Derbyshire Safeguarding Adults Board

Derbyshire Safeguarding Adults Board Annual Report 2025–2026

Working together to support and empower people in Derbyshire to stay safe and to live a life free from harm, abuse, and exploitation.

Prevention | **Inclusion** | **Performance**

2025–2026 at a glance

A summary of the Board's key activity, safeguarding data and partnership focus for the reporting year.

8885	2246	90%	167
Safeguarding Adult referrals	Section 42 enquiries	Risk reduced or removed	People supported through MARM

What we focused on

Embedding inclusion, prevention, performance and partnership across Board activity.

Strengthening assurance through data, audits, learning from safeguarding adult reviews and partner accountability.

Improving safeguarding information, guidance and resources for professionals and the public.

What improved

Prevention was strengthened through improved guidance, accessible learning resources, awareness campaigns and earlier multi-agency responses to risk.

Lived experience, co-production and accessible information were more consistently used to strengthen inclusion and person-centred safeguarding practice.

Stronger use of data, multi-agency audits and learning from Safeguarding Adult Reviews improved partnership assurance, accountability and continuous improvement.

Looking ahead

During 2026–2027, the Board will continue to focus on improving outcomes for adults with care and support needs by strengthening assurance, listening to people's experiences, embedding safeguarding knowledge and challenging partners to work together effectively.

Introduction from the Independent Chair

I am pleased to introduce the Derbyshire Safeguarding Adults Board Annual Report for 2025–2026. This report reflects the shared commitment of organisations across Derbyshire to safeguard adults with care and support needs and to help people live safely, with dignity and choice.

During the year, the Board and its partners have continued to strengthen prevention, improve assurance and promote inclusive, person-centred safeguarding practice. This has included learning from Safeguarding Adult Reviews, developing practical resources, examining performance and listening more closely to the experiences of people who have been supported through safeguarding.

Effective safeguarding depends on strong relationships, open discussion and a willingness to learn and improve. As Independent Chair, I value the constructive challenge that Board members bring, and the way partners work together to address shared risks. I would like to thank Board and subgroup members, practitioners, partner agencies and most importantly, people with lived experience for their time, expertise and continued contribution.

The report demonstrates good progress, while also recognising the areas where further work is needed. During 2026–2027, the Board will continue to focus on improving the quality and consistency of safeguarding practice, measuring the impact of learning and the effectiveness of partnership arrangements. We will also strengthen how we hear and respond to people's experiences, ensuring that their voices are valued and remain central to our assurance and improvement work.

I remain encouraged by the commitment shown across the partnership, especially in such challenging times, and look forward to working with colleagues and communities to build on this progress. Together, we will continue to support people across Derbyshire to stay safe and live free from abuse, neglect and exploitation.

Amanda Clarke

Amanda Clarke

Independent Chair, Derbyshire Safeguarding Adults Board

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Derbyshire demographic information

Located in the centre of England, Derbyshire comprises of a diverse mix of urban centres, market towns and rural communities. The county's population was estimated at 827,217 in 2025, an increase of 0.8% since 2024. Population projections based on 2022 Office for National Statistics data suggest that this could rise to 924,887 by 2047. Levels of deprivation and poverty vary across the county, with some communities experiencing greater disadvantage than the national average. These inequalities can affect people's health, wellbeing and access to support. Derbyshire also has an ageing population. In 2022, 22% of residents were aged 65 or over. This is projected to increase to 27% by 2047. The population is 51% female and 49% male.

Whilst just over 90% of Derbyshire residents are White British, the county is also home to people from a range of backgrounds and communities. Understanding the needs and experiences of all communities in Derbyshire is important in ensuring that safeguarding information, services and support are inclusive and accessible.

Governance and legislative context

The Care Act 2014 placed a statutory duty on each local authority to establish a Safeguarding Adults Board (SAB) from April 2015. The local authority, Integrated Care Board and police are statutory members of the Board. Derbyshire SAB benefits from broader representation across partner agencies, as set out in Appendix 1. SABs operate independently, enabling them to provide effective scrutiny and assurance of local adult safeguarding arrangements. The local authority is responsible for ensuring the SAB is in place and appointing the Independent Chair, in consultation with statutory partners.

The effectiveness of the SAB depends on strong collaboration between members, partner agencies, and other local and regional partnerships. The Care Act 2014 places agencies under a duty to co-operate with the SAB, supporting shared accountability and coordinated action to safeguard adults with care and support needs.

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 in accordance with Section 44 of the Care Act 2014.

Wider responsibilities of the Board

Alongside its statutory functions, the Derbyshire SAB plays an important preventative and developmental role in strengthening safeguarding practice across Derbyshire.

Policy and practice development	Derbyshire and Derby Safeguarding Adults Boards maintain joint safeguarding adults policies and procedures. Regularly reviews and creation of new guidance helps to strengthen and support consistent and effective safeguarding practice.
Making Safeguarding Personal	The Board identifies and shares effective practice where Making Safeguarding Personal principles have been successfully applied, helping to embed person-centred approaches across the partnership.
Community awareness	The Board raises public awareness of how to recognise and report abuse and neglect, using accessible formats and multilingual resources to reach Derbyshire's diverse communities.
Assurance and challenge	The Board seeks assurance, scrutinises performance and constructively challenges partners to deliver safe, effective and high quality safeguarding services.

The six safeguarding principles

The Care Act 2014 identifies six equally important principles that underpin adult safeguarding. Together, they support an approach that is person-centred, preventative, proportionate and accountable.

Empowerment **People are supported and encouraged to make their own decisions and give informed consent.** *"I am asked what I want to happen."*	**Prevention** **Action is taken before harm occurs, with safeguarding embedded in everyday practice.** *"I receive clear information to help me stay safe."*
Proportionality **The response is the least intrusive action appropriate to the level of risk.** *"Professionals work with me and only intervene as much as needed."*	**Protection** **People in greatest need are offered support, representation and protection from harm.** *"I receive help and support to report abuse and take part in safeguarding."*
Partnership **Services and communities work together to prevent, identify and respond to abuse and neglect.** *"Agencies work together, while respecting my privacy."*	**Accountability** **Safeguarding practice is transparent, with clear roles, decisions and responsibilities.** *"I understand what is happening and who is responsible."*

Strategic plan and priorities 2025–2028

The Derbyshire SAB Strategic Plan 2025–2028 is underpinned by the Board's vision and mission and provides a framework for partnership activity, assurance and continuous improvement. The Board would like to thank the Derbyshire County Council Adult Social Care Stakeholder Engagement (DSEB) for co-producing a separate easy-read version of the plan.

A Board action plan sets out the priority areas of work and guides delivery across the subgroups. The Board reviews and updates the action plan regularly to monitor progress and respond to emerging priorities. Each subgroup also maintains a business plan setting out how it will contribute to the strategic objectives, with progress reviewed quarterly.

Our vision

People in Derbyshire are empowered to make choices to stay safe and to live a life free from harm, abuse, and exploitation

Our mission

The Derbyshire Safeguarding Adults Board members will support and challenge each other to achieve the best possible outcomes for people in Derbyshire by putting the person at the centre of every part of the safeguarding process.

Our vision and mission include people who are placed or living outside Derbyshire and reflect our cross-border responsibilities in line with our policies and procedures.

Our three strategic priorities 2025-2028

Prevention	Inclusion	Performance
Strengthening early help, awareness and partnership activity to reduce the risk of abuse and neglect.	Ensuring people, families and communities can understand, access and influence safeguarding systems and support.	Using data, audit and assurance activity to understand effectiveness, identify risk and drive improvement.

Impact during year 1 of the Strategic Plan

The Board has delivered strong early progress against all three strategic priorities, particularly in Prevention and Performance, with solid foundations in place to improve Inclusion in the safeguarding process during 2026–27.

Prevention	Inclusion	Performance
Early risk identification A November 2025 MARM audit, including lived experience feedback, provided assurance on early identification and prevention of further harm. **Prevention Principles** Published in October 2025	**Lived experience and co-production** Links with Derbyshire County Council's co-production group created clearer routes for people's experiences to influence communications, resources and assurance. **Board development**	**SAR learning and impact** Recommendations and impact logs are routinely reviewed, with one-year impact assurance exercises under consideration. **Board accountability** A joint Board Members' Information Pack was

and promoted through the website, newsletter and Safeguarding Adults Week. Subgroup plans provide a consistent ‘golden thread’.

Repeat referrals

Multiagency audit and data analysis are informing definitions, workflows and more consistent practice.

Accessible learning

An online themes library covering learning from local multi agency reviews launched in February 2026.

Awareness and empowerment

An easy read ‘What to Expect’ leaflet, targeted communications and partnership training strengthened public awareness and lived experience involvement.

Partnership alignment

The Joint Chairs Liaison Group was re-established and links with the Children’s Partnership strengthened.

A May 2026 development session will strengthen understanding of inclusion, cultural competence and engagement with diverse communities.

Feedback and participation

Work with Adult Social Care is developing safeguarding feedback surveys in multiple formats to widen participation.

Barriers to access

Scoping has begun on barriers affecting people who are homeless, people from non-White British backgrounds and people with learning disabilities and/or autism.

published in August 2025. Attendance and engagement are now actively monitored.

Care sector and regulator engagement

Care home representation and audit involvement increased. Findings were shared at the March 2026 provider summit and CQC representation was re-established.

Performance and data

The Performance and Improvement Subgroup is reviewing KPIs, agreeing datasets and improving multiagency reporting consistency.

National best practice

National learning on measuring SAR impact is being adapted for local use and Board assurance.

Feedback from people with lived experience

Feedback from people with lived experience helps the Board understand whether safeguarding practice feels person-centred, respectful and effective.

Co-production and safeguarding adults in Derbyshire

Listening to lived experience

Noel Mitchell, a member of Derbyshire County Council's Safeguarding Co-production Group, supported the facilitation of a session during Safeguarding Adults Week 2025 alongside Ottiley Baker, Service Manager in Derbyshire County Council Adult Social Care. Noel highlighted to practitioners the importance of working alongside people with lived experience of the safeguarding process so that their knowledge and perspectives can influence services and practice.

Noel said:

"Co-production shows that people are listening. Organisations tend to be faceless, and you only see people when there are issues. Co-production allows you to input into the system. It benefits staff to know how individuals feel when they access services.

"I think it's really important to go down the co-production route, as it gives everyone a broader view than simply following what the system says you are supposed to do.

"The way to learn is to listen to other people and take on board their life experiences."

Development of a new safeguarding feedback process

During 2025–2026, work took place to develop a new survey and supporting process for gathering feedback from people with lived experience. The aim is to provide a consistent and meaningful way for people to share how they experienced the safeguarding process and whether they felt listened to, involved and supported.

The survey was developed with support from Healthwatch Derbyshire and Derbyshire County Council's Safeguarding Co-production Group. Their involvement helped ensure that the questions were clear, relevant and focused on the issues that matter most to people who have experienced safeguarding. This collaborative approach also helped shape how the survey will be offered and how feedback will be gathered. The new process will create a clearer route for people's experiences to inform safeguarding practice. Feedback will help the Board and its partners understand what is working well, identify where people's experiences could be improved and monitor whether safeguarding remains person-centred and focused on the outcomes people want to achieve.

How feedback will be used

Survey feedback will be reviewed regularly to identify themes, examples of good practice and areas where safeguarding services or processes could be improved. Findings will be considered alongside performance information and other assurance activity, helping the Board and its partners to agree priorities and make evidence informed changes that respond to people's experiences.

