




Derby Safeguarding Adults Board

Annual Report 2025-2026

derby safeguarding adults board

Introduction from the Independent Chair



It is my privilege to introduce Derby Safeguarding Adults Board (DSAB) annual report for 2025-26. The report not only demonstrates the breadth of safeguarding activity in Derby but the evident commitment of partners in responding to an increasingly complex and demanding safeguarding landscape.

Organisations have despite challenges faced in relation to boundary changes and structural reorganisation have continued to work collaboratively to protect adults at risk with care and support needs across Derby City.

The report provides evidence of impact in relation to the delivery of our strategic priorities with clear tangible evidence of improvement activity, together with the capture of the lived experience of individuals within the adult safeguarding system which we will use to improve the work which we do as a board.

This report highlights the progress that has been made and captures our shared ambition as a partnership to continue with our journey of continuous improvement.

Best wishes,

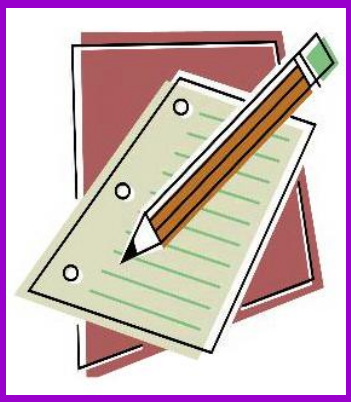
Richard Proctor

Independent Chair, Derby Safeguarding Adults Board

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1. Demographic information of Derby



1.1 Demographic Information of Derby



The 2021 Census estimated Derby's population at 261,400, an increase of 5.1% from around 248,800 in 2011. This was a smaller increase than the 7.7% increase across the East Midlands.

Derby has a young population, with 20% of residents aged 15 years and under, 63.7% aged 16 to 64 years and 16.4% aged 65 years and over. The median age increased from 36 to 37 years between 2011 and 2021, although Derby remained younger than both the East Midlands (median age 41) and England (median age 40).

Derby has become increasingly diverse. In 2021, 73.8% of residents identified their ethnic group within the 'White' category, compared with 80.3% in 2011. The proportion identifying within the 'Asian, Asian British or Asian Welsh' category increased from 12.5% in 2011 to 15.6%. In addition, 78.7% of Derby residents reported their country of birth as England, compared with 84.0% in 2011.

These demographic changes provide important context for the work of Derby Safeguarding Adults Board (DSAB). The diversity of Derby's population means that safeguarding services need to be accessible, inclusive and responsive to different cultural, communication and support needs.

What this means for safeguarding

The demographic profile provides an important context for DSAB's priorities during 2025-26. In considering safeguarding activity and assurance, DSAB has sought to understand not only the volume of safeguarding concerns and enquiries, but also whether safeguarding arrangements are effectively reaching and supporting Derby's diverse population.

Where demographic information indicates potential inequalities or differing experiences, this should be considered alongside local safeguarding data, feedback and learning to identify any areas requiring further assurance, partnership action or targeted work during 2026-27.

2. Governance arrangements and legislative context

2.1 Governance arrangements and legislative context

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

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

Safeguarding Adults Boards have the following statutory duties:

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

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

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

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

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

DSAB holds partners to account through performance monitoring, Key Performance Indicators (KPIs), quality assurance, audit, safeguarding reviews and constructive challenge. The Board uses these mechanisms to seek assurance about the effectiveness of local safeguarding arrangements, identify areas for improvement and monitor partner actions and outcomes. Further evidence of how DSAB provides assurance and holds partners to account is set out throughout this Annual Report in the relevant sections.

3. Derby Safeguarding Adults Board (DSAB) 2025-26

derby safeguarding adults board

3.1 Derby Safeguarding Adults Board (DSAB)

3.1.1 DSAB Strategic Plan and Priorities:

The new and agreed Derby Safeguarding Adults Board Strategic Plan 2025-28 has the three key priorities below to achieve its vision:

Quality Assurance	Empowerment	Prevention

3.1.2 Vision of the Derby SAB for 2025-26:

"We will work together to enable people in Derby to make choices to stay safe and to live a life free from fear, harm and abuse."

The DSAB is independently chaired by Richard Proctor, who provides impartial oversight, constructive challenge and strategic leadership. The Board meets quarterly and works closely with other strategic boards and partnerships to support a coordinated, multi-agency approach to safeguarding adults. Its overarching role is to provide assurance that local safeguarding arrangements are effective, partners meet their statutory responsibilities, and adults at risk are protected, supported and have their rights upheld in line with the Care Act 2014.

3.2 Resources and Funding for DSAB:

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

3.2.1 Derby SAB Budget Contributions 2025-26:

Derby City Council	£58,495.00
NHS Derby and Derbyshire ICB	£58,495.00
Derbyshire Police	£58,495.00
Derbyshire Fire and Rescue Service	£5k
Derby Homes	£5k
Total Contributions	**£185,485**
Total Amount Spent	**£186,714**

Derby Safeguarding Adult Review (SAR) expenses are included within the above Derby SAB budget expenditure The total expenditure for safeguarding adult reviews during 2025-2026 was £11k.

3.3 Key DSAB achievements and progress 2025-2026

During 2025-26, DSAB's work was driven by the three priorities within the DSAB Strategic Plan 2025-2028: Prevention, Empowerment and Quality Assurance & Accountability. The achievements below demonstrate the activity undertaken during the year and, where evidence is available, the difference this work has made to safeguarding practice, partnership working and the experience of adults in Derby.

Prevention:

Derby and Derbyshire SAB Prevention Principles

The Care Act 2014 identifies prevention as one of the six key principles underpinning adult safeguarding. Prevention is a strategic priority for the DSAB, recognising that preventing abuse and neglect is a shared responsibility across the partnership.

During 2025-26, the Derby and Derbyshire SABs developed joint Prevention Principles to establish a shared framework for strengthening preventative approaches across the partnership.

The principles focus on:

- improving awareness;
- embedding prevention within practice;

- promoting Making Safeguarding Personal and strengths-based approaches;
- strengthening partnership working; and
- supporting transparency and accountability

The Prevention Principles have established a common framework and shared expectations for prevention across the Derby and Derbyshire safeguarding partnerships. This provides partner organisations with a basis for considering how effectively prevention is embedded within their own services and practice.

The intended longer-term impact is earlier identification and management of risk, increased opportunities for early intervention and a reduction in the likelihood of abuse or neglect occurring or escalating.

During 2026-27, DSAB will build on this work through the development of a Prevention Strategy, providing an opportunity to establish how the implementation and impact of prevention will be measured and evidenced across the partnership.

Derby SAB Multi-Agency Training

During 2025-26, DSAB continued to deliver a comprehensive multi-agency safeguarding training programme involving statutory, voluntary, community and third-sector organisations across Derby.

A total of 1,050 people attended DSAB training during the year, representing a wide range of agencies and professional backgrounds.

Evaluation feedback demonstrated a positive impact:

- 99% of delegates reported an improved understanding of safeguarding concepts and procedures.
- 99% reported increased confidence in recognising and responding to safeguarding concerns.
- 95.5% reported that the training would improve their practice.

The programme combined core multi-agency safeguarding training with specialist and bespoke learning developed in response to identified need and emerging areas of practice.

A key area of development was Making Safeguarding Personal (MSP). DSAB developed a dedicated course in partnership with Cygnet Hospital, which contributed specialist knowledge to the course content and co-delivery.

