Norfolk Safeguarding Adults Board

Annual Report

1 April 2024 – 31 March 2025

Contents

Norfolk Safeguarding Adults Board 03
Message from Heather Roach, Independent Chair 05
Message from Walter Lloyd-Smith, Board Manager 06
Review of our Business Delivery Plan: 09
Safeguarding Adults Reviews 19
Contributions from our three statutory partners 26
Locality Safeguarding Adults Partnerships (LSAPs) 29
Self-neglect and Hoarding subgroup 32
Quality and Assurance subgroup 33
Coalition for Change (C4C) 34
Our website, social media, and comms 35
Safeguarding Adults Collection Return 2024 / 25 37
Financial summary 2024 / 25 40
Strategic plan 2023-26 42

Norfolk Safeguarding Adults Board

Safeguarding Adults Boards are required in each local authority area under section 43 of the Care Act 2014. They are a partnership of organisations in that area who work together to safeguard people who have care and support needs, from abuse and harm.

Norfolk Safeguarding Adults Board (NSAB) leads work across Norfolk to ensure that all agencies, and individuals, do everything they can to prevent abuse from occurring in the first place, to respond quickly when abuse and neglect happens, and that safeguarding practice improves the quality of life of adults in the county.

We recognise the importance of public, private and community organisations, and the people within them, working together in the key areas of prevention, managing enquiries and shared learning from Safeguarding Adult Reviews (SARs), as well as highlighting the need for professional curiosity to be encouraged and supported if we are to make Norfolk a safer place for people who need care and support.

As a partnership, we are committed to the principles of Making Safeguarding Personal (MSP) this means listening to what the adult or their representative would like to achieve, and ensuring support is available which enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

We want people to be able to live safely in communities that:

- have a culture that does not tolerate abuse in any environment
- work together to prevent harm
- know what to do when abuse happens

Our Strategic plan 2023-26 tells you more about our vision and our plan to achieve it. You can see our 'plan on a page' at the end of this report along with the ways we measure our success.

You can also find more about NSAB on our website, including our core duties.

This chart shows the organisations that our board members, or their deputies, are from and the board meetings that they have attended.

Organisation	May 2024	July	September	November	January 2025	March
Acute hospitals	Kelly O'Donovan Kim Goodby	Kim Goodby	Kelly O'Donovan Kim Goodby	Kelly O'Donovan Tina Chuma	Kelly O'Donovan Tina Chuma	Tina Chuma
Adult social services	Debbie Bartlett Helen Thacker	Helen Thacker	Craig Chalmers Helen Thacker	Craig Chalmers Helen Thacker	Craig Chalmers	Helen Thacker
Autism board	-	-	Trevor Key	Trevor Key	-	-
Build Charity	James Kearns	James Kearns	James Kearns	-	James Kearns	James Kearns
District councils	-	Mike Pursehouse	Mike Pursehouse	Mike Pursehouse	Sarah Wolstenholme-Smy	-
Dept of Work & Pensions	-	Lisa Barraclough	Lisa Barraclough	-	Lisa Barraclough	Lisa Barraclough
Healthwatch	Judith Sharpe	Judith Sharpe	Judith Sharpe	Judith Sharpe	Judith Sharpe	Judith Sharpe
Councillor	-	Mark Kiddle-Morris	-	Alison Thomas	Alison Thomas	Alison Thomas
Norfolk Community Hospitals / Trusts	Carolyn Fowler	Rob Black Victoria Aspinall	Carolyn Fowler	Carolyn Fowler	-	Carolyn Fowler
Norfolk Care Association	Michael Millage Angela Steggles	-	Michael Millage	Michael Millage	Michael Millage	Michael Millage
Norfolk Constabulary	Mark Joyce	Chris Balmer	Chris Balmer Mark Joyce	Mark Joyce	Dave Freeman	Dave Freeman
Norfolk Fire & Rescue	Emyr Gough	Emyr Gough	Emyr Gough	-	-	Emyr Gough
Norfolk & Waveney Integrated Care Board	Tricia D'Orsi Gary Woodward	Tricia D'Orsi Gary Woodward	Rebecca Hulme Kate Brolly	Rebecca Hulme Gary Woodward	Rebecca Hulme Christine Hodby Gary Woodward	Rebecca Hulme Christine Hodby Gary Woodward
Norfolk & Suffolk NHS Foundation Trust	-	-	Jane Christmas	Anthony Deary	Anthony Deary	Hannah Brookes
Office of the Police & Crime Commissioner	Amanda Murr	-	Amanda Murr	Amanda Murr	Amanda Murr	Gavin Thompson
Prison service	-	-	-	-	-	-
Probation	-	Pauline Parke-Chatten	Pauline Parke-Chatten	-	-	Pauline Parke-Chatten
Public health	-	Chris Butwright	Chris Butwright	-	Chris Butwright	Chris Butwright
University of East Anglia	-	-	-	-	-	-
Voluntary sector	-	-	Laura Bloomfield	-	Daniel Childerhouse	-