The findings and proposed actions will be shared with Derbyshire County Council's Safeguarding Co-production Group and the Performance and Improvement Subgroup. This will enable people with lived experience and partner agencies to consider the evidence together, contribute to discussions and help shape decisions about service and process developments. Progress against agreed actions will be monitored and the impact of changes reviewed. Outcomes will be shared back with both groups, creating a clear feedback loop and helping to ensure that improvements are meaningful, transparent and informed by the people who use safeguarding services.

The survey and supporting process are due to go live on 1 April 2026. This represents an important step forward in strengthening the voice of people with lived experience and ensuring that their views contribute directly to service improvement.

Subgroups and working groups

Subgroups and working groups translate the Board's priorities into action, provide assurance and support shared learning across the partnership. Derbyshire SAB delivers its strategic priorities through a structured network of subgroups and working groups. Each subgroup maintains a dedicated action plan that sets out its contribution to the Board's priorities and supports the monitoring of progress and impact.

Groups supporting the DSAB during 2025–2026 *Indicates a joint subgroup with Derby SAB	
Core Business Group *	Coordinates delivery of the Board's core functions.
Safeguarding Adult Review (SAR) Subgroup	Oversee the commissioning and management of SARs in line with Section 44 of the Care Act 2014.
Performance and Improvement Subgroup (PISG)	Monitors performance data, oversees audits and leads assurance activity to support continuous improvement.
Policy and Procedures Subgroup (P&P) *	Ensure safeguarding policies and procedures remain current, consistent and effective.
Making Safeguarding Personal (MSP) Subgroup *	Embeds person-centred approaches in safeguarding practice.
Multiagency Adult Risk Management (MARM) Working Group	Provides quality assurance on strategic and operational matters relating to the MARM process.
Financial Abuse Working Group	Focuses on preventing and detecting financial abuse and scams and raising awareness.

Strategic partnerships

The DSAB works collaboratively with partner agencies and other strategic partnerships to improve wellbeing, including:

- 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, and the Regional and National Independent Chairs Network

A structure chart is provided at Appendix 2.

Derbyshire SAB budget

Derbyshire SAB is funded by its statutory partners to support delivery of its statutory functions, partnership priorities and learning activity.

Budget contributions 2025–2026

Statutory partner	Contribution
Derbyshire County Council Adult Social Care	£53,386.07
Derby and Derbyshire Integrated Care Board	£53,386.07
Derbyshire Police	£53,386.07
Total contributions	**£160,158.21**
Total expenditure	**£162,161.96**

Safeguarding Adult Review expenditure

Safeguarding Adult Review costs are managed separately from the main Derbyshire SAB budget.

When a review is completed, expenditure is shared equally between the Board's three statutory partners. For 2025–2026, this equates to £2,885.08 per partner.

2025–2026 total expenditure

£8655.25

Safeguarding Adult Reviews completed 2025–2026

A Safeguarding Adult Review (SAR) is undertaken when an adult with care and support needs has died or experienced serious harm as a result of abuse or neglect, and there is concern about how agencies worked together to safeguard them (S.44 of the Care Act 2014). Its purpose is not to apportion blame, but to identify learning and improvements that can strengthen local safeguarding practice and help prevent similar harm in the future. During 2025–2026, two SARs were completed in Derbyshire in relation to Mary (SAR23A) and Bob (SAR24A).

SAR23A 'Mary' Learning resources published September 2025

Mary was a White British woman with moderate to severe learning disabilities. She had lived in a Derbyshire nursing home for almost 30 years and was in her sixties when she died in hospital in 2022. She had been admitted with pressure damage to her skin that had occurred at the care home.

8

recommendations

Key learning themes

Multiagency working	Training and awareness	Safeguarding processes
Review and oversight	Deprivation of Liberty Safeguards communication	

Learning resources: Read the learning brief | Read the learning on one page

Taking learning forward

The Board has an action plan in place to oversee implementation and seek assurance that learning is reflected in practice.

Impact of the SAR23A recommendations

The review has led to clearer guidance, stronger information sharing and more consistent multi-agency working to safeguard adults with learning disabilities.

6 of 8

recommendations completed

Two remain in progress

Improvements made

- Learning has been shared across health, social care, public health and care providers, strengthening awareness that changes in behaviour may have physical or psychological causes.
- New organisational abuse guidance has been launched, and stronger monitoring arrangements support earlier and more accurate identification of concerns.
- Information about care service concerns is more visible across Adult Social Care through Mosaic recording, regular intelligence updates and fortnightly multi-agency meetings.
- Communication between the DoLS team, care homes and hospitals has been strengthened, with clearer expectations for reporting significant changes and checking current case information.
- An audit of provider-led safeguarding enquiries has informed improvements in co-operation and the quality and timeliness of responses.
- Revised Section 42 guidance now distinguishes an information request from delegation of an enquiry and clarifies escalation routes where responses are delayed.
- Further work is assessing provider knowledge of specialist pressure area support and developing guidance for prompt joint reviews when the health of an adult with learning disabilities deteriorates.

Next step for assurance

The strongest evidence currently relates to improved systems, guidance, professional awareness and partnership arrangements. Work will continue to demonstrate that these changes are used consistently in practice and are improving people's experiences and outcomes.

SAR24A 'Bob' Learning resources published January 2026

Bob was a White British man in his seventies who died in 2022. He had complex physical and mental health needs, including Type 1 diabetes, Alzheimer's disease and depression. Following the death of his wife, he experienced severe depression and was admitted to hospital under the Mental Health Act 1983. His care involved several transitions between home, hospital and care settings.

5

recommendations

Key learning themes

Family engagement	Support for attorneys under a registered Lasting Power of Attorney
Strategic planning for co-morbidities	Enhanced multidisciplinary team working
Referral quality and feedback	

Learning resources: Read the learning brief | Read the learning on one page

Taking learning forward

The Board has an action plan in place to oversee implementation and seek assurance that learning is reflected in practice.

Impact of the SAR24A recommendations

Progress has been made to strengthen family and carer involvement, legal literacy, multi-agency working, referral quality and safeguarding assurance.

1 of 5

recommendations completed

Two are on track and two continue to progress

Improvements made

- Recording has been strengthened to capture the carer's voice, with learning shared through primary care governance and safeguarding communications.
- Local Lasting Power of Attorney guidance and myth-busting resources have been drafted, supported by assurance on verification, involvement, escalation and safeguarding arrangements.
- Learning on multi-agency meetings, information sharing, contingency planning and effective transitions has been communicated across health, social care, ambulance and other partner services.
- Revised Section 42 guidance and referral documentation have been published.
- The electronic safeguarding referral form is now used for around 60% of referrals, supporting more consistent information and better data quality, and decision-making guidance has been relaunched.
- Adult Social Care has introduced end-of-enquiry reporting to the Performance and Improvement Subgroup. Police also undertake monthly quality checks, with individual and wider learning shared where required.
- Early 2026–2027 safeguarding data indicates a reduction in inappropriate referrals.

Next step for assurance

Work will continue to co-produce guidance for staff working with families and carers, promote Lasting Power of Attorney resources, review integrated care for people with co-existing mental and physical health conditions, and develop legal literacy learning. Follow-up engagement and planned audits will assess whether improvements are embedded consistently and are improving practice and outcomes.

Key achievements 2025–2026

This section highlights partnership activity, practical resources, awareness campaigns and improvements delivered during the reporting year.

5 newsletters published	**98** practitioners attended World Elder Abuse Awareness Day webinars	**13** partner agencies represented at training
7 webinars delivered during Safeguarding Adults Week	**265** attendees during Safeguarding Adults Week	**11** individuals and teams recognised during Dignity Action Month

Equality, Diversity and Inclusion Charter

The Derby and Derbyshire Safeguarding Adults Equality, Diversity and Inclusion Charter was launched to reinforce the importance of accessible information and establish a shared commitment to embedding equality, diversity and inclusion across adult safeguarding strategy and practice. The Charter was introduced at the joint Boards' Development Day, where members formally endorsed its principles.

Meeting titles and acronyms crib sheet

The meeting titles and acronyms crib sheet was produced to help practitioners understand full meeting titles, commonly used acronyms and the purpose of each forum.

Lasting Power of Attorney posters

Two public information posters on Lasting Power of Attorney and Advance Decisions to Refuse Treatment were launched. They explain that a 'next of kin' has no legal authority to make decisions and encourage people to record their wishes in advance.

Persons in a Position of Trust guidance re-launch

In August 2025, Derbyshire and Derby Safeguarding Adults Boards relaunched their joint PiPoT framework and process, following partner feedback and review by the Policy and Procedures Subgroup. The refreshed guidance and leaflet promote consistent and proportionate responses to allegations involving anyone working, paid or unpaid, with adults who have care and support needs.

Learning Themes Library

Launched in February 2026, the Learning Themes Library brings together practical guidance and learning from Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, Domestic Abuse Related Death Reviews and LeDeR reviews.

Featured themes: domestic abuse; legal literacy; Making Safeguarding Personal; professional curiosity; unpaid carers; fire safety; constipation and sepsis; multiagency working and information sharing; and substance use.

Organisational Abuse Guide

In March 2026, the Derby and Derbyshire Safeguarding Adults Boards published a new Organisational Abuse Guide. The resource supports everyone working with adults at risk across partner agencies and helps practitioners understand organisational abuse, recognise indicators and risk factors, and take effective multiagency action.

Multiagency Adult Risk Management podcast

The MARM podcast gives frontline staff and managers an accessible overview of the process, explaining why it matters and offering practical tips for collaborative management of complex risk.

Safeguarding Adults What to Expect leaflet easy-read version

An easy read version of the Safeguarding Adults: What to Expect leaflet was produced. It explains the safeguarding process, records key contacts and enables people to note questions, wishes and feelings. The leaflet was co-produced with the Derbyshire Stakeholder Engagement Board and people previously supported through safeguarding.

Board Newsletters

Five Derbyshire SAB newsletters were produced and published, including a special regional edition newsletter for National Safeguarding Adults Week 2025.

World Elder Abuse Awareness Day 2025

World Elder Abuse Awareness Day (WEAAD) takes place each year on 15 June. To mark the campaign, Derbyshire Safeguarding Adults Board hosted two webinars on 16 June 2025, raising awareness of domestic and sexual abuse of older people and the support available locally. Thank you to SV2, The Elm Foundation, NCHA Derbyshire Wish and Bambuuu for sharing their knowledge and experience. **98 practitioners attended** from **13 partner agencies**.

Safeguarding Adults Week 2025

Safeguarding adults week took place 17 to 21 November 2025, the Derby and Derbyshire Boards collaborated to support the national campaign **Prevention: Act Before Abuse**. During the week the Boards arranged seven webinars for frontline practitioners and managers.

- Cybercrime and online safety
- Co-production and safeguarding
- Sexual abuse and older people
- Low level support and Home from Hospital
- Safeguarding and carer support
- Domestic abuse and older people
- Safer cultures in sport

The Safeguarding Adults Week webinars attracted **265 attendees** in total. Feedback showed that the webinars increased awareness, confidence and practical knowledge. Attendees valued lived experience, case studies, videos and clear information about support and referral routes. Comments included:

“The session was absolutely a revelation”,

“Very informative and dealt with sensitively given the subject matter”

“I will listen and involve people more.”