Specialist learning was also supported by external organisations and professionals in areas including domestic abuse, mental capacity and coroner-related learning. New areas of delivery included hoarding and self-neglect, alongside bespoke training for individual organisations and services.

DSAB also continued its community outreach training, taking safeguarding learning directly into local organisations and communities and adapting delivery to identified need.

Training evaluation demonstrates a clear immediate impact on participants' knowledge and confidence, with almost all delegates reporting improvements following training and 95.5% anticipating that learning would improve their practice.

The use of partner expertise and co-delivery has also enabled DSAB to bring specialist safeguarding knowledge directly into multi-agency learning, while bespoke and community-based delivery has allowed training to respond to specific local needs.

Collectively, this supports a more knowledgeable, confident and consistent safeguarding workforce across Derby, better equipped to recognise concerns and respond appropriately.

The next step is to strengthen evaluation of longer-term impact, including whether delegates have subsequently changed their practice and whether learning is reflected in casework and organisational assurance.

National Safeguarding Adults Week Webinars 17-23 November 2025

During National Safeguarding Adults Week, Derby SAB worked jointly with Derbyshire Safeguarding Adults Board to deliver a programme of webinars reflecting the national theme of Prevention.

The webinars covered:

- Co-Production
- Cybercrime and Online Safety
- Domestic Abuse and Older adult’s
- Low level support and home from Hospital
- Sexual Abuse and Older adults
- Safer Cultures in Sport
- Who Cares for Carers

271 delegates attended across Derby and Derbyshire:

- 97.3% reported improved knowledge, confidence and understanding of safeguarding concepts and procedures.
- 95.7% reported that attending the webinars would improve their practice.

The evaluation provides evidence that the programme increased participants' safeguarding knowledge, understanding and confidence, while also giving practitioners opportunities to explore prevention across a range of safeguarding issues.

Bringing together organisations and practitioners across Derby and Derbyshire also enabled learning and expertise to be shared across organisational boundaries, reinforcing the message that preventing abuse and neglect requires a partnership approach.

DSAB Newsletters

In 2025-26, DSAB launched its first newsletter, establishing a regular communication channel for sharing safeguarding information, resources, learning and good practice with partners and practitioners. Three editions were produced during the year, covering the Board's strategic priorities, safeguarding guidance, multi-agency learning, Safeguarding Adults Reviews, training opportunities, prevention activity and emerging safeguarding resources.

The newsletters have created a consistent mechanism for communicating safeguarding learning and developments across the partnership, making information and resources more readily available to practitioners and partner organisations. This supports wider awareness of DSAB's work and provides another route for translating learning, guidance and emerging safeguarding issues into practice.

DSAB will continue the newsletter during 2026-27 and will seek opportunities to understand its reach and usefulness, enabling the Board to assess more clearly how the newsletter is supporting safeguarding practice across Derby.

Launch of the new Learning Themes Library

During 2025-26, Derby and Derbyshire SABs, alongside other partnerships, launched a Learning Themes Library, bringing together guidance, resources and learning relating to recurring themes identified through Safeguarding Adults Reviews,

Child Safeguarding Practice Reviews, Domestic Abuse-Related Death Reviews and LeDeR Reviews.

The library includes resources relating to:

- domestic abuse;
- fire safety;
- legal literacy;
- Making Safeguarding Personal;
- multi-agency working and information sharing;
- professional curiosity;
- substance use; and
- unpaid carers

The library has created a central and accessible route through which learning from different types of statutory and safeguarding reviews can be translated into practical resources for practitioners.

Importantly, bringing recurring themes together also helps DSAB and partners to identify connections between learning arising from different review processes, rather than considering each review in isolation.

The library will continue to develop as new learning emerges. Monitoring its use will help DSAB understand its reach and provide stronger evidence of whether practitioners are using review learning to inform practice.

Empowerment:

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

Following requests for the Safeguarding Adults: What to Expect leaflet to be available in additional languages, the leaflet was reviewed and updated during 2025-26 to better reflect the needs of Derby's diverse communities. Versions were produced in several languages alongside the approved Easy Read version.

Increasing the range of accessible versions has reduced a potential barrier to adults and families understanding the safeguarding process. It means information can be provided in formats that better meet individuals' communication and language needs, supporting people to understand what safeguarding involves and what they can expect.

This contributes to a more accessible and person-centred safeguarding system, supporting people's involvement in decisions and promoting the principles of Making Safeguarding Personal.

Developed Customer Feedback Arrangements

With support from Healthwatch colleagues, DSAB finalised a survey to gather feedback directly from adults following the completion of safeguarding processes. The survey will be introduced from April 2026 and will provide adults with an opportunity to share their experience of safeguarding, including whether they felt listened to, involved in decisions and supported to achieve the outcomes that mattered to them.

Feedback will provide DSAB with valuable understanding into how safeguarding is experienced by adults and help identify what is working well and where improvements are needed. Findings will inform the Board's assurance and improvement activity and strengthen the voice of adults within safeguarding practice.

Dignity Action Month

During February 2026, DSAB supported the Dignity Action Month, promoting dignity, respect and person-centred care and support across Derby and Derbyshire.

Colleagues were encouraged to become Dignity Champions, reinforcing dignity as a fundamental element of good care and support.

The Dignity Tea event brought together professionals from across the partnership and residents and provided an opportunity to recognise individuals and teams demonstrating compassionate, person-centred practice and a commitment to upholding dignity.

Dignity Action Month provided a visible opportunity to reinforce the importance of dignity, respect, empowerment and person-centred practice across the safeguarding partnership.

Recognising positive practice also enabled DSAB to promote examples of the behaviours and approaches it expects to see across services, supporting a safeguarding culture in which the rights, wishes and experiences of adults are central to practice.

Quality Assurance and Accountability:

Multi-Agency Case File Audits and Learning

During 2025-26, DSAB's Quality Assurance Subgroup undertook three multi-agency case file audits, focusing on:

- Mental Capacity Act practice;
- referrals where safeguarding criteria were not met; and
- repeat referrals.

The audits examined practice across partner agencies and identified areas of good practice alongside areas requiring improvement.

Learning from each audit was summarised in a Learning on One Page and shared across the partnership to support reflection and improvements in practice. Recommendations arising from the audits are being progressed through DSAB's quality assurance arrangements.

The audits have enabled DSAB to move beyond reviewing performance data to examine the quality of safeguarding practice within individual cases, providing richer evidence about how multi-agency safeguarding arrangements are operating in practice.

They have identified specific areas for improvement and enabled learning to be shared with practitioners across the partnership.

Importantly, the process creates a cycle of assurance and improvement:

Audit → identify learning → share learning → implement recommendations → seek assurance → review improvement

During 2026-27, DSAB will review progress against recommendations and seek evidence that learning has been embedded. This will enable the Board to assess whether the audits have resulted in demonstrable improvements in safeguarding practice, rather than measuring completion of recommendations alone.

Information Sharing Agreement

During 2025-26, DSAB reviewed and updated its Information Sharing Agreement (ISA) to provide partners with a clear framework for lawful and effective information sharing across the safeguarding partnership.

The revised agreement has provided a common framework for partner organisations to understand their responsibilities when sharing information for safeguarding purposes, supporting greater clarity and consistency in multi-agency working.

Effective information sharing is fundamental to identifying risk, coordinating safeguarding responses and enabling DSAB to obtain the information it requires for its assurance activity.

Derby City Council Adult Social Care - Provider Reporting Web Form

During 2025-26, DSAB worked with Derby City Council to promote the Provider Reporting Web Form, providing care providers with a clear alternative route for reporting incidents and information that do not meet safeguarding criteria.