November 2024 Cllr Alison Thomas joins NSAB, replacing Cllr Mark Kiddle-Morris. At the same time, Sarah Wolstenholme-Smy replaces Mike Pursehouse, representing district councils. Claire Pratt from UEA replaced by Darren Yaxley as UEA representative on NSAB in January 2025.

Message from **Heather Roach, Independent Chair**

Welcome to the Norfolk Safeguarding Adults Board annual report for 2024 / 25. This will be my last report as the independent chair for the board, as I stand down at the end of March 2025.

The focus for the board and its partners over the last 12 months has been on the impact that our work in raising awareness of safeguarding adults at risk has made. We have developed a range of measures that are both qualitative and quantitative to try and establish how we have affected safeguarding practice and how we have improved outcomes for people learning from our Safeguarding Adult Reviews.

The board has continued to develop and deliver a range of resources that helps to support our partners, including webinars, learning events, 7-minute briefings and animated videos. I would particularly like to recognise the work undertaken by our deputy board manager, Becky Booth, and Will Wright from the Suffolk Safeguarding Partnership, who re-launched the Herbert Protocol during the year with an engaging animation and an awareness raising campaign.

I am also proud of the work we have been able to do in ensuring that our multi-agency safeguarding policies and procedures are accessible, and we have worked closely with Norfolk County Council's equality, diversity and inclusion lead, Claire Charlwood. Claire has also been instrumental in the board developing an anti-racism commitment in response to a recommendation from the Joanna, Jon and Ben SAR, published in 2021.

Commissioning and publishing SARs are a statutory function for the board but the embedding of recommendations from those SARs is crucial. As a board we revisit our action plans 12 months post publication to identify progress and help remove any blockages. Determination and persistence are key attributes, and we have continued to revisit recommendations from the Joanna, Jon and Ben SAR to maintain the focus on improved care for people with learning disabilities. This year we held a roundtable event locally to identify what has changed in Norfolk since the SAR was published.

Continuous learning and improvement have been key themes for us as we also embraced the opportunity to take part in a peer review with Wigan Safeguarding Adults Board and also completed a self-assessment of our statutory duties, alongside the other SABs within the eastern region.

As the independent chair I have also had the privilege of chairing the eastern regional network of safeguarding board chairs and been part of the national executive group.

This has afforded me the opportunity to access some of the best practice nationally and to influence national direction.

I want to extend my sincere thanks to all the partners who are part of the board for their support throughout my tenure and of course to the NSAB team who work tirelessly to deliver an amazing amount of work making a difference to the people in Norfolk. To Walter, Becky, Andrea and Petra thank you for all that you do.