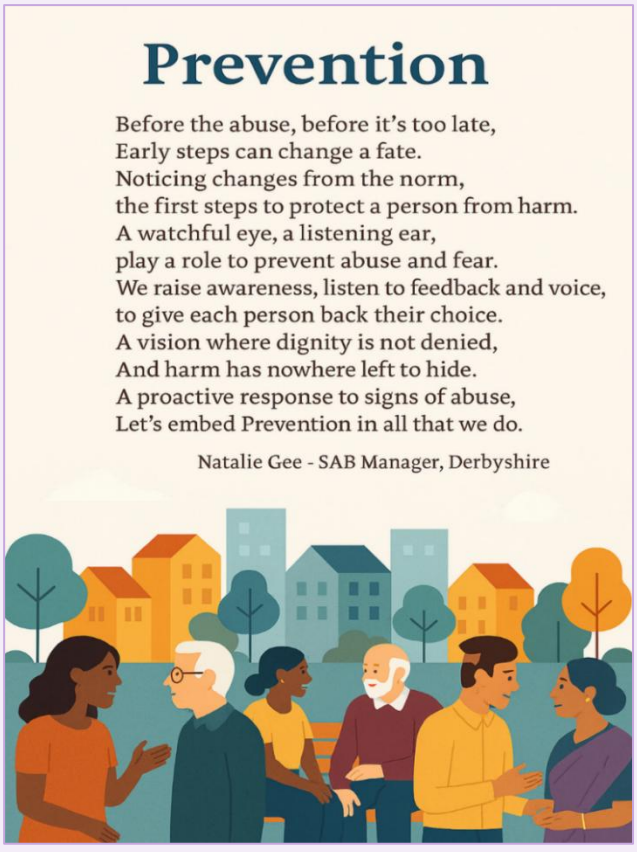
Others said they would be better able to recognise abuse, respond confidently, strengthen online security and signpost carers to support.

Prevention Principles

The Derby and Derbyshire Safeguarding Adults Boards launched the new Prevention Principles during safeguarding adults week 2025 , setting out a shared commitment to preventing abuse and neglect before it occurs. Grounded in the Care Act 2014 and aligned with the Boards’ strategic priorities, the document identifies collaborative action across public awareness, strengths-based safeguarding, partnership working and accountability.

Prevention Poem

Written by the Derbyshire SAB Board Manager, the poem was shared across the region during National Safeguarding Adults Week 2025.



Board Members' Information Pack

The new Derby and Derbyshire Safeguarding Adults Boards Members' Information Pack explains the roles and functions of the Boards, their membership and subgroup arrangements. It sets out what is expected of Board and subgroup members, helping new and existing members understand their responsibilities and contribute effectively to the Boards' strategic objectives.

Rights of access: gaining access to support an adult

The seven-minute briefing supports practitioners who need to gain access to an adult to provide care or support, or where abuse or neglect is known or suspected. It explains the specific legal options available to the police and local authority and sets out the steps practitioners from other agencies should take.

Raising awareness about support for unpaid carers

Unpaid carers provide vital support to family members, friends and neighbours who could not manage without their help. Every caring role is different and may change over time. On 29 November 2025, Derbyshire County Council Councillor for adult social care, Joss Barnes attended Chesterfield FC's home match at the SMH Group Stadium to highlight the contribution made by unpaid carers. The campaign message featured in the match programme and on screens around the stadium, helping it reach supporters across the community. Chesterfield FC Charitable Trust supported the Board to share this important message with the wider community.

Dignity Action Month February 2026

Dignity Action Month in February 2026 provided an opportunity for Board partners to reaffirm their commitment to promoting and upholding every individual's right to dignity. As part of the month's activities, the annual Derby and Derbyshire Safeguarding Adults Boards Dignity Tea took place on 2 February 2026. The event saw a range of professionals from various care services receive recognition for upholding the dignity and care of the people they work with. Certificates were presented by the Mayor of Derby, Ajit Atwal, Richard Proctor, Independent Chair of Derby SAB, and Amanda Clarke, Independent Chair of Derbyshire SAB. A poem, 'Dignity in Care', written by Matthew Fowler, a Derby resident, was also read out. Awards were presented to:

- Hayley Crossley, Palliative Specialist Nurse at University Hospitals of Derby and Burton.
- Alana Biggs, Lead Nurse, Aitune Medical Practice
- Sharleen Gonza, JS Supported Living Services
- David Shardlow, Social Worker, Derby City Council
- Rubine Sharief, Registered Manager, Waythrough
- Steven Stockley, Staying Close, The Children and Young Adults Supportive Care Services, Derby City Council
- Joe Michael, Derventio Housing Trust
- Luca Marini, Social Worker, Derbyshire County Council
- Sarah Wigley, Derbyshire Fire and Rescue Service

- Cygnet Derby Safeguarding Champions Group
- Temporary Accommodation Team at Derby Homes

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. The website is maintained and updated throughout the year, with new resources added to provide current and useful safeguarding information.

47,597 **page views during 2025–2026**

Ranking in 2025–2026 (2024–2025)	Section or page on the Derbyshire SAB website	2025–2026 page views
1 (1)	Homepage	13,334
2 (2)	Safeguarding Adult Referrals	9,954
3 (3)	Persons in a Position of Trust (PIPOT)	2,053
4 (4)	Multiagency Adult Risk Management (MARM)	1,814
5 (5)	Adult Safeguarding Decision-Making Guidance	1,516
6 (8)	Training Courses	1,133
7 (6)	Professionals Section	1,111
8 (10)	Policies, Procedures and Practice Guidance	1,074
9 (7)	Safeguarding Adult Reviews	940
10 (9)	Section 42 Enquiries	880

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 2025, National Safeguarding Adults Week 2025 and Scams Awareness Week 2025 as well as other local and national awareness campaigns including Carers Week and Carers Rights day.

991	627	15.5k
X followers	Facebook followers	views of content from or about the Derbyshire SAB Facebook page during 2025–2026

Subgroup activity 2025–2026

This section summarises how each subgroup contributed to the Board's strategic priorities, strengthened partnership assurance and supported improvements in safeguarding practice during 2025–2026.

Core Business Group

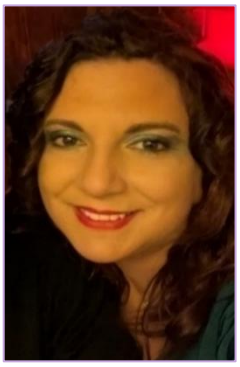
Chairs: Amanda Clarke and Richard Proctor

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 core business group meets quarterly as a minimum in between Board meetings. The purpose of the Core Business Group is to:

1. Receive updates and assurance from the SAB statutory partners.
2. Monitor the effectiveness of the SABs and their subgroups in relation to safeguarding adults in Derbyshire and Derby City, bringing good practice and areas for further scrutiny to main Board.
3. Discuss any current or emerging issues or areas or risk, both locally and nationally that may impact the SABs.

Policy and Procedures Subgroup

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



This is a joint subgroup supporting the policies and procedures work of both the Derby and Derbyshire safeguarding adults boards and is well attended and supported by a breadth of agencies across the city and county.

The purpose of the Joint Policies and Procedures Subgroup is to establish and review multi-agency policies, 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. The subgroup has demonstrated steady progress across 2025-2026, with a consistent programme of reviewing existing guidance; development of new materials responding to practice needs; improved forward planning through allocated review ownership.

In 2025-2026, seven existing guidance documents were reviewed and approved:

- Equality, diversity and inclusion in safeguarding adult practice
- Vulnerable witnesses
- Working with the coroner
- Persons in a Position of Trust (PiPoT)
- Definition of abuse guidance
- Multi-Agency Hoarding Framework
- Self-neglect toolkit

These updates demonstrate continued maintenance of core safeguarding guidance to ensure it remains relevant and effective.

New and additional guidance produced during the year included:

- New briefing note on rights of access (7-minute briefing)
- Cuckooing: guidance for front line practitioners
- Organisational abuse guide

This reflects a strong focus on developing new resources to support frontline practice and emerging safeguarding themes.

In February 2026, the subgroup scheduled ten pieces of guidance scheduled for review in June/July 2026.

Safeguarding Adult Review (SAR) Subgroup

Chair: Lynne Hyland, Derbyshire County Council Adult Social Care

The Safeguarding Adult Review Subgroup continues to benefit from strong and consistent representation from partners across all agencies, including statutory services, health, police, and wider safeguarding partners. This breadth of engagement remains a key strength of the Subgroup, enabling comprehensive analysis of complex safeguarding systems and ensuring that multiple professional perspectives inform decision making. The Safeguarding Adult Review Subgroup operates within a culture of openness, transparency and learning, where members feel able to engage in honest and reflective discussion. There is a clear emphasis on understanding systemic issues, professional interfaces and organisational pressures, rather than attributing individual blame. This safeguarding culture enables the Subgroup to identify learning rigorously, including where findings extend beyond Derbyshire's local control.

The Subgroup remains confident in identifying, recording and escalating learning and recommendations appropriately, including those that require consideration at regional or national level, ensuring that SARs contribute to wider system improvement wherever possible. Over the past twelve months, the Safeguarding Adult Review Subgroup has overseen the completion and publication of two Safeguarding Adult Reviews, both progressed in line with the statutory requirements of the Care Act 2014 and local governance arrangements. These reviews were undertaken with a clear focus on proportionality, quality and meaningful learning, ensuring that the process remained centred on safeguarding improvement rather than procedural compliance. The recommendations arising from both reviews are actively being progressed by all relevant agencies, with ownership clearly identified and timescales agreed.

The subgroup maintains robust oversight of all SAR action plans, tracking progress, challenging delays, and seeking assurance that learning is being translated into tangible changes in policy, practice, workforce development and inter agency working. This approach provides confidence that SAR learning is not static but continues to be driven forward until impact is evidenced. Year 1 of the Strategic Plan has marked a period of strong delivery and consolidation, and the achievements that follow reflect how partnership commitment and learning have been translated into measurable progress:

- Strengthened links with Public Health, with regular meetings in place and Public Health representation at DSAB Board meetings. SAR learning is now informing wider public health priorities, including homelessness and rough sleeping.
- Cross-SAB learning embedded, with learning reviewed from SARs outside Derbyshire (including West Sussex and Nottinghamshire) and assurance discussions initiated locally.
- Learning Themes Library launched on the DSAB website (January 2026), providing accessible SAR learning through multiple formats. A clear framework is now in place to support ongoing development and review of learning resources.
- Early work on impact measurement established, including the development of SAR impact logs and KPIs, aligned to national SAR workstreams on measuring learning and impact.
- Consistent involvement of people and families in SARs, with assurance that subjects of reviews, families and carers are invited to contribute and kept informed throughout the SAR

process.

- Positive practice embedded as standard, now included in SAR reports, learning briefs, LOOPs, and scoping information shared with agencies.
- Equality, Diversity and Inclusion principles embedded, with the DSAB EDI Charter explicitly referenced in SAR Terms of Reference and reports, ensuring a clear ‘golden thread’ throughout the SAR process.
- A new checklist for working with people and families was agreed in April 2026, strengthening consistency and quality of engagement.
- Improved quality assurance of SARs, including adoption of the SCIE SAR Quality Markers for commissioning.

