarding Leads subgroup and members of the Derbyshire County Council Trusted Trader scheme in July 2024. It is a safeguarding factsheet for tradespeople who visit people's homes. Workers who enter homes to carry out their work, may be in a position to notice and report signs of neglect, exploitation and abuse, thereby playing an essential role in keeping members of the public safe.

Derby and Derbyshire SAB Multi-Agency Training

The training course, ‘Chairing multi-agency meetings’ is a joint course for Derbyshire and Derby City Safeguarding Adults Boards, hosted by the Derbyshire County Council electronic system, Derbyshire Learning Online. The course is available for all professionals working for partner agencies across Derbyshire and Derby City, including the voluntary sector.

Key learning outcomes for this course are listed below:

- Explore how to plan and chair multi-agency meetings where someone is at risk, whilst maintaining the values that underpin Making Safeguarding Personal.
- Consider how to chair meetings to best practice standards, applying relevant legislation and guidance, including information sharing protocols.
- Discuss how to prepare for a meeting, ensuring that participants are clear about their roles and what outcomes are to be achieved.
- Recognise and practice a range of interpersonal skills to manage the meeting and achieve specified outcomes for individuals.
- Identify some of the things that may go wrong in meetings and consider what actions can be taken to ensure the meeting remains focussed.

Ten sessions took place during 2024-2025 with 301 practitioners in attendance.

Scams Awareness Week 21-27 October 2024

During Scams Awareness Week 2024, members of the Financial Abuse Working Group arranged and delivered events and activities, including a webinar for practitioners, a face-to-face public event, and a social media campaign. Colleagues from Derbyshire County Council's Community Safety Unit and Derbyshire Police produced a podcast that examines the tactics employed by criminals to target individuals with investment scams. Chesterfield Royal Hospital hosted a scams awareness event in the main foyer at the hospital on 21st October 2024. Members of the public were able to speak with representatives from the hospital, Derbyshire Police and England Illegal Money Lending Team about scams and how to avoid them. The Derbyshire SAB hosted a Scams Workshop online on 22nd October 2024 for practitioners as a “Lunch and Learn” session. The workshop was presented by Rachel Daniels from Derbyshire County Council Trading Standards and Vicky Powers, a Public Health Practitioner for Financial Inclusion with Derbyshire County Council.

National Safeguarding Adults Week Webinars 18-22 November 2024

During National Safeguarding Week 2024 the Derby and Derbyshire SABs arranged eight webinar sessions aimed at front-line practitioners and managers working for partner agencies across Derby and Derbyshire. The webinars focused on the following subjects to support the theme for the week, 'Working in Partnership to Create Safer Cultures'.

- 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

The webinars were attended by a total of 420 professionals during the week. A special edition newsletter was published with articles in relation to the above themes.

To mark Safeguarding Adults week, the Derbyshire SAB Board manager wrote a poem about Making Safegauding Personal which was published in the special edition newsletter and shared with partner agencies.

Derbyshire Safeguarding Adults Board

Making Safeguarding Personal Poem

For safeguarding adults practice to shine, we should tailor our approach, every time.

Outcomes discussed and views recorded; personalisation is the way we move forward.

Whilst working together to keep people safe, remember each person is different, we should work at their pace.

Think about the extra help someone might need- advocates, interpreters, easy read.

Ask what we did well, where can we improve? So we give the best service, with barriers removed.

Remember the initials 'MSP'-make every interaction the best it can be.

Natalie Gee, DSAB Board Manager

Derbyshire SAB Website

The Derbyshire SAB website www.DerbyshireSAB.org.uk contains a wide range of information and resources for both the public and professionals.

During the year 2024-2025 the website had **78,377** pageviews.

Section or Page	2024/2025 pageviews
Safeguarding adult referrals	10,669 (+9%)
Homepage	10,260 (-28%)
Persons in a position of trust (PIPOT)	3,965 (-26%)
Leaflets and posters	3,091 (+188%)
Vulnerable Adult Risk Management (VARM)[1]	3,061 (-40%)
Adult safeguarding decision-making guidance	1,988 (+19%)
Professionals section	1,837 (-34%)
Safeguarding Adult Reviews	1,678 (+73%)
Training courses	1,552 (-21%)
Section 42 enquiries	1,313 (-12%)

Derbyshire SAB social media @DerbyshireSAB

The Derbyshire SAB office team use social media to advertise Board events and projects as well as raising awareness about recognising and reporting abuse and neglect and promoting information about a range of safeguarding topics. Social media campaigns took place during World Elder Abuse Awareness Day 2024, National Safeguarding Adults Week 2024 and Scams Awareness Week 2024. The numbers of X followers at the end of March 2025 was **1013.** The number of Facebook followers was **597**. During the period 1st April 2024 to 31st March 2025, there were 5.5k views of content from or about Derbyshire SAB Facebook page, which represents an increase of 81.3% from 3k for the previous year, 2023/2024.

[1] Known as Multiagency Adult Risk Management (MARM) from 1st January 2025.

Subgroup activity 2024-2025

Core Business Group
Chairs: Amanda Clarke and Richard Proctor

The DSAB Core Business Group is a subgroup of both Derbyshire and Derby City SABs with membership from the Independent Chairs of Derbyshire and Derby City SAB, the Derbyshire and Derby City SAB Board managers and the statutory partners of the two Boards.

The purpose of the Core Business Group is to;

- inform and agree the agenda for each Board meeting.
- discuss and follow up on SAB Business in between Board meetings.
- co-ordinate the production and implementation of the SABs Business Plans.
- monitor the effectiveness of the SABs and their subgroups in relation to safeguarding adults in Derbyshire and Derby City, bringing good practice/areas for further scrutiny to main Board.
- monitor the effectiveness of processes and areas that are routinely reported to the SABs.
- establish and monitor financial arrangements for the SABs.

The core business group meets quarterly as a minimum in between Board meetings.

The Learning and Development Subgroup

Chair: Gareth Smethem (Derbyshire Police)

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 Kerene 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.

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. 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.

The Mental Capacity Act (MCA) Subgroup

Chair: 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 DSAB website. Key themes included:

- Mental Capacity and Best Interests Decisions – Everyone's Business
- 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 MCA-related 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.