Following promotion of the form, there was an increase in provider reporting through this route alongside a reduction in referrals that did not meet safeguarding criteria.

This provides encouraging evidence of a change in provider reporting behaviour. The combination of increased use of the appropriate reporting route and fewer referrals that did not meet safeguarding criteria indicates that providers are becoming better able to distinguish between safeguarding concerns and other reportable incidents.

This supports:

- more appropriate referral pathways;
- better targeting of safeguarding resources;
- reduced inappropriate demand on safeguarding processes; and
- appropriate oversight of concerns that require a response outside safeguarding procedures.

Derby and Derbyshire SAB safeguarding adults practice guidance

During 2025-26, seven existing multi-agency safeguarding guidance documents were reviewed and approved, helping to ensure that practitioners continued to have access to relevant and up-to-date guidance.

Guidance is developed and reviewed in response to identified practice issues, learning and requests from partners, supporting practitioners to apply a clear and consistent multi-agency approach to safeguarding.

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
- Multi-agency working and safeguarding.

The review and development of guidance have strengthened the practical resources available to practitioners when responding to safeguarding concerns, particularly in areas where partners have identified a need for additional clarity or support.

Providing shared multi-agency guidance also helped reduce variation in practice between organisations and promotes a common understanding of safeguarding responsibilities and approaches across Derby and Derbyshire.

Derby and Derbyshire SAB Members Information Pack

During 2025-26, Derby and Derbyshire Safeguarding Adults Boards developed a Board Member Information Pack to support Board and subgroup members in understanding their roles, responsibilities and contribution to effective safeguarding.

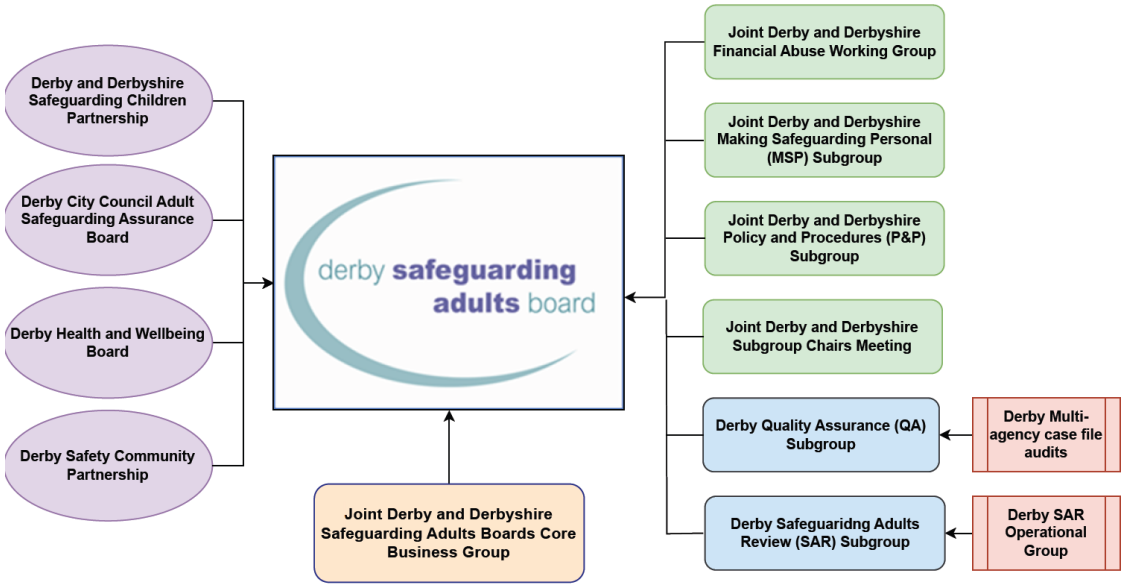
The pack provides a shared introduction to adult safeguarding, safeguarding principles, Board and subgroup structures, membership responsibilities and the role of the Independent Chair.

The pack provides a consistent induction and reference resource for Board and subgroup members, supporting greater clarity about what is expected of members and how individual organisations contribute to the work of the safeguarding partnership.

This is intended to strengthen effective participation, constructive challenge and organisational accountability, supporting DSAB's ability to operate as an effective multi-agency strategic partnership.

The pack will also provide a consistent basis for the induction of new members, helping to maintain organisational knowledge when membership changes.

3.4 DSAB Subgroups:



The Board's work programme is supported by six multi-agency subgroups, with representation from statutory and non-statutory organisations, as well as health and social care services. Each subgroup is accountable to the Board for delivering the actions set out in the business plan and provides a highlight report at each Board meeting. These reports focus on progress against the actions required to deliver the current Board Strategic Plan. The six key subgroups are:

3.4.1 Derby and Derbyshire Joint Core Group Meeting

The Derby and Derbyshire SABs Core Business Group brings together key statutory partners from Derbyshire and Derby City Safeguarding Adults Boards (SABs). The group is attended by the Independent Chairs of both SABs and the Derby and Derbyshire SAB Board Managers.

The Core Business Group meets at least quarterly between formal SAB Board meetings.

The purpose of the Core Business Group is to:

- Discuss, advise and make recommendations to the Derby and/or Derbyshire SABs on key safeguarding issues and Board agenda items, including opportunities for joint working and co-production across Derby City and Derbyshire.

- Monitor and follow up priority SAB business, including matters requiring escalation or action across Derby City and Derbyshire between Board meetings.
- Identify issues requiring further scrutiny by one or both SABs, including matters relating to partner agency engagement and participation at Board and subgroup meetings.
- Consider emerging and urgent safeguarding themes at local and national level, ensuring that appropriate and timely action can be identified and considered.

The Core Business Group provides an important link between the two SABs, supporting effective information sharing, joint working and coordinated responses to safeguarding priorities across Derby City and Derbyshire.

3.4.2 Quality Assurance (QA) Subgroup



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

The Quality Assurance Subgroup has maintained a clear focus on the quality of referrals, sharing learning between organisations about how thresholds are understood and how referrals are quality assured prior to submission.

As a standing agenda item, partners provide regular assurance to the Quality Assurance Subgroup on safeguarding processes and practice within their individual agencies. This enables the Subgroup to maintain oversight of safeguarding arrangements across the partnership, identify areas requiring further assurance or challenge, and share good practice. Partners are also required to provide assurance on how learning identified through multi-agency case file audits is shared, implemented and embedded within their organisations, supporting continuous improvement and ensuring that learning leads to changes in practice.

Learning from this work has directly informed the development of Derby's front door Artificial Intelligence (AI) assistants. Additional eligibility information has been built into the system so that Care Act assessment information is incorporated into decision-making and advice, helping to prevent people from being inappropriately directed through safeguarding pathways. The impact of this work will be monitored and is expected to reduce the time a vulnerable adult waits to receive care and

support when this is the most appropriate intervention, as well as reducing the number of inappropriate referrals received by the Council.

Across the year, the quality and appropriateness of referrals from DSAB partners have improved and been sustained. While some predictable regression has occurred, this has been identified quickly and addressed.

The number of safeguarding referrals received by Derby City Council, and the number of Section 42 enquiries undertaken, remain high compared to other unitary authorities. The percentage increase in referrals received was above national averages in 2022/23 (11.8%), 2023/24 (7.9%) and 2024/25 (16.8%). In 2025/26, the percentage increase was far lower (1.9%) than in previous years and below the national average of around 5% annually. It is our collective view that the work undertaken across all statutory Board partners has contributed to this improvement.