Derbyshire District Councils Safeguarding Leads Subgroup

Chair: 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 brings together safeguarding leads from district and borough councils across Derbyshire. It provides a practical forum for sharing learning, reviewing policy and legislation changes, improving local responses, promoting best practice and contributing to the statutory safeguarding functions of both the Derby and Derbyshire Safeguarding Children Partnership and the Derbyshire Safeguarding Adults Board. It is particularly relevant to frontline services such as housing, environmental health, community safety and customer-facing teams, where concerns may first be identified.

During the year, the subgroup focused on building staff confidence, raising awareness of vulnerability and encouraging councils to embed suicide prevention in day-to-day practice. This included helping frontline teams recognise warning signs, understand signposting routes and respond sensitively when someone may be at risk of harm. Guest speakers and training sessions gave members practical input on domestic abuse, mental capacity, mental health support and local referral pathways, with a focus on applying learning in everyday practice. Examples of guest speakers and training have included:

- Domestic Abuse awareness training
- Understanding mental capacity, including consent, decision-making and recording clear rationale
- Community Mental Health Team input on local support pathways and working with adults experiencing mental ill-health
- Living Well in Derbyshire, including approaches to community-based mental health support
- Mentell, awareness of support available for men’s mental health and wellbeing
- The Elm Foundation, including awareness of domestic abuse support and referral routes.

The shared action plan has provided a clear focus, including training, embedding learning from reviews, strengthening recording and audit processes, and building stronger links with partner organisations. It also seeks to address operational issue through changes in policy and legislation.

Positive Impact The subgroup has made a positive contribution by bringing leads together to share

learning, discuss local issues and develop practical responses.

What has worked well:

- Sharing practical ideas and local solutions across district and borough councils.
- Improving relationships with partners and access to local support services.
- Encouraging earlier identification of risk and more timely, accessible and appropriate support.

Safeguarding work continues to be affected by rising demand, complex situations and pressure on frontline capacity. Concerns often involve connected issues such as mental health, financial hardship, domestic abuse, self-neglect and social isolation, making coordinated action essential.

The key ongoing challenges are:

- Responding to higher levels of demand and more complex concerns.
- Managing capacity pressures while supporting residents with multiple needs.
- Keeping safeguarding practice clear during organisational change, including local government reform.

Looking ahead, the DDSLSG will use its action plan to maintain progress, strengthen joint working and encourage confident, person-centred responses, while keeping prevention, inclusion and performance at the centre of its work. As part of a restructure linked to the Children's Partnership Board, the DDSLSG will move from quarterly to bi-annual meetings. The revised pattern will help the subgroup focus on priority actions, review progress and keep a clear route for district and borough councils to contribute to wider safeguarding work while preparing for local government reform.

Performance and Improvement Subgroup

Chair: Gemma Poulter, Derbyshire County Council Adult Social Care

During 2025–2026, the Performance and Improvement Sub-Group has made significant progress in supporting the Derbyshire Safeguarding Adults Board's 3 strategic priorities through a comprehensive programme of performance assurance, audit activity, learning reviews, and improvement work.

Prevention has been a key focus throughout the year. The subgroup analysed safeguarding trends and repeat referral data to better understand the causes of repeat and inappropriate referrals, particularly from care home settings and involving people with learning disabilities. This resulted in a multi-agency audit, development of improvement actions, and work to support agencies in learning from inappropriate referrals. The subgroup also reviewed MARM activity and learning, highlighting the positive impact of multi-agency risk management approaches in improving safety outcomes and reducing future harm. Training and awareness sessions on domestic abuse, sexual abuse, and support for unpaid carers further contributed to strengthening preventative practice across the partnership.

In relation to making safeguarding personal and inclusion, the subgroup supported implementation of learning from Safeguarding Adult Reviews and sought assurance from partner agencies regarding making safeguarding personal and application of the mental capacity act and completion of capacity assessments. Attention was given to barriers experienced by people requiring interpreter services, including British Sign Language users, and actions were identified to improve accessibility and inclusion. Work was also undertaken to understand practitioner awareness of carers' needs and

available support services, with findings informing workforce development activities and future family partnership guidance. Positive feedback from Safeguarding Adults Week events demonstrated increased practitioner confidence and knowledge in these key areas

The subgroup has made a substantial contribution to the Board's priority of performance and accountability. Quarterly safeguarding performance reports, MARM (multi-agency risk meetings) data, agency assurance information, and audit findings have been scrutinised to provide robust challenge and oversight. Significant improvements were made to safeguarding data quality through multi-agency data exercises and analysis of data discrepancies across organisations. The subgroup reviewed and refined key performance indicators, updated the multi-agency audit framework, introduced a revised Section 42 safeguarding form for trial, and provided assurance evidence to support partners with CQC inspection readiness. Learning from audits has been systematically shared through Learning on One Page (LOOP) documents, ensuring transparency, accountability, and continuous improvement across the safeguarding partnership.

Overall, the work undertaken during 2025–2026 has strengthened the Board's assurance framework, improved organisational learning, and supported better outcomes for adults at risk. While challenges remain, including repeat referrals, interpreter access, advocacy delays and ongoing system change, the subgroup has established strong foundations for continued improvement and partnership working in 2026–2027.

Making Safeguarding Personal (MSP) Subgroup

Chair: Bill Nicol, Derby and Derbyshire Integrated Care Board

The Derby City Safeguarding Adults Board's (SAB) Making Safeguarding Personal (MSP) Subgroup is chaired by Bill Nicol, Derby and Derbyshire NHS Integrated Care Board.

The primary focus of the MSP Subgroup is to promote Making Safeguarding Personal across Derby and Derbyshire, ensuring that the views, wishes and experiences of adults who have been involved in safeguarding processes are reflected in practice. The subgroup also supports continuous improvement and strengthens multi-agency working to ensure safeguarding remains person-centred and outcome-focused.

During 2025–26, the MSP Subgroup:

- Developed customer feedback arrangements – With support from Healthwatch colleagues, a survey was finalised to gather feedback from adults following the completion of safeguarding processes. The survey will be launched from April 2026.
- Developing MSP training and awareness materials – Progressed the development of a safeguarding awareness video explaining what adult safeguarding is and what people can expect from the safeguarding process. The video will be recorded and shared on the Derby and Derbyshire Safeguarding Adults Board website.
- Shared and reviewed MSP assurance activity – Received presentations and feedback from partner agencies on their approaches to Making Safeguarding Personal (MSP), including the findings of internal MSP audits and assurance activity. This provided an opportunity to share learning and identify areas for improvement.
- MSP Data – Regularly reviewed MSP data to monitor performance, identify trends and support continuous improvement in safeguarding practice.

- Promoted good practice - Cygnet Healthcare and its safeguarding group developed a video showcasing the work undertaken within the organisation to strengthen safeguarding practice and promote safeguarding and MSP.
- National Safeguarding Adults Awareness Week (NSAAW) – Supported activities to raise awareness of adult safeguarding and promote the principles of Making Safeguarding Personal.
- Dignity Event – Supported the Dignity Awards, recognising and promoting good practice in relation to dignity and person-centred approaches across Derby and Derbyshire.
- Reviewing of leaflets - Reviewed the Adult Safeguarding 'What to Expect' leaflet. The easy-read version was finalised, approved and circulated. The leaflet has also been made available in several languages and can be accessed through the SABs websites.
- Strengthened subgroup membership - Increased representation from the voluntary and community sector, with representatives now attending the subgroup and contributing to discussions.
- Monitored MSP training – Received quarterly data on MSP training attendance, enabling the subgroup to monitor participation and identify any areas where further training or development may be required.

Overall, the MSP Subgroup continued to support a person-centred approach to safeguarding, with a particular focus on listening to the experiences of adults, using feedback and assurance activity to improve practice, and strengthening partnership working across Derby and Derbyshire.

Financial Abuse Working Group

Chair: Katy Pugh, Age UK Derby and Derbyshire

The Derby and Derbyshire Financial Abuse Working Group (FAWG) continues to bring together partners from adult social care, health, police, Trading Standards, the voluntary sector and the England Illegal Money Lending Team to coordinate activity aimed at preventing financial abuse, fraud and scams across Derby and Derbyshire. During 2025/26 the group met in July 2025 and January 2026, maintaining strong partnership engagement and progressing actions aligned to the Board's priorities of Prevention, Inclusion and Performance.

A significant focus throughout the year was awareness raising. The group supported and promoted a range of national and local campaigns, including Safer Internet Day, National Safeguarding Adults Week, Stop Loan Sharks Week, Citizens Advice Consumer Awareness Campaign, World Elder Abuse Awareness Day and romance fraud awareness activity.

Partners agreed a coordinated approach to communications, with the Derbyshire Safeguarding Adults Board acting as the central point for developing and sharing campaign materials to maximise reach and consistency of messaging.

The group received updates on emerging scam trends and financial abuse risks affecting local communities. Derbyshire Police and Trading Standards highlighted increased reports of doorstep crime, rogue traders, card payment scams and issues relating to spray foam insulation schemes. Members shared intelligence and prevention messages to help professionals and the public recognise and respond to financial abuse risks.

Partnership learning remained a priority. The group heard from Octopus Energy regarding its

innovative social work service, which provides holistic support for vulnerable customers experiencing financial hardship, debt and other vulnerabilities. Information about the service was subsequently shared through safeguarding networks, professional forums and newsletters to increase awareness amongst practitioners and partner agencies.

During the year, the group also strengthened links with wider partnership arrangements, including Community Safety Partnership work on online harms and cyber-crime prevention. Members supported the delivery of cyber-crime awareness training and agreed actions to promote online safety resources through coordinated social media campaigns. The group reviewed and updated its Strategic Plan and Action Plan for 2025-2028, ensuring that future activity remains focused on prevention, awareness raising and improving outcomes for adults at risk of financial abuse.

Financial Abuse Working Group has demonstrated effective partnership working, delivered a coordinated programme of awareness activity, shared intelligence, strengthened professional knowledge and continued to promote support and resources to help protect adults from financial abuse across Derby and Derbyshire.

Safeguarding data 2025–2026

8885

Safeguarding adult referrals

19% increase from previous year

2246

Section 42 enquiries

25% of referrals made resulting in enquiries

90%

Risk to the person reduced or removed

Safeguarding outcomes

167

People supported through MARM

Multiagency adult risk management

Demographics of adults referred

63%

People referred were aged 65 or over

58%

Referrals for women

40% men; 2% not known

37%

The person lacked capacity

at the point of referral

92%

Referrals White British

2.5% White other; 2% ethnic minority groups; 2.5% not recorded

Referral source

35%

care homes

Residential and nursing homes combined; the largest referral source

6%

hospitals

combined total from all local hospitals

6%

Supported living care provider

and

6% Derbyshire Community Health Services

The highest referral sources are shown above. Self-referrals and referrals from family, friends, and members of the public accounted for **4%** of referrals during the quarter.

Locality, type and location of risk

Referrals by locality

21% Chesterfield	**15%** Erewash	**15%** Amber Valley

11% North East Derbyshire

Bolsover and South Derbyshire (10% each), High Peak 9%, Derbyshire Dale 8%, Out of area 1%

Types of risk recorded, 1 April 2025 to 31 March 2026

Neglect and Acts of Omission remained the most frequently recorded type of risk, followed by Physical Abuse and Self-neglect which is unchanged from previous years.