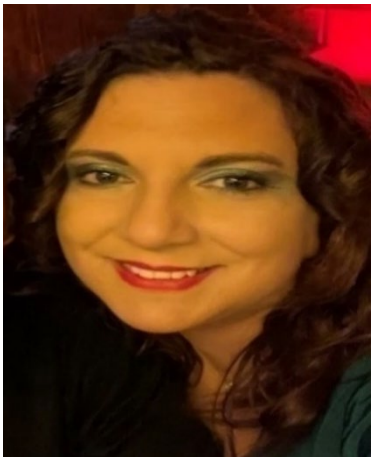
Audit Feedback

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 safeguarding adults 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.

The Policy and Procedures Subgroup

Chair: Zoe Rodger-Fox, Chesterfield Royal Hospital NHS Foundation Trust.



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 whom attending 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;
    - 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
    - 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 procedure is 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 have 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.

	2019-2020	**2020-2021**	**2021-2022**	**2022-2023**	**2023-2024**	**2024-2025**
RED Document required and not started yet	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

The Derbyshire Safeguarding Adults Review (SAR) Subgroup
Chair: Lynne Hyland, Derbyshire County Council, Adult Social Care

The SAR Sub-group continues to play a pivotal role in ensuring that learning from Safeguarding Adults Reviews (SARs) is embedded across all partner agencies. The group meets quarterly, is well attended and includes representatives from DSAB partner agencies.

Four SAR referrals were received during the reporting period, with one progressing to full review.

Published Reviews

• SAR 22A – "William" (Published May 2024): Accompanied by a nationally shared animation developed in collaboration with the police, this review has received widespread positive feedback.

•SAR 23B – "Karolina" (Published February 2025): Supporting materials, including a Learning on One Page and a Learning Brief, have been widely disseminated. An animation is currently in development.

Learning from External Reviews

The group has also reviewed and actioned learning from SARs conducted in other areas, such as the Bexley SAR "Aaron and Millie," with assurance work completed to support local implementation.

Collaborative Learning and Integration

The SAR Sub-group continues to strengthen its links with other review processes including:

• Domestic Homicide Reviews (DHRs): Regular updates and thematic learning are shared through DCC Community Safety's participation in the sub-group.

• LeDeR Programme: Ongoing collaboration includes attendance at SAR panels where appropriate, with shared learning across all review mechanisms.

Priorities for 2025–2026

• Finalise and publish learning from SAR 23A and SAR 24A.

• Appoint a reviewer and initiate the SAR 25A process.

• Enhance quality assurance and impact evaluation mechanisms for SARs.

• Develop integrated learning resources, combining themes from SARs, DHRs, and LeDeR, accessible via the DSAB website.

• Ensure alignment of the SAR Sub-group action plan with the strategic priorities of the Derbyshire Safeguarding Adults Board.

The Multi Agency Adult Risk Management (MARM) Working Group

Chair: Debbie Yoxall, Derbyshire Police

From 1st January 2025, the Vulnerable Adult Risk Management process (VARM) was renamed as the Multiagency Adult Risk Management (MARM) process to reflect the language within the Care Act. The DSAB MARM Working Group has a focus on both strategic and operational matters relating to the VARM process. A separate MARM annual report for 2024-2025 has been produced containing statistical data and qualitiative information in relation to MARM and can be requested via emailing DerbyshireSAB@derbyshire.gov.uk.

DSAB MARM Working Group Key Achievements 2024-2025

- Quarterly MARM data reports were produced and presented to the MARM working group for discussion and analysis.
- The Group carried out a piece of work to ensure all the MARM documentation is accessible, and the "MARM What to Expect" leaflet has been translated into Russian, Polish, Romanian, Ukrainian, Simplified Chines, and Urdu.
- Two MARM newsletters were produced and shared across the partnership during 2024-2025.
- In July 2024 an audit to review the support provided to non-white British people in the MARM process was undertaken, and a further MARM case file audit took place in November 2024.
- In 2024-2025 a peer review was initiated with Sandwell Safeguarding Adults Board, where professionals from both SABs observed MARM meetings. This piece of work is still on-going, and the learning will be disseminated later this year.
- Staff within the Derbyshire County Council adult social care training team delivered a webinar version of the MARM briefing training during 2024-2025 with 608 professionals receiving the training from the following agencies.

Derbyshire SAB Financial Abuse Working Group

Chair: Katy Pugh, Age UK Derby and Derbyshire

The DSAB financial abuse working group met twice during 2024-2025. The group has a well-established virtual network and regular communication takes place to share information about financial scams, resources and campaigns. A suite of information is available on the DSAB website which can be used by the public and professionals to learn about the risks and how to access support. The group coordinated communications and activity for scams awareness week in October 2024 which is featured with this annual report.

Derbyshire District Councils Safeguarding Leads subgroup

Di Parker- North East Derbyshire District Council

The Derbyshire Districts Safeguarding Leads Subgroup (DDSLSG) is a subgroup of the Derby and Derbyshire Safeguarding Children Partnership (DDSCP) and the Derbyshire Safeguarding Adults Board (DSAB).

The DDSLSG seeks to promote and safeguard the welfare of all children and adults at risk within Derbyshire.

- To support the DDSCP and DSAB in fulfilling their statutory duties by working to ensure effective coordination, cooperation and implementation within partners working at district / borough areas.
- To promote consistency of high quality, effective safeguarding practice across Derbyshire.
- To provide a local forum where Councils and their partners working across district / borough areas can meet collectively to achieve positive outcomes for children and vulnerable adults.
- To provide two-way communication between attendees and the DDSCP/DSAB.

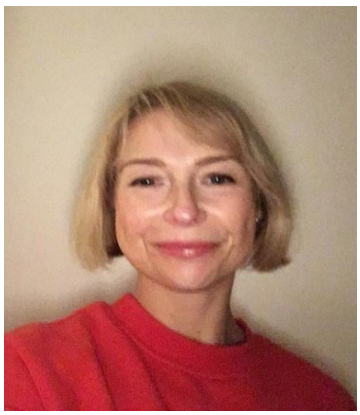
The subgroup recently reviewed the Terms of Reference to identify future direction, engagement and priorities. The key priorities identified were already relevant and in line with the current agenda, this includes: training, best practice, partnership working, health issues, sharing learning, Safeguarding challenges and issues and alignment with the Safeguarding Board Priorities. However, the review highlighted future work surrounding performance data areas of risk and referral trends and the impact of the Local Government Review (devolution from the White Paper). All of which are now incorporated onto the group's agenda.

In addition to the Terms of Reference review the group also reviewed the current Action Plan to ensure that it is fit for purpose.