Despite the high number of enquiries, Making Safeguarding Personal continues to be a core focus within the MASH. In 84% of cases, the person or their representative was asked for, and had, their desired outcomes recorded, compared with 87% nationally. In 96% of cases where a desired outcome was expressed, outcomes were fully or partially achieved, compared with a national figure of 95%. Positive progress has also been made in relation to the prevention agenda.

A multidisciplinary audit focusing on cuckooing is planned for 2026-27. This audit will be used as a test case to assess what each agency knew about the vulnerable person and whether more effective information sharing could have prevented abuse from occurring.

Through collaboration with all Board partners, the Subgroup has developed a draft DSAB Prevention Strategy. The strategy aims to support a shift from reactive responses towards a more proactive and preventative approach. Its objectives are to prevent abuse and neglect before it occurs, to utilise data and intelligence to identify early signs of potential risk, to reduce repeat harm and escalation, and to promote wellbeing, independence, and resilience.

By strengthening collaboration and information sharing, our goal is to use present and historical referrals to help predict future demand, thereby enabling the reduction, prevention, and delay of abuse within our communities.

Drawing on the wider principles of neighbourhood working, partners will identify patterns and trends affecting individual neighbourhoods and work together to develop tailored solutions that meet local need.

3.4.3 Making Safeguarding Personal (MSP) Subgroup



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 highlighting 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.

3.4.4 Policies and Procedures (P&P) Subgroup



The Policy and Procedures (P&P) Subgroup, chaired by Zoe Rodger-Fox, is a joint subgroup with Derby and Derbyshire. The aim of the subgroup is to support the policies and procedures work of both the Derby and Derbyshire Safeguarding Adults Bards 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, with each item allocated to specific reviewers, ensuring clear ownership and accountability for completion.

3.4.5 Financial Abuse Working Group

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.

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.

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

3.4.6 Safeguarding Adults Review (SAR) Subgroup



The Safeguarding Adults Review (SAR) Subgroup, chaired by Andy Smith, Derby City Council, plays a key role in considering SAR referrals and determining whether they meet the statutory criteria for a SAR under the Care Act 2014. The Subgroup supports the identification of learning where an adult with care and support needs has died or experienced serious harm as a result of abuse or neglect, particularly where there are concerns about how agencies worked together.

A dedicated SAR Operational Group supports the implementation of learning from SARs and other relevant reviews. The group monitors progress against action plans, evaluates the impact of actions taken, and supports the sharing of local and national learning across partner agencies.

Partners are required to provide regular updates to the SAR Operational Group demonstrating how learning from SARs and other relevant reviews has been disseminated and embedded within their organisations. This enables DSAB to monitor not only the completion of actions, but also the implementation and impact of learning, providing assurance that identified learning is informing safeguarding practice and resulting in sustainable improvements across the partnership.

During 2025-26:

- **New referrals** - Three SAR referrals were received during 2025-26.
    - **Derby SAR REF02** – The referral was considered by the SAR Subgroup during 2025-26 and was determined not to meet the statutory criteria for a SAR. Although the adult had care and support needs, there was no evidence of serious abuse or neglect and no reasonable cause for concern about how agencies had worked together to safeguard the adult. The Subgroup did, however, identify opportunities for wider multi-agency learning for future consideration and the referring agency was advised to follow its internal procedures to raise a formal complaint.
    - **Derby SAR REF03** – The referral was considered by the SAR Subgroup during 2025-26, and it was agreed that the criteria for SAR were met and that the review is to be commissioned to an Independent Reviewer (**Derby SAR06**).
    - **Derby SAR REF04** - The referral has been scheduled for consideration by the SAR Subgroup in April 2026.

- **Derby SAR05** - Continued to oversee Derby SAR05, accepted by the SAR Subgroup in July 2024, which is being commissioned to an Independent Reviewer.
- **Doreen (Derby SAR02)** - Continued to monitor progress against the Derby SAR02 action plan. The SAR was formally approved by the Board and published in July 2023, and implementation of its recommendations has been monitored through the SAR Operational Group since that time. At 31 March 2026, one action remained outstanding, with the full action plan expected to be completed and signed off during 2026-27.
- **Dylan (Derby SAR04)** - Derby SAR04 was formally signed off by DSAB in March 2025. The review used a System Findings methodology, which identified system learning and posed questions for the partnership. During 2025-26, the SAR Operational Group used the findings and questions from the review to develop a set of SMART recommendations, which were agreed in February 2026. Publication of the SAR was subsequently agreed for April 2026, alongside the recommendations developed from the review. This approach enabled DSAB to translate the system learning identified through the review into clear and measurable actions for the partnership, providing a framework through which implementation and impact can be monitored.

During 2025-26, DSAB did not make any decisions not to implement findings arising from a Safeguarding Adults Review.

SARs ongoing on 31 March 2026

On 31 March 2026, Derby SAR05 and Derby SAR06 remained ongoing. Both reviews were in the process of being commissioned to independent reviewers.

SARs commissioned to independent reviewers are allocated across the three statutory partners.

3.5 Published Safeguarding Adults Reviews and Learning

Pink (Derby SAR03)

Derby SAR03 was formally approved by the Board in July 2025 and published in March 2026. The review identified seven recommendations and found a number of areas requiring improvement, including:

- inconsistent responses to Pink's views, wishes and preferences;
- limited understanding of her communication needs and abilities;
- insufficient application and recording of mental capacity and best interests' processes;
- a lack of observation of eating and drinking following the closure of the day service;
- reduced contact with services during the COVID-19 pandemic;
- and limited multi-agency identification, management and escalation of risk.

The recommendations focus on:

- improving communication and reasonable adjustments for people with learning disabilities,
- strengthening the application and recording of Mental Capacity Act processes,
- improving the identification and management of Was Not Brought appointments,
- providing appropriate support to carers,
- and ensuring that existing processes for raising and sharing concerns are consistently used.

The recommendations are being monitored by the SAR Operational Group, which will seek assurance from the agencies involved that the required actions are being implemented and are informing future practice.

The Learning Brief and Learning On One Page (LOOP) documents can be found on Derby Safeguarding Adults Board website:

Learning Brief – Safeguarding Adults Review: Pink

Learning On One Page (LOOP): Pink

The Board continues to use SARs to identify learning, strengthen partnership working and improve safeguarding practice. Progress against SAR recommendations and actions is monitored through the SAR Operational Group, with significant learning shared across partner agencies.

Further information on Safeguarding Adults Reviews, including published reviews, can be found on the Derby Safeguarding Adults Board website.

What families told us about the SAR process?

Following completion of SAR03, DSAB sought feedback from a family member about their experience of being involved in the review. The family member felt listened to and able to express and challenge views and could see their contribution reflected in the final report. They also valued having the opportunity to comment on the report and learning brief.

However, the feedback identified areas where the SAR process could be improved. The family member would have welcomed more regular communication, clearer information about the review and its timescales, and greater involvement at the beginning of the process, including an opportunity to contribute to the Terms of Reference.

The family member also emphasised the importance of knowing whether the recommendations arising from the review are subsequently implemented.

What will we do differently?

The feedback will be used to strengthen DSAB's approach to involving families in future SARs. In particular, DSAB will consider how families can be involved earlier in determining the focus of reviews, how accessibility and communication preferences are identified from the outset, and how more regular updates can be provided throughout the review process. We will also ensure that families are kept informed about the learning and actions arising from reviews, where appropriate.