Category of abuse	Number	% of referrals
Neglect and Acts of Omission	3,642	**31.44%**
Physical Abuse	2,546	**21.98%**
Self-neglect	1,508	**13.02%**
Financial or Material Abuse	1,131	**9.76%**
Psychological Abuse	1,116	**9.63%**
Domestic Abuse	683	**5.90%**
Organisational Abuse	475	**4.10%**
Sexual Abuse	280	**2.42%**
Sexual Exploitation	101	**0.87%**
Discriminatory Abuse	75	**0.65%**

Modern Slavery	27	**0.23%**

Most common locations of abuse

39.9%	**26.4%**	**14.5%**
Person’s own home	Residential care settings	Nursing care homes
3,515 referrals	2,343 referrals	1,280 referrals

9.41% in community services (836 referrals)

Context: More than one location can be recorded for each safeguarding case. Residential and nursing care homes combined continued to be the most frequently recorded location of abuse.

Derbyshire SAB Key Performance Indicators (KPIs)

A Key Performance Indicator (KPI) is a measurable value used to assess performance against an agreed target. The Board monitors KPIs to identify strengths, explore areas of further development and seek assurance that safeguarding arrangements are effective and improving outcomes for adults.

2025–2026 KPI performance at a glance

6 of 10	99.3%	96.2%
KPIs met or exceeded target	Safety plan in place Target: 95%	Adults satisfied their outcomes were achieved Target: 80%

Meeting or exceeding target

Overall, six of the ten KPIs met or exceeded their targets in 2025–2026. Performance was particularly strong for safety planning, involving adults in enquiries and achieving their desired outcomes, indicating effective risk management and person-centred practice.

✓ **Mental capacity established at the point of referral** **87.8%** against an 85% target	✓ **Support to give views via an advocate** **91.9%** against a 90% target	✓ **Risk to the person reduced or removed** **93.9%** against a 92% target
✓ **Safety plan in place** **99.34%** against a 95% target	✓ **Views of the person sought (S.42 enquiry)** **95.28%** against a 90% target	✓ **Person's outcomes achieved** **96.23%** against an 80% target

Further exploration and improvement required

Four KPIs require further exploration. The main gaps relate to discussion and consent at referral, application of Section 42 criteria and the representation of adults from ethnic minority groups, requiring focused review of practice, access, recording and the suitability of current targets.

Discussion with the adult at point of referral

63.3% against an 80% target

Explore recording and barriers to involving the adult at referral.

Consent at the point of referral

48.9% against an 80% target

Review recording and reasons for referrals without consent.

Section 42 criteria met

26.10% against a 70% target

Explore referral quality, safeguarding interpretation and whether the target of 70% remains appropriate due to the National average being 28.9%.

Safeguarding Concerns for people who are not white British

2.81% of adults requiring a Section 42 enquiry identified as being from an ethnic minority group, compared with the 4.2% local target.

Further analysis is required to understand whether this reflects patterns of need, access, referral routes or data quality.

Assurance reports from Derbyshire SAB partner agencies 2025–2026

Partner assurance reports set out how organisations contributed to the Board's statutory functions, strategic priorities and shared safeguarding responsibilities during 2025–2026.

Derbyshire County Council Adult Social Care and Health

Senior lead: Gemma Poulter, Director for Adult Social Care

Derbyshire County Council (DCC) continues to play a central leadership role in supporting the Derbyshire Safeguarding Adults Board (DSAB) to deliver its strategic priorities of prevention, performance and inclusion.

Adult Social Care remains an active and committed partner within the Board and its sub-groups. This includes chairing both the Safeguarding Adult Review (SAR) subgroup and the Performance and Improvement subgroup, alongside providing robust safeguarding data, intelligence and analysis to support assurance, scrutiny and continuous improvement. DCC also hosts the DSAB business unit and contributes to the effective coordination of partnership activity.

A key development during 2025/2026 was the development of a new safeguarding feedback process in partnership with the DSAB, launched in April 2026. This represents a significant step forward in how the partnership captures and uses the experiences of adults to inform learning and improvement. The approach has been co-developed with partners, including Healthwatch and the Adult Social Care (ASC) Safeguarding Co-production Group, ensuring that lived experience directly informs practice and system change. The introduction of a consent-to-contact approach will enable more meaningful engagement with adults following safeguarding enquiries, strengthening the voice of the adult across the partnership.

The ASC Safeguarding Co-production Group continues to provide valuable insight and constructive challenge, supporting the review and development of safeguarding processes and contributing to DSAB priorities. This strengthens the partnership's commitment to co-production and ensures that improvements are informed by lived experience.

Multi-agency audit activity remains a key mechanism for quality assurance. DCC continues to support this by combining performance data with qualitative feedback from adults and practitioners, providing a more comprehensive understanding of safeguarding practice and outcomes across agencies.

Safeguarding demand continues to increase, with 8,885 safeguarding concerns received during 2025/2026, reflecting ongoing pressure across the system. A proportion of these concerns relate to individuals who experience repeat safeguarding episodes, highlighting the complexity of need and the importance of a multi-agency response focused on prevention and early intervention.

Performance data demonstrates strong outcomes for people, with the majority of safeguarding interventions resulting in reduced or removed risk and consistently high levels of satisfaction with outcomes achieved. Practice also reflects a continued focus on Making Safeguarding Personal, with adults being asked about their views, wishes and desired outcomes during safeguarding processes.

However, some challenges remain. The quality and consistency of safeguarding referrals, including consent at the point of referral and application of Section 42 criteria, continue to require improvement in partnership with agencies. Repeat referrals also remain a key area of focus,

reflecting the complexity of needs for some individuals and the importance of coordinated, preventative approaches.

Key safeguarding themes remain consistent, with neglect and physical abuse continuing to account for the highest proportion of concerns, alongside ongoing challenges relating to self-neglect.

Looking ahead, DCC will continue to prioritise its contribution to the work of DSAB, with a focus on embedding the new feedback framework, strengthening referral quality, and using performance data, audit and co-production to drive continuous improvement. Through strong partnership working, Derbyshire will continue to strengthen safeguarding practice and deliver improved outcomes for adults at risk.

Derbyshire Constabulary

Senior lead: Gareth Smethem, Head of Public Protection

Over the last year, Derbyshire Police has strengthened adult safeguarding practice through a preventative, partnership-led approach. Key activity has included proactive management of high-risk domestic abuse, stalking and exploitation offenders, there has been training around vulnerability assessments, training and an increase in the use of protective orders and quicker more relevant information sharing through multi-agency safeguarding arrangements. Targeted interventions have focused on reducing repeat victimisation, whilst training has enhanced officers' ability to recognise coercive control, cuckooing, exploitation and self-neglect at the earliest opportunity ensuring that capacity is a key consideration. We are above the national average in applications made for Civil orders.

The force has embedded a person-centred approach that prioritises inclusion and empowerment staff are trained to seek Victims' views, the desired outcomes and lived experience considered through safeguarding plans, risk assessments and multi-agency discussions, ensuring interventions are proportionate and tailored to individual needs. Performance and quality assurance has been strengthened through regular audits and reporting in governance and performance meetings and dip-sampling safeguarding investigations and PPN submissions with regular feedback provided. The learning identified from local and national Safeguarding Adult Reviews has been translated into operational guidance where needed and informed training and supervisory expectations. A new learning and development board is being developed which will enable us to identify common themes across not only SAR’s; but DADR and CSPRs to develop specific training and deliver consistent messaging across the organisation which will support organisation accountability in the partnership moving forward.

Over the last 12 months, Derbyshire Police has actively supported the Derbyshire Safeguarding Adults Board through consistent Board and subgroup representation, contributing to strategic priorities, performance scrutiny and policy development. The force has participated in Safeguarding Adult Reviews by completing reviews, training and communications. Officers have also contributed to multi-agency audits and quality assurance activity; whilst supporting safeguarding campaigns including Safeguarding adults week to raise awareness of domestic abuse, exploitation, self-neglect, financial abuse and exploitation and modern slavery; strengthening partnership working and improving outcomes for vulnerable adults.

Over the next 12 months, policing will continue to experience increasing demand from adults with complex and multiple vulnerabilities, including domestic abuse, exploitation, mental health, self-neglect, substance misuse and repeat missing episodes. The rising reports of fraud, cyber-enabled crime, cuckooing and AI-enabled scams targeting vulnerable adults will require enhanced investigative capability and preventative activity which will place additional pressures on specialist

safeguarding teams and frontline officers. Key priorities will be to strengthen multi-agency problem solving through the Safeguarding Adults Board, improve repeat vulnerability identification through data and analytics, continue to embed learning from Safeguarding Adult Reviews, enhance workforce capability through further vulnerability training, focus resources on prevention by managing the highest-risk offenders.

Derbyshire police will also look to develop and enhance its automation processes to provide quicker and more effective safeguarding interventions ensuring the right care is given through the most appropriate agency taking the lead by having the right information to support decision making as quickly as possible.

Derby and Derbyshire Integrated Care Board

Senior lead: 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 have been 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 2025-26 to a variety of health staff across Derby and Derbyshire. The DDICB participates in safeguarding 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.

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 2026-27.

The ICB continues with its re-structure following the Department of Health announcement in March 2025 and the safeguarding structures have been maintained and recruitment has commenced into key posts.

Derbyshire County Council Community Safety Unit

Senior lead: Christine Flinton, Head of Community Safety

The Council’s Community Safety Team (CST) 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 have been used to inform the rationalisation of thematic boards through a new Responsible Authorities Chief Officers Group (RACOG). A further event will be held in September 2026 to review the effective delivery of current community safety priorities.

The CST delivers a range of training to multi-agency partners working in Derbyshire. Training was accessed by 6,621 delegates in 2025/26. 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 Derbyshire County Council's Assistant Director of Public Health. The CST have commissioned a range of evidence-based interventions using Public Health funding.
- 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. A Multi-disciplinary Team process is in place across Derby and Derbyshire to respond to and address concerns relating to potential cases of exploitation amongst workers in health and care settings. Derbyshire County Council along with Derby City Council jointly commission the Rebuild East Midlands charity to provide initial 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 and the Afghan Resettlement Programme. To date the County has welcomed 223 individuals in family groups 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 2000 Ukrainian guests under the Homes for Ukraine scheme.

Department for Work and Pensions (DWP)

Senior lead: Karen Hartley, Advanced Customer Support Senior Leader

As outlined in the recently published Pathways to Work Green Paper, the Department is reviewing the approach it takes to safeguarding and is working to introduce and publish a DWP wide 'safeguarding approach' and has established a multi-disciplinary team to develop this, and this work is ongoing! The Department has also been supporting the Work and Pensions Select Committee's (WPSC's) Safeguarding Vulnerable Claimants inquiry and will consider recommendations the WPSC make in their report as it develops its safeguarding approach. In the meantime, the Department continues to deliver the layers of support it offers to all customers and remains committed to working with Safeguarding Adult Boards and other agencies to make sure its most vulnerable claimants get the support they need at critical points in their benefit journey.

I attend and contribute at Board and sub-group meetings and participate in SARs, DARDRs and some audits.

Healthwatch Derbyshire

Senior lead: Helen Henderson, Chief Executive

The main role of Healthwatch Derbyshire has been to stay connected to the board and its priorities, and ensure there is a synergy with our workplan. We have also been able to offer advice around collecting feedback, and using insight to help drive quality. We have attended board and the MSP subgroup when possible

Workforce, demand and system transformation means the context is challenging for the year ahead but the board is very aware of this, and is mindful of the risks involved.