Training has been a positive collaboration between agencies, including Safeguarding Training provided by Derbyshire County Council, attended by the subgroup members and their colleagues. Also guest speakers from the Derbyshire Healthcare NHS Foundation Trust attended a subgroup meeting to raise awareness of Mental Health and the pathways to services. Both of which gave a better understanding of the available support and referral process.

Work is ongoing with regards to understanding the number of Asylum Seekers placed in accommodation in Derbyshire and the associated potential Safeguarding risks.

The Performance and Improvement subgroup
Chair: Gemma Poulter Derbyshire County Council Adult Social Care



There has been good and consistent attendance at the subgroup meetings by most members; however, a small number of members have not attended subgroup meetings.

The work of the sub-group has been focused in 2024/2025 on the following areas:

Performance and Assurance

An overview of the adult safeguarding data collected by individual agencies represented in the PISG has been gathered; the DSAB performance data supplied by Derbyshire County Council has been monitored with action agreed and taken to improve the report's accuracy and to delete obsolete key performance indicators, and to identify areas for focused activity; monitoring Multiagency adult risk management (MARM) data.

Identification of thematic issues in completed agency self-assessments to inform future activity; review of Risk 1, DSAB risk register, in relation to the continued increasing volume of referrals and feedback obtained from partners around work undertaken to mitigate this risk; multi agency audits completed via the multi-agency audit group (PISG members with additional representatives invited- theme dependant) and learning on one-page summaries produced:

- 12th June 2024 – use of advocacy in S42 enquiries
- 4th September 2024 – hate crime
- 5th December 2024 – domestic abuse where the family carer is the alleged perpetrator
- 5th March 2025 – modern slavery

Key learning themes identified included a lack of clarity regarding meeting titles and their purpose resulting in a guide being produced, and learning around cultural competency which resulted in equality, diversity and inclusion and safeguarding practice guidance being developed (approved by the P&P subgroup in March 2025). Positive practice was also highlighted resulting in compliments made via the DSAB office to colleagues working for adult social care and DCHS.

Making Safeguarding Personal and Prevention

Learning from Derbyshire Community Health Service's making safeguarding personal audit was shared in May 2024 and the Derbyshire County Council making safeguarding personal report was also shared which contained feedback and learning themes from people with lived experience.

Focused activity has been completed to improve individual agencies' oversight of the feedback received from the local authority in relation to adult safeguarding referrals given the disconnect between the local authority's good performance and agencies' identification of this area as a weakness in the local authority's inspection by the Care Quality Commission in April 2024.

Usage of the "Safeguarding Adults; What to Expect" leaflet and of the electronic referral form for adult safeguarding has been monitored with corresponding action to improve functionality and usage, and thematic learning from multi-agency audits and safeguarding adult reviews (SARs) has been monitored with action agreed and delivered to implement and embed associated improvement and change, and monitoring of impact.

Priority Areas of work for 2025-2026

• Focused work to ensure that DSAB activity contributes to improved safety for Derbyshire residents given the continued significant increase in safeguarding referrals, including analysis of data regarding repeat referrals for the same category of abuse within 12 months and development and delivery of associated action plan.

• Development of a set of KPIs to enable monitoring of the impact of the DSAB's delivery of its 3-year strategic plan.

• Review of subgroup membership.

• Continued monitoring of, and action to implement, thematic learning from multi-agency audits, safeguarding adults reviews, and feedback

• Ongoing quality assurance of the quality and impact of safeguarding procedures via performance reports, agency self-assessments, audits, safeguarding adults reviews and feedback.

The Making Safeguarding Personal (MSP) Subgroup

Chair: Bill Nicol, Derby and Derbyshire ICB

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.

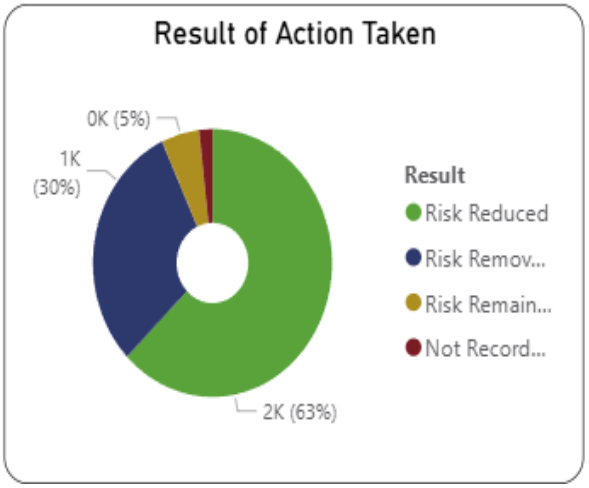
The Communication Strategy was also updated and is now a joint Derby and Derbyshire SAB strategy. Its aim is to ensure that safeguarding information is communicated clearly, consistently, and effectively to the appropriate audiences using the most suitable channels at the right time.

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.

Derbyshire SAB Safeguarding adults' data 2024-2025

Safeguarding Activity Overview



- **Safeguarding adult referrals**: 7,467 (↑11% from previous year).
- **S.42 enquiries**: 2,420 with a conversion rate of **32.41%**
- **Outcomes:** In **93%** of cases, it was recorded that the risk of harm to the adult was completely removed or was reduced.
- **Multiagency Adult Risk Management (MARM:** 208 people supported.

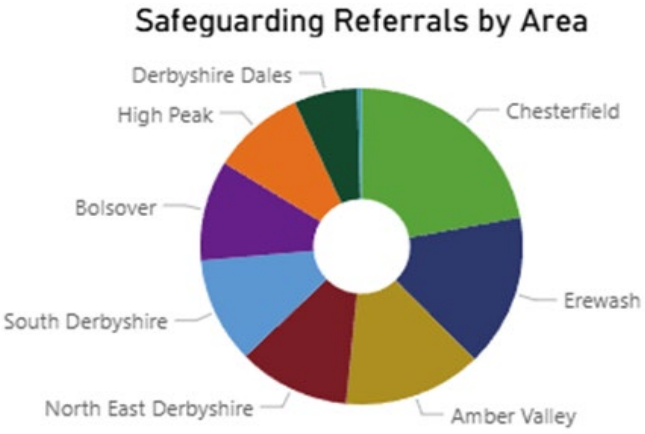
Demographics

- **Age**: 61% of referrals were for adults aged 65+ (↓1% from previous year).
- **Gender**: 57% of referrals were for women; 42% for men (1% not known).
- **Mental Capacity**: 39% of people referred lacked capacity at the point of referral;
- **Ethnicity**: 93.6% White British; 1.5% White (other), 2% from ethnic minority groups, 3% not known or not recorded.