H Roach

Heather Roach,
Independent Chair

Message from **Walter Lloyd-Smith, Board Manager**

I am very pleased to present this annual report for 2024 / 25. It reflects another year of progress, partnership, and commitment to safeguarding adults at risk of abuse and harm across Norfolk. This report is a key opportunity to pay tribute to and acknowledge what I have witnessed first-hand: the dedication and commitment of individuals, teams, partner agencies, and the wider networks working together to protect the most vulnerable members of our communities.

This year, our focus has remained on driving forward the strategic priorities of the board: prevention; making safeguarding personal and strengthening multi-agency working. These priorities continue to shape how we work across a wider partnership – health, social care, housing, policing and criminal justice plus voluntary sectors, to identify and address safeguarding concerns in a timely and person-centred way.

The year has brought some significant achievements as shown in the report while at the same time I acknowledge we haven't been able to do all that we would like to. The ability of the NSAB business team to do everything that it does (… and then some) is testimony to their dedicated hard work and commitment. Becky, Andrea and Petra, thank you.

Notwithstanding the limitation in the business team's capacity, I am tremendously proud of work we have delivered, as captured in this report.

Herbert protocol launch September 2024

Strategic Prioritisation and Focus

The anchor for each year's work is the strategic plan. In early 2024 the Business Group did a piece of work to reduce our priorities from 16 to three, to enable a more targeted approach to our actions, such as raising safeguarding awareness among vulnerable groups, promoting inclusive practices, and disseminating insights from safeguarding reviews across the multi-agency partnership.

Our collective achievements reflect the output of colleagues from across a wide range of agencies working together despite all the competing demands to push safeguarding adults work forward. During this year work included:

- **Enhancing multi-agency collaboration** – NSAB advocated for the increased use of multi-agency meetings to address complex safeguarding cases effectively. Drawing from SARs, such as those of Adult P and Adult S, which highlight the benefits of coordinated responses in identifying risks, sharing information, and developing joint action plans. These meetings can be instrumental in addressing issues like exploitation, mental health concerns, and safety planning, demonstrating the value of collaborative approaches in safeguarding practices.
- **Learning from SARs** – the publication of the review for Adult P in February 2024 provided critical insights into systemic issues, including delays in emergency responses and the effectiveness of community alarm systems. The recommendations prompted NSAB and its partners to implement changes aimed at improving risk assessments and inter-agency communication, enhancing the safety and well-being of vulnerable adults. More generally, we have made improvements to the ways in which we support practitioners to reflect, share, and apply learning through communities of practice and targeted learning sessions (thanks to Becky for this.)
- **Homelessness** – the board introduced a new subgroup on homelessness to ensure a coordinated NSAB response to the recommendations made in the Ministerial letter of May 2024. Thank you to Kim Goodby who will chair this group.
- **Partnership actions working towards eliminating racism at work** – (linked to a recommendation from the Joanna, Jon and Ben SAR published 2021).
- **Addressing fire risks associated with emollient products** – following some fatal fires and linked with scientific testing showing fabrics contaminated with these products can ignite rapidly, NSAB partners came together to set up an Emollient fire risk working group. This coordinated educational efforts, developed easy-read materials, and provided training for clinical prescribers and social care staff. A webinar held in January 2025, jointly hosted with Norfolk Fire & Rescue, was attended by over 300 people and featured national experts discussing strategies to mitigate these risks, emphasising the importance of awareness and preventive measures.

In 2024 / 25, NSAB continued to strengthen its joint working and collaboration with the Norfolk Safeguarding Children Partnership and Norfolk Community Safety Partnership. This approach has continued to help support a more integrated response to shared safeguarding priorities, including exploitation, domestic abuse and transition from children's to adults' services. Through close liaison, joint meetings and working to align strategic planning, the partnerships worked to reduce duplication, enhance communication and ensure consistent practice across agencies. The continued focus on whole-family safeguarding and cross-sector learning contributes to improved outcomes for individuals with complex needs and a more coherent safeguarding system across Norfolk.