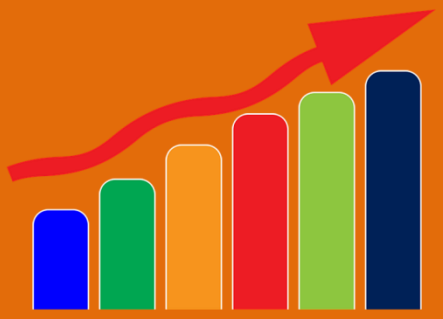
Family voice

The family member shared reflections on both their experience of being involved in the SAR and their family's experience of services before the person died:

"I was listened to and I could get my views over at different points."

"All the agencies try to do their own thing... when it should be one big body."

4. Activity Reports



4.1 Activity Reports:

4.1.1 Safeguarding Adults 2025-26 Data

The 2025-26 Safeguarding Adults Collection (SAC) records details about safeguarding activity for adults aged 18 and over and was amended in line with the changes brought about by the Care Act 2014.

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

- **Safeguarding Concerns:** This means cases where a sign of suspected abuse or neglect is reported to the council or identified by the council. Derby City Council have captured information about concerns that were raised during 2025-26, that is the date the concern was raised with the council falls within the reporting year, regardless of the date the incident took place.
- **Safeguarding Enquiries:** This means the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult to a more formal multi-agency plan or course of action.
- **Section 42 Safeguarding Enquiries:** The enquiries where an adult meets all of the section 42 criteria.
- **Other Safeguarding Enquiries:** The enquiries where an adult does not meet all of the section 42 criteria, but the council considers it necessary and proportionate to have a safeguarding enquiry.

The next two pages will highlight the total number of safeguarding referrals received 2025-26 with the following breakdown:

- **Number of safeguarding referrals received during 2025-26.**
- **Safeguarding enquiries started and concluded during 2025-26.**

Total Number of Safeguarding Referrals received in Derby during 2025-26

Total Number of Safeguarding Referrals Received in 2025-26 — 6258

Total Percentage increase in Referrals from 2024-25 — 2%

Total Number of Section 42 Safeguarding Enquiries — 4655

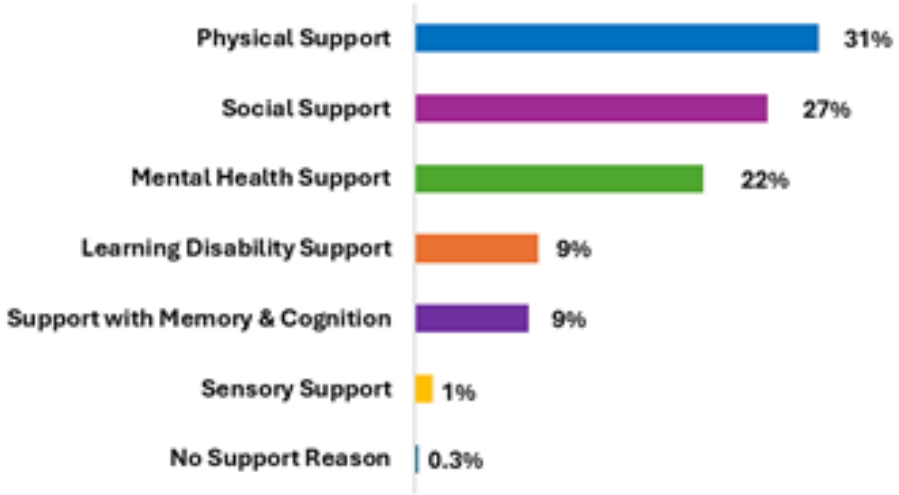
Age and Gender



55% of referrals were in relation to women were whilst 45% were in relation to men.
The average population of females in Derby 50.5%.

People between 18-64 received the most referrals amounting to 53%. This is the same as 2024-25.

Primary Support Reasons



Ethnicity

2024-25	2025-26	Ethnicity
68%	67%	White / White British
2%	2%	Mixed / Multiple
6%	6%	Asian / Asian British
4%	4%	Black / African / Caribbean / Black British
1%	2%	Other Ethnic Group
19%	20%	Undeclared / Not Known

The average population of Derby who are White/White British is 73.8%

White/White British is the largest ethnicity group for safeguarding referrals with 67%. This is a slight decrease from 2024-25.

Referral Source

Majority of referrals were made by care homes 14.5%

1.8% of referrals were self-referrals.

Safeguarding Enquiries concluded in Derby during 2025-26

Location of Abuse

55% of Safeguarding Enquiries concluded were where alleged abuse took place in the individuals own home. This is an increase of **2%** from 2024-25.





19% of concluded referrals were where abuse took place in a care home (nursing or residential), which is a **1%** decrease from 2023-24 whilst **7%** were in a hospital setting.

Advocacy



21.6% of people who lacked mental capacity during the safeguarding process of which **82.8%** were supported by an advocate.

Making Safeguarding Personal

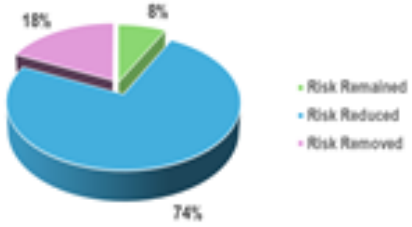
79.8% of people were asked of their desired outcomes, of which **81.8%** expressed their desired outcomes.

Of those who expressed their desired outcomes, **74.7%** people said their outcomes were either fully or partially achieved.

Type of Abuse

2024-25	2025-26	Type of Abuse
23%	20%	Neglect and Acts of Omission
19%	19%	Physical Abuse
14%	14%	Psychological Abuse
14%	14%	Financial or Material Abuse
13%	14%	Self-Neglect
9%	8%	Domestic Abuse
4%	4%	Sexual Abuse
2%	4%	Organisational Abuse
1%	1%	Sexual Exploitation
1%	1%	Discriminatory Abuse
<1%	<1%	Modern Slavery

Result of action Taken



Feeling Safe

46% reported that they felt safer as a result of the safeguarding intervention and **4%** reported that they didn't feel safe. For the remaining **50%,** feedback was not obtained, either because the person did not provide a response or because their circumstances meant they were no longer available or able to provide feedback.

4.1.2 What is the data telling us?

DSAB The safeguarding data shows that demand remains high but is beginning to stabilise. Derby received 6,258 safeguarding concerns in 2025-26, compared with 6,163 in 2024-25. This represents an increase of around 1.7%, which is smaller than the increases seen in the previous three years. This could indicate that the rapid year-on-year growth in safeguarding concerns is beginning to level off, although this will need to be monitored over time.

There has also been a reduction in the proportion of concerns progressing to a Section 42 enquiry, from 59.7% in 2024-25 to 55.1% in 2025-26. This means that, although overall concerns increased slightly, fewer progressed to a formal safeguarding enquiry. Alongside DSAB's work on referral quality and safeguarding thresholds, this is an important trend for the Board to continue to scrutinise.

The profile of people involved in safeguarding remains broadly consistent. Women continue to account for the majority of Section 42 enquiries, although the proportion reduced slightly, while there was a corresponding increase for men. The largest proportion of enquiries continues to relate to adults aged 65 and over, reinforcing the importance of safeguarding activity which recognises the risks associated with age, care and support needs, dependency and caring arrangements.

The pattern of abuse also remains stable. Neglect and acts of omission continue to be the most frequently recorded type of abuse, followed by physical, psychological and financial or material abuse. This reinforces the importance of DSAB's ongoing work with care providers and partner agencies around prevention, early identification, quality of care and professional curiosity.