Referral Source

- **Highest referral sources**: Care homes (34%), hospitals (9%), DCHS (7%).
- **Self/family/public referrals**: 4.3% (↑1% from previous year).

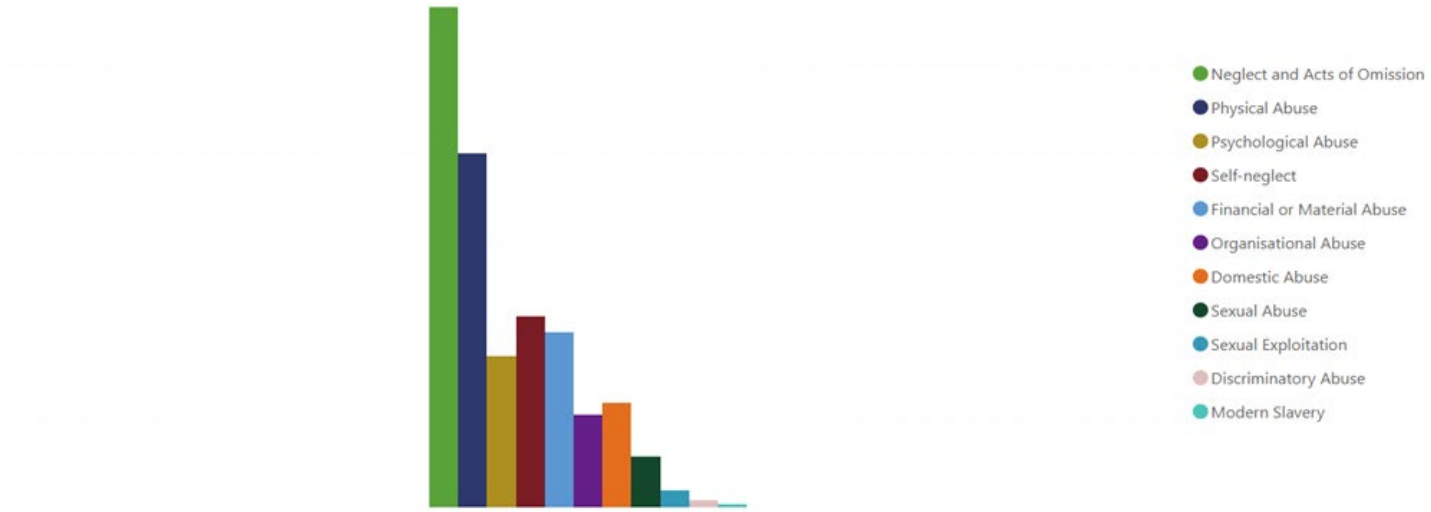
Locality, type, and location of abuse



Referrals by locality area: Chesterfield (22%), Erewash (15.6%), Amber Valley (13.9%), North East Derbyshire (11.2%)

Most common types of abuse: Neglect (30.5%), physical abuse (21.5%), self-neglect (11.6%), financial abuse (10.6%).

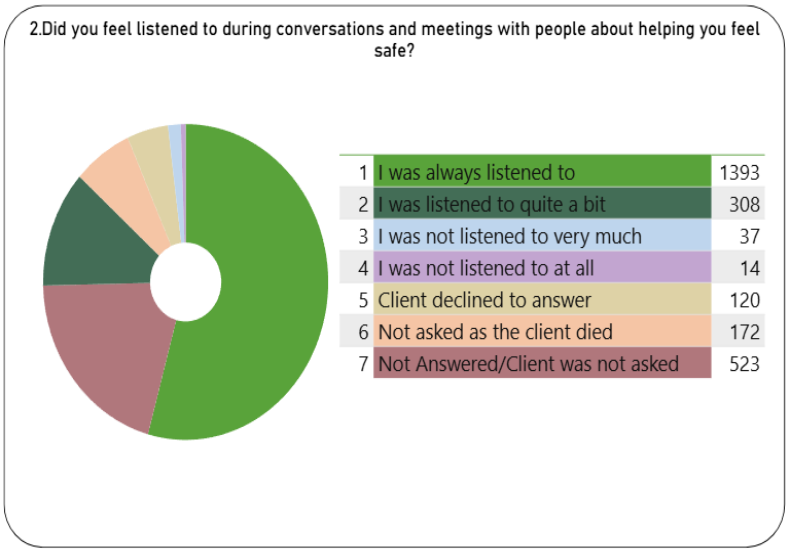
Most common location of abuse: Own home (42%) Residential care (30%) Nursing care (14%) Community services (10%).



Derbyshire SAB Key Performance Indicators (KPIs)

- **Meeting or exceeding target:**
  - Mental capacity established at referral: 85.3%.
  - Advocacy/support for adults lacking capacity: 93.3%.
  - Risk to the person reduced/removed: 94.8%.
  - Person consulted during safeguarding enquiries: 94.5%.
  - Satisfaction with outcomes: 95.6%.
- **Areas for improvement**:
  - Consent at the point of referral: 50.2% (target: 80%).
  - Referrals meeting S.42 criteria: 33.7% (target: 70%).
  - Safety plans in place: 75.9% (target: 95%).

Making Safeguarding Personal



:

96% of people felt able to discuss desired outcomes during the safeguarding process.

97% of people said they felt listened to during the safeguarding process.

93% were satisfied with the result of the safeguarding process

94% of people felt their desired outcomes were achieved or mostly achieved.

Feedback from people with lived experience

The Derbyshire SAB seeks feedback from people with lived experience as part of its multi-agency audit and quality assurance process to learn and improve safeguarding systems and processes. Martin's story is one example of feedback obtained during 2024-2025. The feedback from Martin was incorporated into a learning on one page (LOOP) resource for practitioners and was shared and discussed DSAB meetings and forums during 2024-2025 to highlight the importance of having a trauma informed approach and taking the time to build relationships with people at their own pace.

Background/Martin's Story

Martin is a White British man in his 60's who lives in his own home in Derbyshire. He has a diagnosis of treatment resistant hoarding disorder, anxiety, and depression.

The VARM process was initiated in 2023 due to Martin being at risk of eviction due to his hoarded property. Services involved in the VARM process including adult social care, housing, environmental health, mental health services and Martin's GP.