DHU Healthcare

Senior lead: Julie Tomlinson, Lead Nurse for Adult Safeguarding

DHU Healthcare provides NHS 111, Out of Hours, Urgent and Emergency care across multiple Integrated Care Systems. Safeguarding remains a core organisational priority, embedded within clinical practice, governance arrangements and quality improvement programmes. Throughout 2025/26, DHU has continued to work collaboratively with both Derbyshire and Derby Safeguarding Adults Boards to promote the safety, wellbeing and rights of adults with care and support needs. The DHU Safeguarding Team actively promotes the principles of Making Safeguarding Personal throughout DHU. This is demonstrated through the provision of safeguarding advice, support/supervision to staff, alongside the delivery of bespoke safeguarding training tailored to DHU services.

The training incorporates a "Think Family" approach and has been developed in line with national

intercollegiate safeguarding guidance. DHU Healthcare demonstrates safeguarding compliance through completion of the Safeguarding Adult Assurance Framework (SAAF). This assurance assessment provides opportunity to evidence good practice and ensure compliance with national safeguarding standards and the strategic objectives of both Safeguarding Adults Boards. Safeguarding audits form a core component of the DHU safeguarding quality assurance programme and are delivered in accordance with the DHU Audit Strategy. Audit outcomes are aligned to organisational key performance indicators and safeguarding board expectations. Safeguarding leads have enhanced audit processes through the incorporation of trend analysis and thematic reviews, supporting the proactive identification of risks, emerging themes and opportunities for improvement. DHU has a robust referral process in place for safeguarding and lower-level concerns. These early intervention and prevention-focused referrals help ensure individuals receive the right support at the right time, reducing risk and enabling access to appropriate services. DHU contributes to all safeguarding-related reviews and statutory safeguarding processes. Learning identified through Safeguarding Adult Reviews, incidents, audits and other review mechanisms is disseminated throughout the organisation through governance structures, training and communication processes to strengthen safeguarding practice and improve service delivery.

Throughout 2025/26, DHU has continued to work collaboratively with both Derbyshire and Derby Safeguarding Adults Boards. As active members of both Boards we have continued to contribute to the Board's Strategic key strategic objectives. Throughout 2025/26 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.

During 2025/26, DHU Healthcare continued to contribute to Safeguarding Adult Reviews, multi-agency learning events and partnership initiatives across Derby and Derbyshire. Learning arising from safeguarding reviews, incidents, complaints and audit activity has been incorporated into staff training, supervision, governance processes and quality improvement programmes. This ongoing commitment supports continuous learning, strengthens safeguarding practice and contributes to improve outcomes for adults with care and support needs. Looking Ahead During the coming year, DHU will continue to support the priorities and objectives of the Derbyshire and Derby Safeguarding Adults Boards, while maintaining safeguarding as a core organisational priority. Key areas of focus will include:

- Continuing active participation in Board subgroups and multi-agency safeguarding processes.
- Embedding learning from Safeguarding Adult Reviews, audits and partnership activity into practice.

The changing NHS landscape, including wider service transformation and restructured Integrated Care Boards, is likely to present challenges. DHU will continue to respond proactively, working with partners to manage risk, share learning and improve outcomes for adults with care and support needs.

Diocese of Derby, Church of England

Senior lead: Lisa Marriot, Head of Safeguarding

The Diocese of Derby strengthened safeguarding through training, advice and support for clergy, church officers, employees and volunteers, promoting early identification of risk and safeguarding

awareness. Robust safeguarding, safer recruitment and risk management processes were supported by supervision, multi-agency working and targeted parish support. Ad hoc sessions with the DBS and partnership work with Derbyshire Police increased awareness of safer recruitment, fraud and financial exploitation risks. Enhanced data systems improved monitoring of safeguarding training, DBS renewals and compliance, resulting in stronger oversight, improved compliance and greater confidence in recognising and responding to safeguarding concerns.

The diocese places the views, wishes and outcomes of adults at risk at the centre of safeguarding practice. A key focus during 2025 to 2026 was understanding individuals' communication needs and adapting engagement accordingly, ensuring people could participate meaningfully in decisions about their safeguarding. Safeguarding responses were shaped by what individuals wanted to happen and the outcomes they wished to achieve. The Diocese developed a Survivor Strategy informed by survivors and specialist support agencies, helping shape future priorities and service improvements. Participation in the Boards' Making Safeguarding Personal group, alongside safeguarding training provided by the Boards, has strengthened person-centred practice and improved our safeguarding response. This approach has enhanced engagement, trust and involvement in safeguarding processes.

The diocese assures itself of safeguarding effectiveness through supervision, management oversight, audit activity, National Safeguarding Team (NST) quality assurance processes, compliance monitoring and reporting to senior leaders and governance bodies. Data systems support oversight of safeguarding training, DBS and safer recruitment compliance. During 2025 to 2026, a project manager was appointed to support preparation for the Church of England's independent INEQE safeguarding audit. Learning from SARs, NST quality assurance activity and audit findings has been embedded through training, policy review and reflective practice.

The diocese has actively engaged with both Derby and Derbyshire Safeguarding Adults Boards through attendance at Board and sub group meetings, contributing to partnership discussions, learning and safeguarding developments. The diocese has participated in the MSP subgroup, with learning helping to strengthen person-centred safeguarding practice. Staff have accessed Board training and awareness raising opportunities to enhance safeguarding responses. The diocese has also contributed to safeguarding reviews, audits and partnership initiatives where appropriate, supporting shared learning and continuous improvement across the safeguarding partnership.

Key challenges during 2025 to 2026 have included increasing demand and complexity within safeguarding casework, alongside supporting parishes to meet safeguarding, training and safer recruitment requirements. Emerging risks include the growing impact of dementia, poor mental health, homelessness and social isolation, domestic abuse affecting older adults, and financial exploitation. These challenges are being managed through strengthened quality assurance processes, improved data monitoring, professional supervision, partnership working and targeted support to parishes. The diocese has successfully recruited a new safeguarding team, comprising experienced safeguarding professionals and dedicated administrative support, increasing capacity and strengthening service delivery. As a relatively new team, there is a continued focus on embedding consistent practice, building capacity and supporting continuous improvement. Learning is also shared through regional safeguarding networks across the East Midlands, helping to identify emerging themes, share good practice and strengthen safeguarding responses.

Preparation for the Church of England's independent INEQE safeguarding audit has provided a further opportunity to review and strengthen safeguarding arrangements. Priorities for 2026 to 2027 include implementing learning from the INEQE audit, embedding the Diocese's Survivor Strategy, further developing person-centred safeguarding practice, and maintaining high levels of compliance

with safeguarding training, DBS and safer recruitment requirements.

Derbyshire Fire and Rescue Service

Senior lead: Kay Simcox, Safeguarding Lead

Derbyshire Fire and Rescue Service has participated in several Serious Adult Reviews across both the City and County, resulting in the implementation of measures such as the introduction of the Carers sticker, designed to assist formal and informal carers in identifying heightened fire risks. Additionally, there has been consensus to launch a series of podcasts and webinars for health and social care professionals. These initiatives are intended to support our partners and the wider community in recognising early indicators of fire hazards, thereby enabling us to offer appropriate guidance and assistance to mitigate such risks.

Derbyshire Fire and Rescue Service adhere to the principles of Making Safeguarding Personal, demonstrating a steadfast commitment to ensuring that the perspectives and voices of adults and children at risk of abuse are respected and considered. Our safeguarding referrals are subject to rigorous and continuous monitoring, with particular emphasis on obtaining consent and understanding individual wishes. This approach enables us to deliver tailored, person-centred support that addresses the unique needs of each individual.

Performance and Quality Assurance Derbyshire Fire and Rescue Service has recently undergone a review of the Safeguarding Fire Standards which is a professional framework developed by the Fire Standards Board to guide Fire and Rescue Services on how to embed safeguarding principles into all aspects of service operations. By undertaking this review we can assure our safeguarding practice adheres to the relevant legislation and Local Authority requirements. This activity has provided our Strategic Leadership team assurance that both the community and staff are protected from abuse or neglect. Furthermore, Learning Loops have been embedded into our Internal Safeguarding Board agenda ensuring we have oversight of recommended changes to practice, policy and procedures.

Safeguarding Managers from Derbyshire Fire and Rescue Service have attended all board and sub-groups meetings where possible this year and have been key to supporting SAR25a and SAR04 where fire was a key element to these reviews. We have actively taken part in audits, reviewing the Hoarding Framework and provided a Fire Risk Assessment which is now included in the Derby and Derbyshire SAB Practice Guidance.

This year, Derbyshire Fire and Rescue Service will implement mandatory Level 1 Safeguarding Adults and Children's training for all staff members. In addition, the newly appointed Area and Group Manager will be briefed on our responsibilities in supporting Local Authorities and our communities. This year will also mark the introduction of a new podcast, aimed at providing partners with practical advice and guidance on how we can assist vulnerable members of our community, particularly those at risk of fire, and share vital information regarding emerging risks. Furthermore, we are launching a new 'Carers video' specifically developed for informal carers, which will be shared across our service and partner network to raise awareness of potential risks, and offer practical support to help carers protect vulnerable adults in their care.

Derbyshire Community Health Services

Senior lead: Elaine Summers, Head of Safeguarding

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. DCHS attends meetings where there are concerns regarding abuse, harm, domestic abuse and radicalization, as part of information sharing across agencies including supporting early intervention and risk reduction. Safeguarding supervision is recognised by DCHS as an important element of the safety culture promoting good standards of practice and contributes to improving outcomes for adults at risk and their families.

DCHS consistently seeks the views of people, their families, and/or carers. This includes at an individual level regarding their health care during appointments and service development/improvement. DCHS promotes a culture of listening to adults and taking account of their wishes and feelings through people-centred policies, safeguarding training, supervision, and audit. Practitioners are supported to engage with the people they see in trauma informed ways, to document their views within assessments, and to ensure the person's voice informs decisions including considering the person's voice alongside information from family, carers, partner agencies and clearly documenting the adult's wishes and feelings within health records.

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.

DCHS is a proactive member of both the Derby the Derbyshire SAB's, prioritising attendance at the Board Meetings and sub-groups. The DCHS Named Nurse Safeguarding Adults, chairs the Derbyshire SAB Multi-agency Audit Group and a Specialist Practitioner Safeguarding Adults is deputy chair for the DSAB Policies and Procedures Group. DCHS attends review meetings to contribute to learning and ensures 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.

The Safeguarding Service had a significant period of absence; service delivery and statutory safeguarding functions were maintained. This was supported using a secondment arrangement, which provided additional capacity and ensured continuity of safeguarding leadership, advice, oversight, and operational functions. DCHS continues to work with the SAB's and partners to review social care safeguarding adult referrals, reviewing the quality and that they have met the threshold for safeguarding. A key focus is domestic abuse, with particular emphasis on embedding routine enquiry within Urgent Treatment Centre's. This approach supports the early identification of domestic abuse, enabling staff to recognise concerns, respond appropriately and facilitate access to safeguarding and specialist support services.

Derbyshire Healthcare NHS Foundation Trust

Senior lead: Nicola Roome, Assistant Director Safeguarding Adults

Derbyshire Healthcare (DHCFT) is a has continued to embed safeguarding as a "golden thread" across all services, supported by compliance with the Safeguarding Adult Assurance Framework (SAAF) and alignment with Local Authority KPIs.