People's own homes remain the most common location of abuse, followed by care homes. This is significant for the Board's prevention agenda because safeguarding risks are not confined to regulated care settings. Prevention therefore needs to extend across people's homes, communities and services and be supported by effective multi-agency information sharing and early intervention.

Overall, the data indicates that safeguarding demand in Derby remains high, but the rate of increase has slowed during 2025-26. Fewer concerns are progressing to Section 42 enquiries, while the profile of abuse, people affected and locations remains

consistent. This provides DSAB with important intelligence to target prevention and assurance activity, particularly around neglect, safeguarding within people's own homes and the needs of older adults. The Board will continue to monitor these trends alongside referral quality, Making Safeguarding Personal outcomes and multi-agency assurance activity to understand whether improvements are sustained.

4.1.3 Strengthening the Quality of Safeguarding Referrals

DSAB continues to hold partners to account for the quality of safeguarding referrals through four key measures. Referring organisations are expected to record whether the concern has been discussed with the adult or their representative, whether consent has been sought and appropriately recorded, whether mental capacity has been considered, and whether the safeguarding criteria have been considered at the point of referral. These measures support a person-centred approach, with the Care and Support Statutory Guidance emphasising that care and support should focus on the needs, goals and outcomes that matter to the individual.

During 2025-26, 6,266 safeguarding contacts were received, compared with 6,163 in 2024-25, an increase of approximately 2%. Despite this increase in activity, performance improved across three of the four quality measures:

- concerns discussed with the adult or their representative increased from 50.62% to 57.34%, an improvement of 6.72%
- consent obtained increased from 43.31% to 51.84%, an improvement of 8.53%
- Mental Capacity Act considerations increased significantly from 40.26% to 54.82%, an improvement of 14.56%; and
- recording that the safeguarding criteria had been considered remained broadly stable, reducing slightly from 75.11% to 74.29%.

Impact

The improvements provide greater assurance that safeguarding is becoming more person-centred at the point of referral, with increased evidence of adult involvement and consideration of consent and mental capacity. This aligns with the Care Act 2014 approach of focusing on the individual's wellbeing, wishes and desired outcomes.

While the overall direction is positive, further improvement is needed to ensure these considerations are consistently applied and recorded across the partnership. DSAB will continue to scrutinise performance, seek assurance from partners and use the findings to identify areas for challenge, learning and improvement.

4.1.4 Safeguarding Adults in Practice

Lizzie's Story.



Since joining the Safeguarding Group, I can speak about incidents more openly.

Recently there was an incident involving the shop keeper over the road from the hospital who was trying to coax me into getting into his car, using inappropriate comments.

I felt empowered to report this issue not just for myself but to raise awareness for other people to help and protect them too.

I acted on this and I co-wrote a safeguarding referral, reported this to the Police and I also co-wrote the incident report in my records. I felt empowered and involved. This was my story; I was involved in keeping myself and others safe.

I felt even more empowered when I saw the response from the Safeguarding Team who said that they were satisfied with what had been done to keep me safe and that they were closing the referral. This was the first time that I had been included in a response from the Multi-Agency Safeguarding Hub (MASH), it was good!

This response made me feel better valued as a human being, acknowledged, worthwhile and that I had done something positive, not only for myself but also for others. My story had been read; my voice had been heard.

The stress of the incident was more easily dealt with as I had closure, this gave me a boost to my emotional well-being.

Sam's Story.

The safeguarding concern

Two safeguarding concerns were received regarding Sam, who was experiencing domestic abuse from her partner, Paul, for whom she was also an informal carer.

Sam described controlling behaviour, verbal aggression and physical violence. Police had previously attended incidents at their home. Paul was living with dementia and Korsakoff syndrome, and there were concerns that changes in his cognitive functioning were contributing to increasingly unpredictable behaviour. The situation had become difficult for Sam to manage safely.

Putting Sam at the centre

The Multi-Agency Safeguarding Hub (MASH) worked with Sam to understand what was important to her and reduce the immediate risks to her safety.

Sam did not wish to pursue criminal charges, and her views were respected. During a joint visit, practitioners spoke with Sam alone, undertook safety planning and discussed the support and options available to her. A Domestic Abuse, Stalking and Honour-Based Violence (DASH) Risk Identification Checklist was completed and a referral made to Multi-Agency Risk Assessment Conference (MARAC). Sam also remained in contact with an Independent Domestic Violence Adviser and planned to seek legal advice.

This person-led approach supported Sam to remain involved in decisions about her safety, reflecting the principles of Making Safeguarding Personal.

Working together

Due to the level of risk, MASH coordinated a multi-agency response involving the Dementia Rapid Response Team (DRRT) and Police.

Following assessment, DRRT concluded that a Mental Health Act assessment was required for Paul. Paul was subsequently detained under Section 2 of the Mental Health Act for assessment, allowing his health needs and risks associated with his presentation to be considered further.

The coordinated response addressed Sam's safety and wellbeing alongside Paul's health and care needs, rather than considering either issue in isolation.

The difference made and learning

Multi-agency intervention reduced the immediate risk of further harm to Sam, while ensuring Paul's cognitive and mental health needs could be assessed. Sam was supported to have her wishes heard, develop a safety plan, access specialist domestic abuse support and consider her legal options.

Feedback from DRRT highlighted the intervention as a positive example of effective multi-disciplinary working.

The case demonstrates the importance of recognising domestic abuse within caring relationships, listening to the adult's wishes, effective information sharing and taking timely, proportionate action where risks are significant. Most importantly, safeguarding was undertaken with Sam rather than to Sam, supporting her choice and control while agencies worked together to reduce the risks she faced.

4.1.5 What families and representatives told us

We didn't realise anyone would let us know the outcomes as the care home had not told us the actions put in place and we were happy with the outcome

I would like to thank the worker for looking into the concerns and that action was taken to ensure the issues did not happen again in the care home

It was nice to know that someone had looked into the concerns and made a safety plan and getting the feedback reassured us that family member relative was being cared for.

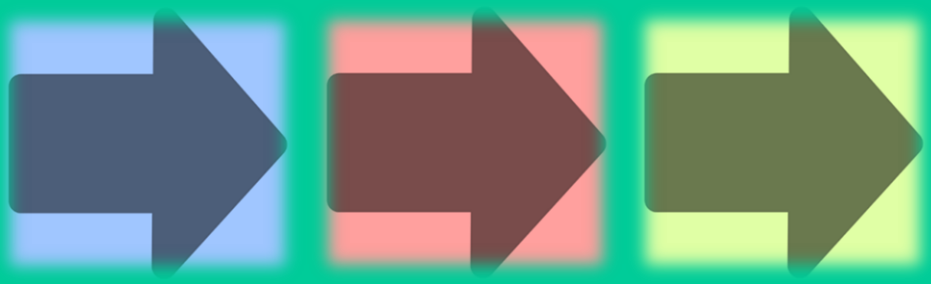
The Social Worker and Quality Monitoring Officer responded promptly to my enquiries and concerns. This provided me with reassurance that appropriate arrangements were in place to ensure my father received safe and appropriate support.

4.1.6 Safeguarding Adults Review Activity

Measure	2025-26
New SAR referrals received	**3**
Referrals considered during the year	**2**
Referrals meeting mandatory SAR criteria	**1**
Referrals not meeting mandatory SAR criteria	**1**
Referrals awaiting consideration at year-end	**1**
SARs ongoing on 31 March 2026	**2**

Further information about SAR referrals, decisions, ongoing reviews and the implementation of learning from completed SARs is provided in the Safeguarding Adults Review Subgroup section of this report.