Martin described how, during his childhood, he was abused by his Mum and stepfather who neglected him and emotionally abused him. He described his Mum throwing his clothes and belongings onto the fire. He recalled having to steal lightbulbs for his room so that he had some light but would have to remove them before his Mum and stepdad returned home. As a teenager Martin began hiding his clothes to prevent them from being destroyed and when Martin moved into his own property at the age of 16, he began to fill his cupboards with items such as sheets and towels. He also began to buy large quantities of clothing.

Four years prior to the VARM process being initiated, Martin tried to access support for his hoarding via a private home clearance firm, but he said they stole from him which made him untrusting of services.

Good practice

- The social worker was patient and took time to build trust with Martin. This meant a lot to Martin as he struggles to trust people and initially would not let the social worker into his home. Martin said, 'trust makes a big difference.'
- Martin described the social worker as being very honest with him and he appreciated this.
- A local firm undertook a house clearance as part of the VARM process. Martin said that the workers were polite and made him laugh. They understood Martin's decision to sit outside whilst they cleared the property. This made a big difference to Martin as he did not feel ashamed because they made him feel comfortable. The house clearance enabled Martin to have space for equipment in his home to support him with managing his medical conditions.
- Martin continues to receive enablement support and has a health and wellbeing worker who he known for a long time. Having the same worker has helped him to feel at ease, feel able to accept help and feel able to talk about his past.

What did not go so well?

- Martin felt that the housing provider exaggerated his situation to enforce action against him.
- Martin felt that at times some services did not believe his account of events, and this upset him because, 'all through my childhood I wasn't believed'.
- The CPN who assessed Martin refused to enter his house and instead rang Martin from outside to assess him. This made Martin feel ashamed and like he was a 'lost cause.'
- Martin was reluctant to pay for services as he preferred to buy items for his home with his money. This created difficulties for agencies in accessing practical support for Martin initially.
- There was a lack of understanding from some agencies about the impact of Martin's previous trauma on his hoarding and his ability to trust people.

Key Learning Themes

The following four factors are all important in ensuring that the best possible outcomes are achieved for adults like Martin.

- **Trauma Informed knowledge and practice**
- **Honesty in professional relationships**
- **Person centered practice (Making Safeguarding Personal).**
- **A consistent worker wherever possible to build trust.**

Please take a moment to reflect on the information provided within this LOOP. If you would like further information in relation to MARM, please email DerbyshireSAB@derbyshire.gov.uk or, visit the MARM pages on the DSAB website DerbyshireSAB.org.uk

Multiagency Adult Risk Management (MARM) - Derbyshire Safeguarding Adults Board

Feedback Exercise: Safeguarding-What to Expect Leaflet 6th November 2024

The safeguarding-adults-what-to-expect-leaflet was first launched in June 2023 by Derbyshire and Derby City SABs as a way to share information with people about the safeguarding adults process. The aim of the leaflet is to provide information which the person can refer to throughout the safeguarding process to promote their understanding, participation and involvement, and to provide a mechanism for the persons' wishes and feelings to be recorded. Since its launch, data shows that around 13% of people in Derbyshire have been given the leaflet during the safeguarding process. The DSAB Board manager, with assistance from colleagues in adult social care undertook a feedback exercise to try to gain a better understand of the impact of the leaflet and whether it has helped people to have a positive experience of the safeguarding process. Five people were spoken with and two people had a clear recollection of the Safeguarding- What to Expect leaflet and found that it helped them to understand what was happening. One person used the leaflet to write down their wishes and feelings. Positive feedback from two people resulted in compliments being raised for staff members who had worked to support them during the safeguarding process.

Assurance reports from Derbyshire SAB Partner Agencies 2024-2025

Derbyshire County Council Adult Social Care and Health

Gemma Poulter- Director for Adult Social Care

Derbyshire County Council is committed to improving outcomes for people who live in Derbyshire as set out in the Council plan for 2025-29. One of the Council's three priorities is "empowered communities where people live safe, happy, healthy and independent lives" which includes safeguarding people who may be at risk of abuse or neglect. Derbyshire County Council continues to support the Derbyshire Safeguarding Adults Board and has a leadership role in the delivery of activity for the safeguarding adult agenda across the county. The Council hosts the board functions and makes an active contribution to the work of the DSAB and its sub-groups. This includes the chairing of the Safeguarding Adult Review and the Performance and Improvement sub-groups, the data capture and analysis for the DSAB, and gathering the views and experiences of adults who have experienced safeguarding procedures to inform the DSAB multi-agency audit activity and continuous improvement.

The volume of safeguarding concerns received by Adult Social Care has increased over the past 3 years with a 17% increase in 2022/23 of 5604 safeguarding concerns received, a 20% increase in 23/24 of 6748 safeguarding concerns received, and an 11% increase in 24/25 with 7467 safeguarding concerns received. The increase in safeguarding activity mirrors other increasing demand for Adult Social Care and improved demand management was a priority for the Council in 2024/25. The Council invested in additional safeguarding capacity funded via grant funding at the department's Adult Care Assessment and Triage Team (ACATT) to release capacity in area teams to focus on the completion of safeguarding concerns which needed a local response and to complete enquiries under s42 of the Care Act 2014. Performance data indicates this additional capacity and investment has been beneficial. The additional capacity has been extended until the end of September 2025 to enable a full review to be completed.

The Council received its first inspection of the delivery of its statutory duties under part 1 of the Care Act 2014 in April 2024 by the Care Quality Commission (CQC) under the new assurance framework for local authorities responsible for the delivery of adult social care duties and achieved a "Good" rating overall. CQC's findings and recommendations generally reflected those identified by the department in its self-assessment which was submitted to the CQC in advance of the on-site assessment visit.

Strengths identified by the CQC included: colleagues who are passionate about serving local people; supportive leadership; assessment and support waiting times were identified as generally low; strong

hospital discharge performance for people who require a supported discharge via adult social care; effective partnership working; creative practice when developing care and support plans with people to achieve their stated outcomes; and generally good feedback from people who draw on care and support.

Areas for improvement included: the communication of outcomes of safeguarding concerns to those who raised them; outcomes achieved for older people in respect of hospital discharge with significantly more people over 65 years of age identified as returning to hospital or entering longer-term care settings following discharge than the national average; improved understanding of the needs of the local population, including from seldom-heard groups, and more work to ensure that people living in our most rural areas are able to access services as easily as people living in more urban areas; and more work to ensure carers have access to sufficient respite care.