NSAB supporting national work

NSAB has continued to play an active role in supporting national networks both through Heather, as board chair, and Walter, as board manager. This is vitally important as it offers an opportunity to connect Norfolk to important national discussions, contribute to work led by the chairs and board managers' national networks, and keeping up to date on developments which can be used to support work locally.

Heather chaired the eastern regional network of safeguarding adult board chairs and has been part of the national executive group. Walter is a member of the national SAB managers network steering group, which supports the national meetings. As part of this group, he helped set up the four workstreams to take forward recommendations from the second national analysis of Safeguarding Adult Reviews.

During 2024/25, NSAB's resources have been shared with other safeguarding adult boards. We have shared the following resources:

- 7 minutes briefing on transitional safeguarding
- Briefing on professional curiosity
- SAR information for families
- Information for informal carers
- SAR panel member guidance

A sincere thank you

At the end of March 2025, Heather Roach our independent chair for the last three and a half years stepped down and I dedicate my page in this annual report to her. Heather led the board with great skill, with an emphasis on collaborative partnerships, strategic oversight and accountability, fostering a culture of continuous learning and improvement in safeguarding practices across Norfolk. I also acknowledge the key contribution made by Detective Superintendent Andy Coller who retired this year and his role in advancing our safeguarding efforts. Our new chair, Natalie Cowland, brings a wealth of experience and skills to take the board forward.

It is appropriate to note that 2025 / 26 will continue to bring challenges posed by rising demand, financial pressures, and the complexities of working across systems which will see significant change. We remain committed to improving outcomes for adults at risk by promoting a shared responsibility for safeguarding, supporting professional curiosity, and fostering a culture of transparency and accountability.

I would like to thank all our partners and practitioners who have contributed to the work of the board over the past year. Your commitment, insights, and partnership are essential to our success. Together, we will continue to learn, adapt, and strive for a safer Norfolk, where adults can live their lives free from abuse and neglect.

Walter Lloyd-Smith
NSAB Board Manager / Business Lead

Review of our Business Delivery Plan:

Completed work 2024 / 25 and some of our plans for 2025 / 26

This plan links with our three-year strategy, structured against the three pillars (prevention, managing and responding to concern and learning lessons and improving future practice) that underpin our approach however, we also streamlined our focus from **June 2024** to concentrate on three areas, one under each pillar. Following on from last year, we include both data and quantitative measures here to consider our effectiveness.

This has been considerably supported by Norfolk County Council's (NCC) insights and analytics team, with a special mention to Alex Scerri who has created a comprehensive, user friendly PowerBI dashboard for our NSAB measures which our board members are able to access.

1. Preventing abuse and neglect priority

> **"We coordinate partnership activities using an evidence-based approach, using language and material that is relevant and accessible, that:**
>
> a. raises safeguarding awareness amongst the people of Norfolk
>
> b. targets safeguarding awareness for particularly vulnerable groups, using an evidence-based approach."

September 2024 saw the launch of our latest animation, the result of a fantastic collaboration with the Suffolk Safeguarding Partnership along with Norfolk and Suffolk police, refreshing the Herbert Protocol (a way of quickly supporting police and others to find someone who may have gone missing, often adults with dementia). We were able to discover more about the original story of 'Herbert' (who was a veteran living in a care home in Norfolk), speak to people who knew him and hold the launch in that home with two of the people who created the protocol in the first place. The Herbert Protocol is now used by most police forces across the country and our animation can be easily adapted so that other areas and organisations can use it too – which they have. It has had over **1.6k views on the YouTube** channel, and our NSAB webpage with the link is the fourth most visited since the animation launched. We have continued to support the use of the protocol including promoting its move to an online service – Safe and Found Online.

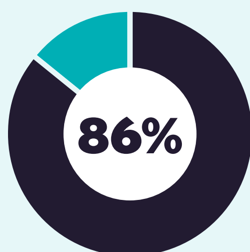
Over the last 12 months we have continued to see the impact of work as a result of the SAR for Joanna, Jon and Ben, with feedback that NSAB's managing racist abuse 7 minute briefing was the catalyst for a significant amount of work undertaken by Norfolk County Council. The organisational eLearning on this subject has been accessed by more than **3,000 people and by 300 care providers**.