5. Moving Forward…



5.1 Moving Forward: Priorities for 2026-27

Building on the progress and learning from 2025-26, Derby Safeguarding Adults Board will continue to work with partners to deliver its three strategic priorities.

During 2026-27, our focus will be on the following areas:

5.1.1 Prevention

- Develop and implement the DSAB Prevention Strategy
- Work with partners to strengthen the use of data and intelligence to identify emerging risks and opportunities for earlier intervention.
- Strengthen how we measure and demonstrate the impact of preventative activity.

5.1.2 Empowerment

- Launch the new feedback arrangements for adults who have experienced safeguarding.
- Use lived experience and feedback from adults, families and representatives to inform Board priorities and improvement activity.
- Continue to improve the accessibility of safeguarding information, ensuring people can understand the safeguarding process and the support available to them.

5.1.3 Quality Assurance & Accountability

- Monitor and seek assurance on the implementation of multi-agency case file audit recommendations.
- Continue to strengthen the quality and appropriateness of safeguarding referrals.
- Seek assurance that learning from Safeguarding Adults Reviews is embedded within partner organisations and is influencing practice.
- Strengthen how DSAB evidences the impact and outcomes of its work.
- Complete and implement the DSAB Assurance Framework.

6. Statements from Partners



6.1 Statements from Partners:

Each Derby Safeguarding Adults Board member has been asked to provide a statement outlining its contribution to the delivery of the DSAB Strategic Plan during 2025-26, including activity undertaken in relation to prevention, empowerment and quality assurance & accountability.

Derby City Council (DCC)

Placing people at the heart of everything we do remains central to Derby City Council's approach to Adult Social Care. During 2025-26, we continued to support people to live safely, independently and with dignity, ensuring safeguarding responses are person-centred and focused on individuals' choices and desired outcomes. This approach is reflected in the Council's Stronger Together into the Future: Ambitions for 2026 and beyond Adult Social Care Strategy, which places people at the centre of decision-making.

During 2025-26, the Council received 6,258 safeguarding adults' referrals, with 4,655 linked to Section 42 enquiries. This includes referrals linked to existing safeguarding episodes and should not be directly compared with Safeguarding Adults Collection (SAC) data on the proportion of concerns resulting in a Section 42 enquiry, as multiple referrals can relate to the same enquiry. We continue to work with partners to promote a shared understanding of safeguarding responsibilities and thresholds, ensuring concerns are appropriately identified and adults receive a proportionate response based on their circumstances and level of risk.

Prevention and early intervention remain central to our approach and align with the priorities of the Derby Safeguarding Adults Board. The Council continues to strengthen its use of data and intelligence to better understand local needs and risks and inform service planning. Our priorities include enabling people and communities to remain independent, delivering high-quality person-centred care, supporting people to live safely and with dignity, and strengthening partnership and integration.

Partnership working remains fundamental to safeguarding adults in Derby. The Council actively contributes to the work of the Derby Safeguarding Adults Board, its subgroups and wider multi-agency arrangements. We continue to support the Multi-

Agency Safeguarding Hub (MASH), enabling effective information sharing and coordinated responses to safeguarding concerns.

Learning and workforce development remain important elements of our safeguarding work. The Council promotes DSAB's multi-agency training and learning opportunities, supporting our workforce to develop the knowledge and confidence needed to recognise and respond effectively to abuse and neglect.

The Council also contributes to the Board's quality assurance and learning arrangements, including multi-agency assurance activity and case file audits. Learning from these activities is shared across the partnership and within the Council to strengthen practice, identify areas for improvement and support better outcomes for adults at risk.

Looking ahead, Derby City Council will continue to support the delivery of the DSAB Strategic Plan, working with Board partners to strengthen safeguarding practice, prevention and early intervention. Through our developing approach to Adult Social Care, we will focus on improving access to support, strengthening partnership working and ensuring adults in Derby are supported to live safely, independently and with dignity, choice and control.

Derbyshire Police

Key contributions

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.

Engagement with DSAB and Subgroups

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.

Risks, Challenges, and Forward Look

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.

NHS Derby and Derbyshire Integrated Care Board

This has been a productive year for NHS Derby and Derbyshire Integrated Care Board (DDICB). We continue to be active and effective members of DSAB and their supporting architecture. We have been members of every DSAB 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 Safeguarding Adults Assurance Framework (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.

Department for Work and Pensions

Key contributions

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.

Engagement with DSAB and Subgroups

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

Derby Homes

Key contributions

Derby Homes has continued to strengthen its contribution to safeguarding adults through a programme of service development focused on early identification of risk, consistent decision-making, and strengthened multi-agency working. A suite of updated safeguarding guidance has been implemented to support consistent practice across the organisation. This includes Adult Social Care Safeguarding

Decision-Making Guidance supported by a structured referral template designed to improve the quality and completeness of referrals. Further guidance has been developed on care and support needs, signs and indicators of abuse, case recording, Prevent, and data protection/GDPR, strengthening staff confidence across all service areas. Frontline operational capacity has been enhanced through accessible one-page safeguarding guidance for housing operatives, supporting early identification and appropriate escalation of concerns in community-based settings. The Housing Management Hoarding Procedure has also been updated. Internal audit activity has identified themes relating to mental health presentations where alternative health pathways may have been more appropriate. In response, targeted guidance on “working with customers at risk of suicide” has been introduced, alongside reinforcement of expectations where referral information is limited. Derby Homes continues to deliver a Multi-Agency Rough Sleeper Hub supported by a dedicated Social Worker, alongside the embedding of trauma-informed approaches within rough sleeper services to support engagement and risk management. The Safeguarding and Compliance function has been embedded across the organisation over the past 18 months, extending beyond housing management into a wider corporate safeguarding model. The Safeguarding Champions network is being strengthened, with increased representation from Housing Options, to support earlier identification of risk. A new Safeguarding training package has been produced. Feedback from 217 staff demonstrates increased confidence across key areas including Mental Capacity (+59%), safeguarding thresholds (+58%), consent (+48%), and Making Safeguarding Personal (+50.8%). A 10% increase in referrals meeting safeguarding criteria has also been recorded.

Engagement with DSAB and Subgroups

Derby Homes maintains active engagement with the DSAB through participation in key subgroups, including Policy and Procedures, Making Safeguarding Personal, and Quality Assurance. The organisation contributes to multi-agency workstreams, audit activity, and learning from Safeguarding Adult Reviews (SARs), ensuring learning is embedded into practice, guidance, and training. This includes updates to internal safeguarding processes, policy, and workforce development activity. The Rough Sleeper Response Manager attends DSAB meetings, supporting alignment

between operational delivery and strategic safeguarding priorities. This engagement supports shared learning, system assurance, and continuous improvement across partner agencies.

Risks, Challenges, and Forward Look

Derby Homes continues to operate within a safeguarding context shaped by increasing complexity of need, including mental health, homelessness, substance misuse, and housing instability. These factors continue to present challenges in relation to consistent threshold decision-making and appropriate signposting across partner agencies. Frontline workforce pressures remain a key consideration, particularly within Housing Options services where high volumes of reactive demand are managed alongside safeguarding responsibilities. These pressures are supported through updated guidance, training, and operational tools designed to improve consistency and confidence in practice. The 2026-2027 safeguarding campaign “Health in Housing”, will further strengthen understanding of the interface between housing and health, including hospital discharge, mental health, damp and mould, fuel poverty, safeguarding, and complex needs. Partnership working continues through the Multi-Agency Rough Sleeper Hub and dedicated Social Worker provision. Derby Homes remains an active contributor to DSAB subgroups and continues to attend DSAB meetings. The organisation retains Domestic Abuse Housing Alliance (DAHA) accreditation, demonstrating sustained commitment to improving responses to domestic abuse. Full assurance is also provided in relation to People in Positions of Trust (PIPOT), ensuring concerns are appropriately identified and escalated in line with safeguarding requirements.