A comprehensive improvement plan continues to be delivered to drive continuous improvement and to respond to the improvement areas for adult social care which the CQC identified. Improved making safeguarding personal performance is included in this since, although performance improved from 58% in 2023/2024 to 76% in 2024/2025, further work is needed to continue to improve. A comprehensive prevention strategy is also a priority for Adult Social Care and Public Health to ensure that local people can access information, advice, signposting and support which helps reduce, delay and prevent the development of social care needs and supports improved safety, and improved opportunities for providing feedback and co-production ensuring that local people shape service design, delivery and improvement.

Particularly strong performance has been demonstrated in 2024/2025 in relation to feedback to referrers on the outcome of safeguarding adult concerns with adult social care providing feedback for 76% of all safeguarding concerns received, and for 86% of all s.42 enquiries completed.

Adult Social Care and the Council has contributed to the development of the DSAB's strategic plan for the next three years and its three strategic priorities of inclusion, prevention and performance which align with some of adult social care's priorities in 2025/2026. Derbyshire County Council will continue to prioritise its contribution to the work of the Board to support strong delivery.

New internal processes were implemented within Derbyshire County Council in respect of managing allegations against people in a position of trust (PIPOT) in 2023/2024 with related guidance and a risk assessment template published for managers and colleagues. Guidance was revised to further support managers. Changes made to our internal Human Resources recording system enable ongoing monitoring and action and work continues across Adult Social Care and Human Resources to further strengthen processes and advice to managers, and to quality assure the effectiveness of these.

DERBYSHIRE CONSTABULARY

Derbyshire Constabulary

Chris Marriot- T/Detective Superintendent

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.

Derby and Derbyshire Integrated Care Board (DDICB)

Bill Nicol-Deputy Director, Safeguarding Adults

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 subgroup 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.

The 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.

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 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.

DDICB contribute to the SAB's case file audit committee and ensure that learning is disseminated across Primary Care. The ICB 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.

The ICB 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.

Derbyshire County Council – Community Safety Unit

Christine Flinton-Head of Community Safety

The Council's Community Safety Team (CST) works to ensure that local residents and visitors are safe at home, work and when travelling around the county. This is achieved through partnership working with other agencies, initiatives aimed at reducing crime and vulnerability, as well as, through the commissioning of support services for victims of crime. Many of the CST's priorities relate to either adult or child safeguarding issues.

In February 2025, a strategic Risk and Threat event was held to support the review of the community safety governance structure. This event brought together key partners across the community safety landscape to assess emerging and evolving risks. The outcomes of this event are being used to inform the rationalisation of thematic boards through a new Responsible Authorities Chief Officers Group (RACOG).

The CST delivers a range of training to multi-agency partners working in Derbyshire. Training was accessed by 7,352 delegates in 2024/25. Information about Courses and bookings can be found via the Safer Derbyshire Website.

Our key contribution to the Safeguarding Board's priorities relate to Prevention, and work has been undertaken in relation to a range of vulnerabilities relating to crime and community safety, examples of this work include:

•Co-ordination of the Anti-Social Behaviour Sub-Group, which aims to deliver a consistent, multi-agency response to identifying and tackling anti-social behaviour and ensure that victims are at the forefront of our approach. The CST also co-ordinates the Derbyshire Hate Crime Network, to address Hate Crime through collaboration, information sharing, and community engagement.

•Chairing the Derby and Derbyshire Domestic and Sexual Abuse Partnership Board which coordinates the response to DA and SA across the city and county. Derbyshire Domestic Abuse Support Services are commissioned to provide support for victims of abuse, friends and family or professionals supporting them. Access is available through the helpline 24/7 (08000 198668) and website https://www.derbyshiredomesticabusehelpline.co.uk/ . The CST co-ordinates the delivery of Domestic Abuse Related Death Reviews (DARDR), to better safeguard victims by understanding what led to deaths and exploring areas for improvement. The CST hosts a pan-Derbyshire post funded by NHS England to lead work on Sexual Abuse and Assault and co-ordinate local action. Local support for adults and children is available for victims of sexual abuse through SV2 by making a referral at https://www.sv2.org.uk/make-a-referral.php .

•The Serious Violence Duty requires a multi-agency approach to understand the causes and consequences of serious violence and tackle serious violence through prevention and early intervention. The governance is overseen by the Serious Violence Board, which is chaired by the Director of Public Health. The CST have commissioned a range of evidence-based interventions using Public Health funding.

•Supporting the work of the Online Harms Board and have worked with Derbyshire Police to host a series of webinars in support of Cyber Security Awareness Month, to promote the Cyber Choices Programme and a 'Sextortion' input for parents and professionals. An investment fraud podcast was also produced to support Scams Awareness Week for the Derbyshire Safeguarding Adults Board.

•A SOCEx (Serious Organised Crime and Exploitation) strategy has been published and underpinning the work are six-weekly SOCEx tactical meetings where partners work together to address exploitation of children and vulnerable adults. During 2024, there has been a growth in the number of reported incidents of modern slavery taking place in health and care settings. Multi-disciplinary teams meet regularly to respond to and address these concerns. Derbyshire County Council along with Derby City Council jointly re-commissioned the Rebuild East Midlands charity to provide Pre-Nation Referral Mechanism support and care for potential victims of modern slavery.

•The Resettlement Team work jointly with the District and Borough councils to deliver refugee resettlement schemes such as the UK Resettlement scheme, the Afghan Relocations and Assistance Program and the Afghan Resettlement Programme. To date the County has welcomed over 200 people through these schemes. The team works with partner organisations to ensure refugees have access to housing, health, employment, training and education as well as other mainstream support. A specialist keyworker service ensures that refugees have the right support to re-build their lives in their new communities. Since 2022, the remit of the team has expanded to include the Homes for Ukraine scheme. To date Derbyshire has welcomed almost 1800 Ukrainian guests under the Homes for Ukraine scheme.

DHU Healthcare
Julie Tomlinson- Lead Nurse for Adult Safeguarding

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.

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.

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.

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.

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- Church of England
Lisa Marriot-Head of Safeguarding

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.

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.

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.

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.

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.

Derbyshire Fire and Rescue Service

Kay Simcox, Safeguarding Manager

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.

Healthwatch Derbyshire

Helen Henderson, Chief Executive

Healthwatch Derbyshire is the local health and social care champion. We work to make sure that NHS leaders and decision makers are able to hear the voice of patients and the public, and that feedback is used to improve care. We have expertise in engagement, involvement, and co-production, and this year have offered our support to the board to help improve the way in which feedback is gathered and used to create meaningful and useful feedback around the safeguarding process.

Derbyshire Community Health Services NHS Foundation Trust (DCHSFT)

Elaine Summers-Head of Safeguarding

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.