Key preventative activity included:

- Delivery and dissemination of safeguarding guidance, newsletters and decision-making tools to support early identification and appropriate referrals (e.g. falls guidance, safeguarding leaflets around making a good referral, peer on peer abuse also domestic abuse following a recent DHR).
- Active contribution to multi-agency learning and awareness initiatives, including safeguarding training and information shared via organisational safeguarding communications, operational and safeguarding link worker meetings. This has supported improved quality of referrals, earlier intervention and more consistent risk recognition across services.
- DHCFT meets its public protection responsibilities by attendance and active work within MAPPA, Channel and MARAC.

DHCFT promotes Making Safeguarding Personal by supporting practitioners to consider individual wishes, outcomes, and lived experience within safeguarding processes. Service users are supported to understand safeguarding through accessible information (e.g. “What to Expect” leaflets and MCA resources). Lived experience is reflected at Board level and through multi-agency reviews and learning processes.

Staff are equipped through supervision, training and reflective practice to embed person-**centred**, trauma-informed approaches. This has supported improved engagement and clearer communication with individuals involved in safeguarding processes.

DHCFT maintains robust safeguarding assurance through governance, audit and learning systems:

- Regular reporting to the Trust Quality and Safeguarding Committee ensures oversight of safeguarding performance and statutory compliance
- Participation in multi-agency audits, QA subgroups and KPI monitoring strengthens oversight of practice quality and outcomes.
- Active involvement in SARs, DHRs and other reviews, with structured dissemination of learning via training, monthly safeguarding updates and policy review and information sharing documents.
- Learning from reviews is embedded through training, guidance updates and targeted improvement work, if required, ensuring continuous service development and improved safeguarding practice.
- DHCFT has maintained active and consistent engagement with Derbyshire SAB throughout 2025–2026.

DHCFT is a proactive member of the Board and its sub-groups, with regular attendance and contribution to Board meetings and quality assurance forums, supporting delivery of the SAB strategic priorities.

DHCFT has actively participated in multi-agency activity, including Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), and other review processes, contributing to shared learning and system improvement. The Trust has engaged in multi-agency audits and performance activity, including case file audits and KPI monitoring, to strengthen oversight of safeguarding practice and outcomes across the system.

DHCFT has supported SAB-led workstreams and campaigns through dissemination of learning, guidance and training opportunities across the organisation, promoting awareness and consistent practice. This ongoing engagement demonstrates DHCFT’s commitment to collaborative working,

shared learning and continuous improvement in safeguarding practice across Derbyshire.

DHCFT continues to operate within a context of increasing demand and system pressures, including workforce capacity challenges and the complexity of safeguarding need. Rising referrals linked to self-neglect, domestic abuse and mental health presentations require a coordinated, multi-agency response and place pressure on practitioner time and decision-making. To manage these risks, the Trust continues to work with practitioners to strengthen guidance and supervision arrangements, supporting staff to make proportionate, defensible decisions and prioritise early intervention. Ongoing engagement with SAB partners supports shared risk identification and consistent approaches.

Emerging risks align with SAB priorities and include organisational abuse, self-neglect and the impact of social complexity on individuals' ability to engage with safeguarding processes. Multi-agency frameworks and updated guidance are being used to support earlier recognition and coordinated responses. Over the coming year, key areas of focus will be:

- Continuing to improve the quality and timeliness of safeguarding referrals
- Further embedding Making Safeguarding Personal and trauma-informed practice
- Strengthening workforce capability through training and working together to strengthen decision making.
- Ensuring learning from SARs, DHRs and audits is consistently translated into practice.

This approach supports continuous improvement and ensures safeguarding remains responsive, person-centred and risk focused.

University Hospitals Derby and Burton

Senior lead: Yvonne Pabi, Safeguarding Adults Lead

The team provide advice and support for application of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and a wide range of safeguarding issues relating to adults and who may be at risk of abuse or neglect, either deliberately or by acts of omission. They continue to attend the wards when a referral is received, advise staff, liaise with social care and other relevant agencies / professionals, ensure the principles of Making Safeguarding Personal are applied, attend professionals' meetings where safeguarding issues are a factor and ensuring effective multi-agency working and discharge planning takes place. A total of 653 Adult social care referral made by staff 2025-2026. The team also respond to Initial Enquiries (IEs) from several Local Authorities. A total of 399 IE's- Information sharing received. Audits of referrals continue to be 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.

The team also respond to Section 42 (Care Act 2014) enquiries raised by other providers, regulatory bodies or adult social care when there is an allegation or reason to believe that abuse or neglect is taking place or is at risk of taking place. There have been 118 s42 enquiries in 2025-26. When this event / incident is alleged to have happened in the hospital this can be described as a "referral against the Trust. Themes commonly include hospital acquired tissue viability issues, unexplained bruising, discharge and information sharing concerns and "care concerns". The Team are planning to implement quarterly thematic review of s42 referrals in 2026-27

Domestic abuse

The safeguarding team continues to input alerts when Domestic Abuse logs are received from either Derbyshire or Staffordshire police. The Head of Safeguarding is working with senior staff from People Services to ensure effective employee advice and support is in place. Information and guidance has been developed and distributed. 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.

- 1357 MARAC cases responded to
- 563 DV logs from police
- 270 Maternity DV logs received from police

Training compliance

Level 3 safeguarding (adults and children's) is mandatory for all patient facing clinical staff and remains a full day face to face training session (or available via eLearning specifically commissioned for UHDB. Training compliance is monitored in the Trust Safeguarding Group / Trust Vulnerable People Group. With over 13,000 staff at UHDB, training compliance across the Trust remains a significant issue.

Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DARDRs)

The Trust 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). We made 3 submissions to the SAR subgroup to request consideration for undertaking a SAR. DARDRs, UHDB responded to 15 scoping requests and no IMR's have been requested to be undertaken. UHDB also responded to 3 scoping requests for Fatal Fire Learning Reviews.

Chesterfield Royal Hospital NHS Foundation Trust

Senior lead: Kelly Tunicliffe, Named Nurse Safeguarding Adults

CRHFT has prioritised early identification and prevention of abuse and neglect through a "Think Family" approach, recognising the links between safeguarding and complex needs. Staff are supported through a comprehensive safeguarding education programme and targeted training (including MCA, Prevent and domestic abuse), enabling early recognition of risk and timely intervention. Preventative work includes routine enquiry (embedded within maternity and progressing within Emergency Department), proactive risk management, and specialist pathways such as maternity alcohol and substance use services. Multi-agency engagement, including MARAC, MATAC and Safeguarding Adults Board activity, supports coordinated early intervention and risk reduction. The Trust embeds a person-centred approach, ensuring patients' views, wishes and outcomes are central to safeguarding practice. The service promotes empowerment through involvement in decision-making, documentation of patient wishes within referrals, and application of Mental Capacity Act principles. Work across learning disability, dementia and enhanced care supports reasonable adjustments and equitable access to care. Feedback from audits has highlighted the importance of capturing the patient voice (MSP), which has been reinforced through education and governance processes. Specialist initiatives such as enhanced support, HOPE Boxes, and trauma-informed approaches further improve patient experience and engagement. 3. CRHFT has a strong governance framework providing assurance through the Think Family Committee and escalation to Quality Assurance structures. Safeguarding practice is monitored through audit programmes (e.g., referral quality, domestic abuse DASH, and MCA/best interest processes), with learning embedded through training and service improvement. The Trust

contributes to and learns from Safeguarding Adult Reviews (SARs), Child Safeguarding Practice Reviews, and other statutory reviews, ensuring organisational learning is translated into practice. Ongoing participation in the Safeguarding Adult Assurance Framework, Section 11 audits and multi-agency processes provides external assurance. Continuous improvement focuses on strengthening referral quality, supervision, and embedding learning across safeguarding and complex needs services.

CRHFT has actively engaged with the Safeguarding Adults Board (SAB) through representation at Board and sub-group meetings, including leadership contributions such as chairing policy and procedures groups. The Trust participates in multi-agency forums including MARAC, MATAC and Channel Panel, supporting partnership working and information sharing. CRHFT contributes to Safeguarding Adult Reviews (SARs) and other statutory reviews through information submissions, panel involvement and embedding learning into practice. The organisation also engages in multi-agency audits, workstreams and assurance processes, including SAAF, to support continuous improvement and ensure effective safeguarding practice across the Trust.

CRHFT continues to manage increasing demand and complexity across safeguarding and complex needs services, with high volumes of contacts and rising complexity of cases involving mental health, self-neglect, domestic abuse and MCA/DoLS. Workforce and system pressures remain a challenge, particularly in ensuring consistent safeguarding practice, delivering supervision, and managing enhanced care needs. Emerging risks include individuals presenting with multiple vulnerabilities such as substance misuse, social isolation, and mental ill health, alongside challenges in maintaining high-quality referrals and consistently capturing the patient voice in line with Making Safeguarding Personal. System-wide pressures also impact timely multi-agency coordination.

Looking forward, key priorities include improving referral quality and consistency, embedding safeguarding supervision, and fully implementing routine enquiry for domestic abuse. Further focus will be on strengthening MCA/DoLS practice, enhancing learning from SARs and reviews, and improving governance and data capture. Continued investment in workforce development, education, and multi-agency collaboration will support improved outcomes for our patients.

East Midlands Ambulance Service

Senior lead: Lucy Gascoignbe, Head of Safeguarding

Throughout 2025–2026, EMAS demonstrated a strong commitment to preventing abuse and harm through early identification, effective referral pathways, and workforce development. EMAS responded to over one million emergency and urgent incidents across the East Midlands, with safeguarding or care concerns identified in 5.1% of incidents, equating to more than 53,000 referrals. This represents an 8% increase on the previous year and reflects improved staff confidence, clarity around thresholds, and strengthened referral quality rather than increased risk alone.

A key preventative development was the enhanced screening of mental health related safeguarding referrals by Specialist Practitioners, significantly reducing inappropriate referrals to Adult Social Care and improving accuracy. EMAS also plays a unique preventative role in identifying domestic abuse, operating specialist referral pathways across the region and contributing to Domestic Abuse Related Death Reviews. In addition, EMAS is the only ambulance trust in England to offer a structured referral pathway following non-fatal overdoses, enabling earlier intervention and nationally recognised practice in preventing drug related deaths.

Prevent duties remained firmly embedded, with high compliance in Prevent training and clear escalation routes into local authority and counter terrorism pathways, supporting early disruption of radicalisation risks.

EMAS adopts a strong Think Family and trauma informed approach, ensuring safeguarding practice is person-centred and responsive to the diverse needs of adults, children, and families. Safeguarding education is embedded across the organisation using a blended learning model, ensuring all staff; frontline, control room, and non-emergency transport services, are equipped to recognise abuse, understand consent and mental capacity, and apply Making Safeguarding Personal principles in practice.

The voice of the individual is emphasised within safeguarding referrals, with audits showing consistent improvement in recording patient and family views. EMAS also demonstrated inclusive practice through its contribution to Learning Disability Mortality Reviews (LeDeR), Child Death Reviews, and poor prognosis processes, supporting system wide learning and improving outcomes for some of the most vulnerable people in the region.

Internally, the Safeguarding Directorate reported exceptional staff engagement and psychological safety, supporting a confident and resilient workforce able to raise concerns and challenge poor practice.

EMAS provides strong assurance through robust governance, audit, and external scrutiny. Safeguarding is fully integrated within the Quality Directorate, with clear reporting from frontline services to Board level through structured quality and governance arrangements. During 2025–2026, EMAS completed its full audit programme, with the majority of safeguarding referrals achieving over 90% compliance and clear mechanisms in place to address learning where gaps were identified.