Derbyshire Community Health Services (DCHS) NHS Foundation Trust

Prevention

The Safeguarding Service provides advice/support to staff. This includes discussions regarding care and support/safety plans to prevent harm when either someone makes an unwise decision and/or they don’t have capacity and how to make a safeguarding referral to Social Care to enable the people that DCHS staff have contact with to be safeguarded and protected from harm. 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.

Empowerment

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.

Quality Assurance and Accountability

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.

Engagement with DSAB and Subgroups

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.

Risks, Challenges, and Forward Look

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 Fire and Rescue Service

Prevention

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.

Empowerment

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.

Quality Assurance and Accountability

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.

Engagement with DSAB and Subgroups

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.

Risks, Challenges, and Forward Look

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 Healthcare Foundation Trust (DHCFT)

Prevention

DHCFT 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.

Empowerment

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.

Accountability and Quality Assurance

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.
- Engagement with Derby Safeguarding Adults Board (SAB).
- DHCFT has maintained active and consistent engagement with Derby SAB throughout 2025–2026.

Engagement with DSAB and Subgroups

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 Derby.

Risks, Challenges, and Forward Look

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.

DHU Healthcare

Key contributions

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.

Engagement with DSAB and Subgroups

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.

Risks, Challenges, and Forward Look

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

Key contributions

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.

Engagement with DSAB and Subgroups

The diocese has actively engaged with both Derby and Derbyshire Safeguarding Adults Boards through attendance at Board and subgroup 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.

Risks, Challenges, and Forward Look

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 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.

East Midlands Ambulance Service (EMAS)

Prevention

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.

Empowerment

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.

Quality Assurance and Accountability

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.

Healthwatch, Derby

Healthwatch Derby support DSAB by sharing safeguarding initiatives and strategies across our networks and continue to help raise wider awareness of safeguarding strategies and plans aimed at improving care and overall safety.

Healthwatch undertakes surveys with people across Derby, providing an additional opportunity for individuals to raise safeguarding concerns or share feedback about their experiences. Healthwatch provides quarterly updates to DSAB on any safeguarding matters identified through this route. During 2025-26, no safeguarding concerns or feedback were received through these surveys.

Probation Service

Key contributions

In relation to prevention, the Probation Service continues to undertake and use structured risk assessments (OASys) to prevent the risk of abuse and neglect. All staff are expected to complete known person checks and identify cases of concern via the recording of safeguarding flags on our internal recording system (NDelius). Additionally, prevention is supported through referrals to the MASH where there are safeguarding concerns and via active participation in multi-agency meetings such as MAPPA, MARAC We have also sought to improve the quality of our referrals. In 2025-20256, we introduced the WHAT model to further strengthen the analysis, recording and use of safeguarding information in our practice. Local audits are planned for this year to assess the impact of this model on the assessment and response to the information we receive. In respect of inclusion and empowerment, the service has sought to reflect safeguarding principles consistent with Making Safeguarding Personal by promoting professional curiosity, using service-user feedback routes including Engaging People On Probation forums and surveys, and ensuring that assessments, planning and risk management are informed, wherever possible, by the individual's circumstances, voice and outcomes. In relation to performance and quality assurance, the service has drawn on HMIP findings, domestic abuse and safeguarding audits, reflective supervision, management oversight, performance dashboards and monthly review meetings to oversee the effectiveness of safeguarding practice. Learning from audits, inspection activity and wider review processes has been disseminated through briefings, protected learning time and management forums, with action plans in place to embed improvement. Collectively, this has strengthened organisational oversight, practitioner confidence and assurance regarding adult safeguarding practice, whilst recognising that some developments remain as we are at an early stage of implementation for some new processes.

Engagement with DSAB and Subgroups

We have continued to have presence at Board and sub-group level and supported the Digni-tea campaign earlier this year. Attendance is not of concern.

Risks, Challenges, and Forward Look

Over the last year Derby City has seen stability in staffing numbers, however, this has declined over recent months with workloads rising above acceptable levels. Recruitment activity being undertaken to support with the gaps. A risk register is in place locally to capture the impact of staffing on operational activity. Recently, the Safeguarding hub had experienced staff shortages and a key focus for this year is to ensure that a plan is in place to here is resilience in this team. This includes expanding the access of liquid logic to staff within the PDU and recruiting an additional member of staff to this team. The organisation is all going through widespread change through one future probation service programme and changes in the Sentencing Act. The probation service will ensure that communication to partners is ongoing and that impact is continually assessed.

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

Safeguarding Adults

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 have 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.

Training	Target	Compliance 31st March 2026
Level 1 safeguarding adults & children	90%	92.31%
Level 2 safeguarding adults & children	90%	48.21%
Level 3 safeguarding adults & children	90%	84.98%
Basic prevent awareness	90%	89.23%
Prevent WRAP level 3	90%	78.45%
MCA Training	85%	75.82%

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.

6.2 Concluding Statement: Derby SAB Business Manager – Sana Farah



During 2025-26, DSAB has continued to strengthen its approach to assurance, moving beyond measuring activity towards understanding the quality and impact of safeguarding practice. Performance data, multi-agency audits, partner assurance, Safeguarding Adults Reviews and feedback from adults and families have enabled the Board to identify both areas of good practice and where further improvement is required.

The Board recognises that assurance is an ongoing process. During 2026-27, DSAB will continue to seek evidence that learning and recommendations are not only implemented but embedded in practice and leading to improved experiences and outcomes for adults in Derby.

EDI statement

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

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

Derby Safeguarding Adults Board Contact

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

Contact Derby SAB

DSAB@derby.gov.uk

Derby Safeguarding Adults Board website

Appendix 1: Derby SAB Board Membership 2025-2026

1. Derby SAB Independent Chair

Richard Proctor	Independent Chair	Derby Safeguarding Adults Board

2. Derby SAB Vice-Chair

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

3. Derby SAB Board office staff

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

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

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

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

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

Appendix 2: DSAB meeting attendance monitoring form 2025-2026

Key	
	Attended
A	Apologies received
	Did Not Attend

Date of Board meeting	Derby City Council Adult Social Care & Health (DCC ASCH)	Integrated Care Board (ICB)	Derbyshire Constabulary	Care Quality Commission (CQC)	Derby Homes	Department of Working Pensions (DWP)	Derby City Council Community Safety Partnership	Derbyshire Community Health Services Foundation Trust (DCHS)	Derbyshire Fire and Rescue (DFRS)	Derbyshire Healthcare NHS Foundation Trust (DHCFT)	Diocese of Derby	DHU Health Care Community Interest Company (DHU CIC)	East Midlands Ambulance Service NHS Trust (EMAS)	Healthwatch Derby	Office of the Police & Crime Commissioner (OPCC)	Probation Service	University Hospitals of Derby & Burton NHS Foundation Trust (UHDB)	University of Derby (UoD)
10/04/2025 (JDD)					A									A				
16/07/2025							A									A		
13/10/2025		A					A		A									
19/02/2026						A					A	A						

































2025-26 Annual Report

Derby Safeguarding Adults Board

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October 2026

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

derby **safeguarding adults** board