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 bi-monthly 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.

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 Health Care NHS Foundation Trust

Nikki Roome- Assistant Director Safeguarding Adults

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

Please provide a statement on People in Position of Trust (PIPOT) assurance following implementation of the Derbyshire and Derby Safeguarding Adults Boards: Managing Allegations against PIPOT Policy and Procedure and having implemented own process within your Organisation.

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.

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

University Hospitals of Derby and Burton
Yvonne Pabi-Safeguarding Adults Lead

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.

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.

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.

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.

NHS
Chesterfield
Royal Hospital
NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation Trust
Zoe Rodger-Fox- Head of Safeguarding and Complex Needs

Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) is committed to promoting a "Think Family" approach through an integrated safeguarding and complex needs team dedicated to prioritising all vulnerable individuals. The CRHFT Adult Safeguarding policy aligns with the Care Act (2014) and the DSAB joint safeguarding adult policies and procedures and is accessible to all staff within CRHFT. The Trust has established a separate Domestic Abuse policy that acknowledges the distinct nature of

the Domestic Abuse agenda, its specific legislative requirements, and pathways, and complements other safeguarding policies. Additionally, Prevent is incorporated into the Adult safeguarding policies at CRHFT, with a detailed procedure included in the appendix of the Adult Safeguarding Policy. The concept of making safeguarding personal is embedded in the safeguarding policies, and the Trust has integrated the Safeguarding Adults "What to Expect" leaflet as part of its processes.

The head of safeguarding and complex needs chairs the policy and procedure subgroup on behalf of Derby and Derbyshire safeguarding adults boards and is a member of the Derbyshire Safeguarding adults board. The Named Nurse for MCA DoLS support the MCA subgroup and all other subgroups are attended by the named nurse for Adult Safeguarding.

Safeguarding and complex needs sits within the Chief Nurse portfolio and forms part of the quality strategy. There are clear links from the bedside to Board and the reporting mechanisms are via the CRHFT Think Family Committee. This group provide support, oversight and learning across all areas of the safeguarding and complex needs agendas. Any risks that require escalation are taken to the Quality Delivery Committee via the Deputy Chief Nurse and the Quality Assurance Committee via the Chief Nurse. The adult safeguarding and the complex needs team have been engaging with the Trust Achieving Care Excellence (ACE) accreditation and assurance scheme forming part of the assessment team and ensuring that safeguarding is a golden thread throughout ward assurance.

CHRFT have a three year audit plan which provides assurance that process and procedure are embedded in the organisation and during 2024-2025 the audits completed included;

- Quality Assurance of the Safeguarding referral Process
- Quality Assurance of the CAADA DASH referral Process
- Quality Assurance of the MCA and best interest process
- Routine enquiry

These audits provide evidence of compliance with policy and procedure, review quality of information sharing as well as making safeguarding personal. Results are feedback into the board subgroups to support in identifying themes and trends within the Derbyshire as to provide assurance.

The Safeguarding and Complex Needs Team continues to address the demands placed on health and social care professionals in response to our patients' evolving needs, influenced by the post covid environment and austerity measures. Safeguarding referral rates have returned to pre-pandemic levels, with adult referrals stabilising, reflecting efforts to ensure referrals meet the criteria outlined in the decision-making guidance. However, this trend has not been seen in cases of domestic abuse, which have increased. Although there has been a reduction in the overall number of safeguarding cases, there is a notable rise in the complexity involved in managing these cases.

The work of the complex needs side of the team forms a core part of prevention work within CRHFT ensuring those most vulnerable are identified and provided the appropriate care required. This workstream continues to grow with an increase in support being required for patients with complex needs related to reasonable adjustments, the MCA, capacity assessment, DoLS applications, court of protection applications, specialist clinical holding teams and increased education around clinical holding and managing patients with behaviours that challenge.

CRHFT recognises its responsibility to establish clear policies and procedures for addressing allegations against individuals working with adults at risk and children. The Trust has implemented a dedicated policy to manage such behaviours, ensuring both support and early intervention for staff and families when concerns arise. This policy makes a distinct separation between an allegation, a concern about the quality of care or practice, and a complaint.

PiPOT is well established at CRHFT, and since 2019 there has been an increase in referrals managed through the allegations process, as shown below. These cases are often complex and require interprofessional collaboration between the safeguarding team, human resources, and clinical senior leaders. They frequently necessitate multiagency cooperation and coordination with police colleagues. CRHFT will liaise and work with any other agencies where they have made PiPOT referrals concerning professionals working outside of CRHFT. The year 2024-2025 has experienced the highest number of referrals made to the safeguarding team for advice and support, and a continuing rise in concerns identified as PiPOT, triggering external referrals and internal investigations. The rise in numbers has been benchmarked with other NHS organisation and there has been an increase in numbers nationally, providing assurance around systems and processes CRHFT has in place.

Probation Service

Probation Service, Derbyshire
Jonathan Webb-Probation Delivery Unit (PDU) Head

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.

East Midlands Ambulance Services

Lucy Gascoigne. Head of Safeguarding

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.
This reports demonstrates:

- EMAS performance in respect of safeguarding during 2024-2025
- All EMAS staff recognise their safeguarding responsibilities and respond effectively to concerns.
- Good compliance with both statutory requirements and local arrangements for safeguarding adults and children

EMAS continues to work in partnerships to safeguard patients, their families, and members of the public as well as EMAS staff members. EMAS is assured that they have processes in place to protect those who are being abused or are at risk of abuse. There is strong leadership of the safeguarding agenda with engagement from Board to frontline demonstrating a commitment to the protection of children and adults at risk in our society. 2024-2025 has been another challenging year for safeguarding at EMAS, however significant investment in the team in terms of expansion and review of roles and responsibilities has ensured that EMAS are complaint with collegiate responsibilities, safer staffing and has allowed us to expand our reach in terms of the critical work we undertake.

The Section 11 and SAAF external assurance audits were submitted during 2024-2025. Both submissions show full compliance. Assurance visits are due to be completed 2025-2026.

Going forward, 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.

The below demonstrates some of the key achievements against our safeguarding practices in 2024-2025:

- 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- this 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).

HMP/YOI Foston Hall

Simon Baker, Safeguarding lead

HMP/YOI Foston Hall remains committed to making our community safer for all who live and work here. We strive to give all a voice in matters that involve their care, welfare, and individual needs by encouraging and promoting a pro-active approach to safeguarding. Our 'whole prison approach' towards safeguarding acts as an effective means that best supports safety and non-violent attitudes and behaviours.