External assurance was particularly strong, with full compliance achieved in Section 11 audits, the Safeguarding Adults Assurance Framework (SAAF), and the Safeguarding Commissioning Assurance Toolkit (SCAT). Internal audit provided Significant Assurance, evidencing effective controls, timely escalation, and consistently applied safeguarding processes.

EMAS also contributes extensively to multi agency reviews, including Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, and Domestic Abuse Related Death Reviews, with participation increasing to its highest level to date. This demonstrates strong accountability, transparency, and commitment to shared learning across safeguarding partnerships.

HMPPS Sudbury

Senior lead: Samantha Lea, Head of Wellbeing and Services

HMP Sudbury Contribution to Derbyshire Safeguarding Adults Board 2025-2026 HMP Sudbury strengthened safeguarding through a range of preventative, engagement and assurance activities during 2025-2026.

Safeguarding was enhanced through improved induction and early days processes, strengthened transfer arrangements from closed prisons, routine welfare checks, and increased support for vulnerable prisoners. The prison expanded self-harm and neurodiversity support within the Safer Accommodation Unit, promoted domestic abuse services, improved drug and alcohol recovery pathways, and increased access to mutual aid groups. Debt, financial wellbeing and pre-release support were also strengthened to reduce vulnerability and support successful resettlement. These actions contributed to improved engagement, reduced OASys backlogs, increased attendance at recovery programmes and a reduction in work-related disciplinary issues.

Prisoner voices were actively sought through COMCIL, Lammy meetings, cohort forums, food forums, induction surveys and gym consultations. Feedback informed improvements to induction, wellbeing provision, food services and recreational opportunities. Designated cohort SPOCs supported vulnerable groups, including care-experienced prisoners and young adults, while quarterly Lammy reviews promoted fairness, transparency and proportionality. These mechanisms increased prisoner involvement in decision-making and service development.

Safeguarding effectiveness was monitored through audits, dip testing, performance databases, CSIP and ACCT oversight, OASys reviews, cohort meetings and multidisciplinary governance forums. Equality Impact Assessments were embedded within policies and strategies, while action plans arising from audits, surveys and reviews informed improvements in induction, wellbeing, equality, debt management and safety processes. Strong partnership working across operational, healthcare, wellbeing, psychology, education and resettlement teams ensured a coordinated response to safeguarding risks and continuous improvement in prisoner care and support.

HMP Sudbury supports Derbyshire SAB objectives through active partnership working, quality assurance activity and safeguarding improvements. The prison contributes to multi-agency safeguarding through audits, equality reviews, ACCT and CSIP oversight, and collaborative work with healthcare, psychology, education and resettlement services. Learning from reviews has improved induction, self-harm prevention, support for vulnerable groups, domestic abuse awareness, substance misuse services and release planning. Practice Plus Group, the prison's healthcare provider, aims to attend safeguarding meetings every three months, supporting partnership working, information sharing and continuous improvement in safeguarding outcomes for prisoners preparing to return to the community.

HMP Sudbury continues to manage several safeguarding challenges linked to workforce pressures, increasing complexity of need, and service capacity. Key pressures include staffing shortages in some areas, recruitment and training requirements for specialist roles such as ACCT assessors and cohort SPOCs, and maintaining service delivery while managing a growing number of prisoners with complex mental health, neurodiversity, substance misuse and resettlement needs. Emerging risks aligned to Derbyshire SAB priorities include self-harm among vulnerable groups, debt and financial vulnerability, substance misuse, domestic abuse, and ensuring safe transitions into custody and back into the community. These risks are being managed through enhanced induction processes, strengthened ACCT and safety arrangements, improved multi-agency working, targeted support pathways, quarterly Lammy reviews, cohort meetings, and collaborative work with healthcare, psychology, substance misuse and resettlement services.

Over the coming year, HMP Sudbury will focus on strengthening early intervention, improving induction and support for vulnerable prisoners, embedding equality and safeguarding assurance processes, expanding rehabilitation and release planning services, improving staff capability, and enhancing partnership working with organisations including Practice Plus Group and community agencies to support safer outcomes and reduce reoffending.

Probation Service, Derbyshire

Senior lead: Jonathan Webb, Probation Delivery Unit (PDU) Head-Derbyshire

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 and our (newly commissioned) Neuro Diversity Coaching offer 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 Senior Probation

Officers which are benchmarked by our quality development 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

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.

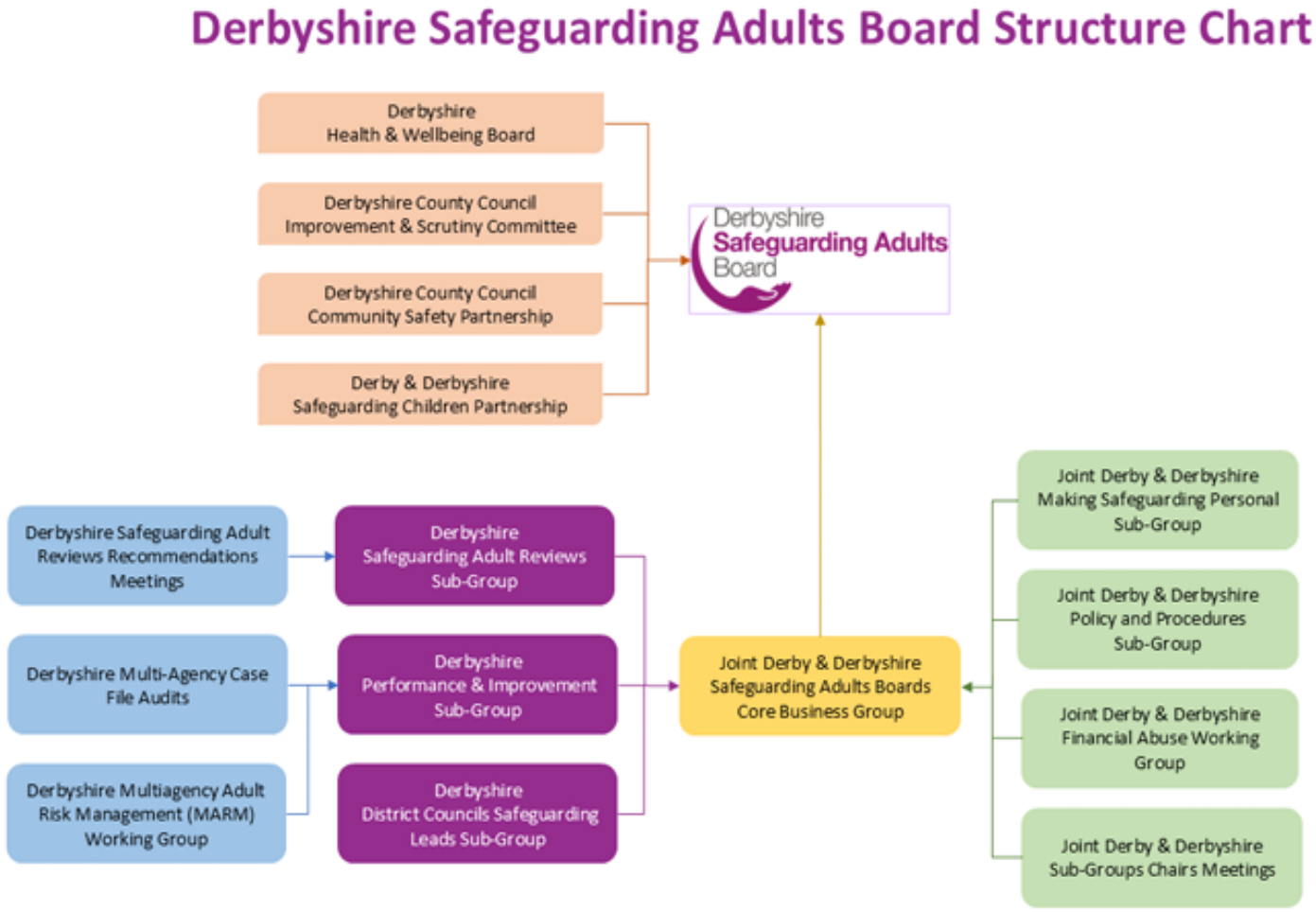
Our 'new starter' induction programme ensures that staff and volunteers are made aware of their adult safeguarding responsibilities. All staff are required to undertaken mandatory training which is in e-learning and face to face classroom events. Reflective practice sessions are offered to all staff 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 and features in training and briefing of all staff.

Appendix 1: Derbyshire SAB Board membership 2025–2026

Statutory Board organisations	
Derbyshire County Council Adult Social Care and Health	NHS Derby and Derbyshire Integrated Care Board
Derbyshire Constabulary	**Independent Chair: Amanda Clarke**
Other organisations represented	
Age UK Derby and Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust
Department for Work and Pensions	Derbyshire Community Health Services NHS Foundation Trust
Derbyshire County Council Community Safety	Derbyshire Fire and Rescue Service
Derbyshire Healthcare NHS Foundation Trust	Derbyshire Voluntary Action
DHU Healthcare	Diocese of Derby
East Midlands Ambulance Service NHS Trust	Healthwatch Derbyshire
HMP and YOI Foston Hall	HMP Sudbury
Housing/Environmental Health (District Councils)	Independent Chair
National Probation Service Derbyshire	Office of the Police and Crime Commissioner Derbyshire
University Hospitals of Derby and Burton NHS Foundation Trust	
Advisers to the Board	
Care Quality Commission	Derbyshire County Council Legal Department

Appendix 2: DSAB Structure Chart



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Appendix 3: Attendance at Derbyshire SAB Board meetings 2025-2026

Partner agency	10 Apr 2025*	10 July 2025	09 Oct 2025
Age UK Derby and Derbyshire	A	A	AR
Chesterfield Royal Hospital NHS Foundation Trust	A	A	A
Cloverleaf Advocacy	AR	DNA	DNA
Derby and Derbyshire Integrated Care Board	A	A	A
Derbyshire Community Health Services NHS Foundation Trust	A	A	A
Derbyshire Constabulary	A	A	A
Derbyshire County Council Adult Social Care and Health	A	A	A
Derbyshire County Council Community Safety	A	DNA	A
Derbyshire District Council Safeguarding Leads Subgroup	A	A	A
Derbyshire Fire and Rescue Service	A	A	AR
Derbyshire Healthcare NHS Foundation Trust	A	DNA	DNA
Derbyshire Voluntary Action	AR	DNA	DNA
Diocese of Derby	A	A	A
DHU Healthcare	A	A	AR
East Midlands Ambulance Service NHS Trust	A	A	DS
Healthwatch Derbyshire	AR	AR	AR
HMP and YOI Foston Hall	DNA	A	DNA

HMP Sudbury	A	AR	AR
Milford Care, representing Derbyshire care homes (Membership officially started in January 2026)	N/A	N/A	A
Office of the Police and Crime Commissioner	A	A	A
Probation Service	AR	AR	AR
University Hospitals of Derby and Burton NHS Foundation Trust	AR	A	A

Key: A = attended; AR = apologies received; DS = deputy sent; DNA = did not attend; N/A = not applicable. *Joint development session.

The meeting scheduled for 15 January 2026 was rescheduled to 2 July 2026 and is therefore not included.

If you have any questions or comments in relation to the Annual Report, please email DerbyshireSAB@derbyshire.gov.uk

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