Our NSAB safeguarding multi-agency policy and procedures have been the subject of an Equality Impact Assessment (EqIA) in 2024 (you can read this on our website Policy and procedures | Norfolk Safeguarding Adults Board) and while overall very positive, it has prompted some further actions in 2025 and beyond. For our Prevention pillar, we plan to look at how to make safeguarding information more accessible to people who have hearing impairments.

Supporting recommendations from our SARs for Adult P and Adult S, a countywide exploitation group has now been set up under the Norfolk Community Safety Partnership (CSP) leading work to develop a stronger partnership approach, review policy, training, and support greater knowledge of the issue.

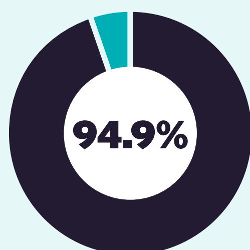
In February 2025 we worked with Norfolk Safeguarding Children Partnership on a Leadership Exchange and Learning Event on transitional safeguarding – looking to galvanise a systems approach to change in this area. The day event was well attended and facilitated by Professor Christine Cocker (University of East Anglia), Dez Holmes (National Children's Bureau/Research in Practice) and Dr Adi Cooper (independent safeguarding consultant).

Strategic plan measures: Develop ways to gather and collate feedback from people providing and using services to measure their confidence / understand their experience of safeguarding.



Percentage of people who define what outcome they want at the beginning of a s42 enquiry

- Desired outcomes asked = **86%** (a small increase from last year).

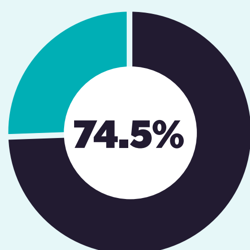


Percentage of people whose identified outcome was me

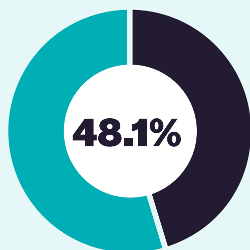
- Desired outcomes achieved = **94.9%** (the same as 2023 / 24).

Access to advocacy

- Enquiries where people at risk were supported = **74.5%**

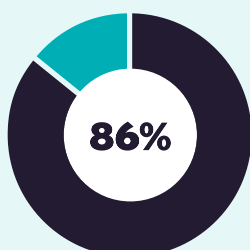


Note: there was a change in the NCC LAS (adult social care database) forms in 2024 which led to significant issues trying to capture this data – the likely reason for it being so much lower than the previous year (24% drop). Through the Quality & Assurance (Q&A) subgroup we're currently testing this assumption to ensure it is not a change in the actual practice taking place.



- Enquiries where referrals for independent advocacy were required and made = **48.1%** (an increase of 6% on the previous year).

Note: this measure has also been subject to some additional work by the Q&A subgroup in 2025, as we've identified some issues with the data that may be making this look lower than it is. We are hopeful we can improve accuracy for next year.



Proportion of people who feel safe after the safeguarding intervention

- People at risk feel safe = **86%** (this is a considerable increase on last year's 48% and is partly due to work completed to improve the accuracy of the data being counted).

Impact and outcomes: NSAB webinars held 2024 / 25

Total of 1,029 signed up

- 753 attended (73%)
- 217 gave feedback (28%)

We held ten webinars in this year and had a total of 1,029 people sign up to attend (double the number from the previous year). Of those, 753 attended (73%); 217 gave feedback (28%) and 99% said that the webinars met learning outcomes where these had been set. This included a record sign up and attendance for the webinar in January 2025 around fire safety and emollient products (see above).

How will it change your practice?

"I will incorporate the new information into my mental bank to pull on as I visit people. I will try out the mindfulness exercise as well and will share learning within my team."