The Safeguarding Committee continues to realise the 'whole-prison approach', by ensuring accountability and ownership by all staff, visitors, and prisoners at HMP/YOI Foston Hall when conducting their day-to-day activities. We continue to ensure that all are given the necessary skills to identify and support vulnerable & isolating prisoners wherever they are in their custodial journey. Along, with ensuring through a robust assurance process that all in our care have their needs placed centrally to everything we do.

In order to ensure we maintain a proactive approach to safeguarding we will.

- Continue to identify and provide up to date and relevant training for all who work with the prisoners at HMP/YOI Foston Hall.
- Continue to use effective evidence-based practice that puts the prisoners at its heart.
- Ensure legitimate use of all available tools, such as the Incentives Policy Framework (IPF) & the Challenge, Support & Intervention Process (CSIP) to encouraging pro-social behaviour whilst challenging negative behaviours and actions.
- Ensure effective partnership working with all agencies including Social Care, Primary & Secondary Health Care Services, Mental Health, Mother & Baby Services, and PACT.
- Continue to maintain a decent, and respectful environment that promotes and supports a culture of safety and continued moral legitimacy.

Appendix 1: Derbyshire SAB Board membership 2024-2025

1. Derbyshire SAB Independent Chair

Andy Searle	Independent Chair	Derbyshire Safeguarding Adults Board (until December 2024)
Amanda Clarke	Independent Chair	Derbyshire Safeguarding Adults Board (from 13th January 2025)

2. Derbyshire SAB Vice-Chair

Bill Nicol	Head of Adult Safeguarding	Derby and Derbyshire Integrated Care Board

3. Derbyshire SAB Board office staff

Natalie Gee	Service Manager	Derbyshire Safeguarding Adults Board
Paul Joyce	Business Services Assistant	Derbyshire Safeguarding Adults Board Minute Taker

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

Dean Howells	Chief Nurse	Derby and Derbyshire Integrated Care Board	Deputy – Tracy Burton
Kerry Pope	Detective Superintendent, Head of Public Protection	Derbyshire Constabulary	Deputy – Detective Inspector Gaz Smethem
Simon Stevens	Executive Director	Derbyshire County Council Adult Social Care and Health	Deputy – Gemma Poulter

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

Katy Pugh	Chief Executive	Age UK Derby and Derbyshire
Zoe Rodger-Fox	Head of Safeguarding	Chesterfield Royal Hospital NHS Foundation Trust
Suzi Henderson	Chief Executive Officer	Cloverleaf Advocacy
Michelle Bateman	Chief Nurse and Director of Quality	Derbyshire Community Health Services NHS Foundation Trust
Christine Flinton	Head of Community Safety	Derbyshire County Council Community Safety
Clive Stanbrook	Area Manager for Community Safety	Derbyshire Fire and Rescue Service
Tumi Banda	Director of Nursing and Patient Experience	Derbyshire Healthcare NHS Foundation Trust
Nicolle Ndiweni	Police and Crime Commissioner for Derbyshire	Derbyshire Office of the Police and Crime Commissioner
Jacqui Willis	Chief Executive	Derbyshire Voluntary Action
Julie Tomlinson	Lead Nurse Safeguarding Adults	DHU Healthcare
Lisa Marriott	Head of Safeguarding and Diocesan Safeguarding Officer	Diocese of Derby
Louise Barlow	Divisional Senior Manager (Quality)	East Midlands Ambulance Service
Helen Henderson	Chief Executive	Healthwatch Derbyshire
Laura Day	Governor	HMP Sudbury
Carrie Byrne	PA to Governor (does not attend but requires notification of meeting dates)	HMP Sudbury
Michelle Quirke	Governor	HMP/FOI Foston Hall
Jonathan Webb	Head of PDU	The Probation Service
Jane O'Daly-Miller	Head of Safeguarding and Vulnerable People	University Hospitals of Derby and Burton NHS Trust

6. Derbyshire SAB advisors to the Board

Rachel Davis	Care Quality Commission – Inspection Manager
Bill Balmer	Derbyshire County Council Legal Department

Appendix 2: Board meeting attendance monitoring form 2024-2025

Key	
	Attended
A	Apologies received
	Did Not Attend

Date	Age UK Derby & Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust (CRHFT)	Cloverleaf Advocacy From 1st May 2024. Was previously Derbyshire Mind	Derby and Derbyshire Integrated Care Board (DDICB)	Derbyshire Community Health Services Foundation Trust (DCHSFT)	Derbyshire Constabulary	Derbyshire County Council Adult Social Care & Health (DCC ASCH)	Derbyshire County Council Community Safety	Derbyshire District Council Safeguarding Leads Sub-Group (DDCSLG) [agreed attendance as twice per year, rather than quarterly]	Derbyshire Fire and Rescue (DFRS)
16/05/2024										
17/07/2024										A
16/10/2024			A							

Date	Derbyshire Healthcare NHS Foundation Trust (DHCFT)	Derbyshire Voluntary Action (DVA)	Diocese of Derby	DHU Health Care Commnity Interest Company (DHU CIC)	East Midlands Ambulance Service NHS Trust (EMAS)	Healthwatch Derbyshire	Office of the Police & Crime Commissioner (OPCC)	Prison Service	Probation Service	University Hospitals of Derby & Burton NHS Foundation Trust (UHDBT)
16/05/2024							New PCC elected on 2nd May 2024	HMP Sudbury and HMP/YOI Foston Hall		
17/07/2024			A			A		HMP Sudbury	A	
16/10/2024			A					HMP/YOI Foston Hall	A	

Appendix 3: Abbreviation index

ADASS	Association of Directors of Adult Social Services
BSL	British Sign Language
COP	Community of Practice
DDCSLSG	Derbyshire District Councils Safeguarding Leads Subgroup
DDSCP	Derby and Derbyshire Safeguarding Children Partnership
DoLS	Deprivation of Liberty Safeguards
EMAS	East Midlands Ambulance Service
ICB	Integrated Care Board
KPI	Key Performance Indicator
LeDeR	Learning from Lives and Deaths – people with a learning disability and autistic people
MCA	Mental Capacity Act
MARM	Multiagency Adult Risk Management
MSP	Making Safeguarding Personal
PiPoT	Persons in a Position of Trust
SAR	Safeguarding Adult Review

If you have any questions or comments in relation to the Annual Report, please email DerbyshireSAB@derbyshire.gov.uk. You can request a copy of our publications in a different format or language

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