"I used the learning from SAR S in regard to thinking about friends and relatives and cuckooing when providing support to a social worker and the importance of asking extra questions."

"I will be more aware that modern slavery can take many subtle forms, and we need to look for small clues in the care sector – be mindful of picking up the signs."

"It has enhanced my teaching session I have planned for the ED Nursing staff."

"Consider exploitative friendships, and how Occupational Therapy can advocate for change in housing situation when move is not an option."

"Embedding a culture of walking in the shoes of the individual, what does this feel like, what changes can you make to make the individuals experience better, using lived experience when designing new delivery models."

"To expand on our current risk assessments. Make conscious observations when carrying out assessments in the home environment."

"As a prescriber, I'll leave an emollient safety leaflet with the patient. I'll also work with our team to ensure template for recording these conversations on patient notes."

"Share it widely throughout council safeguarding champions to inform residents in our 14,000 properties."

2. Managing and responding to concerns about abuse or neglect priority

> **"We recognise the different needs and possible barriers which vary across our communities and aim to be inclusive in all aspects of safeguarding."**

In March 2025 we had the first meeting of our Homelessness subgroup, to ensure our governance structures incorporate clear and sufficient accountability mechanisms for partners with responsibilities towards people rough sleeping. This is not to replicate existing forums but to coordinate and help drive work specific to the SAB in direct response to the ministerial letter of May 2024.

Across 2024 / 25 we completed a pilot framework project to build local tools and guidance with partners in line with the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) framework, to promote confidence in, and consistency of, reporting of safeguarding concerns. This gives us evidence to demonstrate proportionate responses to individual incidents incorporating the wishes of the adult **Making Safeguarding Personal or MSP**. The project involved a condensed framework around some of the most reported incidents from providers of health and social care: falls, medication errors, incidents between adults and pressure areas.

Thank you to our three acute trusts and Norfolk and Suffolk NHS Foundation Trust (NSFT) for supporting the pilot, and while there were several challenges, overall it was found useful in situations where there is less time to read or absorb more lengthy guidance. One outcome of this is a more compact version which will be shared widely with all care providers in 2025.

Strategic plan measures

Develop multi-agency audit processes to identify both qualitative and quantitative data to monitor the reporting of safeguarding concerns and MSP, including understanding the lived experience of those supported by the safeguarding process.

Note: while the data we are using currently is primarily from the local authority (as the lead agency they collect and can share the most detailed data in relation to safeguarding enquiries), we hope to expand this in future.

Examination of s42 conversion rates – in each abuse type

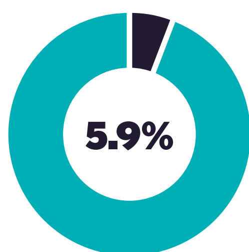
Work through the Q&A subgroup with support from NCC insight and analytics team where we are doing a deep dive into 'neglect' as our most reported form of abuse: where it is occurring, who is most affected and can we be doing more to address it.

Tracking the safeguarding process – time taken to complete s42 enquiry

- Overall median days to start enquiries = **1 working day**
- (New measure) Interim efforts to safeguard were made within **3 working days** = **78.4%**
- Overall median days to close enquiries = **125** (an increase on the previous year's figure however the methodology has changed and this is believed to be a more accurate number).

Start of S42 enquiry

Completed S42 enquiry

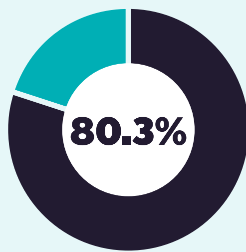


Monitor the number of repeat safeguarding concerns reported that progress to s42 enquiry

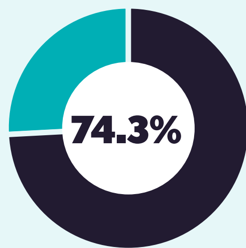
- **5.9%** of cases have repeat s42 enquiry within 12 months (a drop from last year's 12%).

Questions asked through follow up by the local authority at the end of s42 enquiry

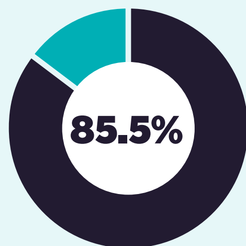
The NCC safeguarding team has continued their MSP work with adults who have been involved in safeguarding enquiries. They're spoken with afterwards, to better understand their experience and the outcomes. This is shared with NSAB, and the overarching theme continues to be the importance of human relationships and connection in feeling 'safe'. Themes feed into social care updates and quarterly Organisational Wide Learning (OWL) briefings. Links have also been made with Norfolk Integrated Domestic Abuse Service with the aim of increasing representation of domestic abuse survivors.



Percentage of people at risk who were informed of the outcomes of their s42 enquiries = 80.3%
(very similar to previous year).



Percentage of people at risk who were satisfied with the outcomes of their s42 enquiries = 74.3%
(big increase from 57.9%).



Percentage of referrers who were informed of the outcomes of the s42 enquiry = 85.5%
(small decrease from 88.4%).

3. Learning lessons and shaping future practice priority

> **"We produce and share relevant insights and guidance across the partnership."**

As mentioned above we held ten webinars using MS Teams in this year, often considering learning, themes and topics that we have seen in our SARs or that have been requested through our Locality Safeguarding Adults Partnerships (LSAPs) and other groups.

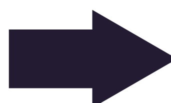
Through the Self-neglect and Hoarding subgroup, we organised a very successful face to face multi-agency partnership event in October, looking at the work taking place in Norfolk, and nationally, and building stronger relationships in our county to support those who may self-neglect and / or hoard.

Work to support better understanding of the Mental Capacity Act in the county is still planned and we hope to progress this in 2025 / 26.

Strategic plan measures

By asking partners to demonstrate how they are implementing actions / learning; developing a way to evidence the impact of learning from SARs and other reviews; considering the corporate / organisational level versus individual experience – what has changed?

All action plans developed from SAR recommendations will now have an 'impact' column added which will require feedback from partners evidencing the implementation of actions / recommendations and timeframe.

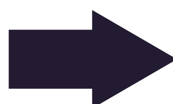


To be incorporated in all SARs / Learning reviews.

The Safeguarding Adults Review Group (SARG) to identify past recommendations / actions to revisit and request partners provide evidence of changes / improved practice.

Included on SARG agendas.

All NSAB training / awareness events to have evaluation forms / feedback to demonstrate improved practice.



On-going: qualitative feedback for webinars (above); annual review of the Train the trainer programme including the refresher session – included within annual report.

NSAB annual survey

Started in 2024, covers participation in NSAB meetings / workstreams / LSAPs / subgroups as well as events / webinars, where guidance or other material has been used, and the impact of this (see below).

Impact and outcomes

We had 63 people complete our **2025 annual survey**, an increase of 117% on last year.
Some of the feedback:

"Newsletter is a great source of motivation to think in creative ways about safeguarding, it's relatable and connects so many aspects in with safeguarding. We have shared lots of social media information posts for example about fire safety and fire risks (emollient creams)."

"I recently heard a very powerful presentation on honour-based abuse which I will be reflecting on with colleagues and partners as part of my wider work."

"It has been helpful for me to talk to other professionals as I improve my adult safeguarding knowledge."

"Cascaded info from face-to-face hoarding session to safeguarding colleagues and other managers of services where home visits take place."

"I'm not a frontline worker so all information is useful, particularly webinars that facilitate hearing from a subject matter expert as well as the question and answer sessions - these make you think differently to see how you can contribute even if you are not frontline in social care. I also chair a safeguarding meeting, so information also allows me to pass on what I have heard to others."

"I'm more vigilant in listening to things that are said by people when completing assessments and braver in discussing this with them."

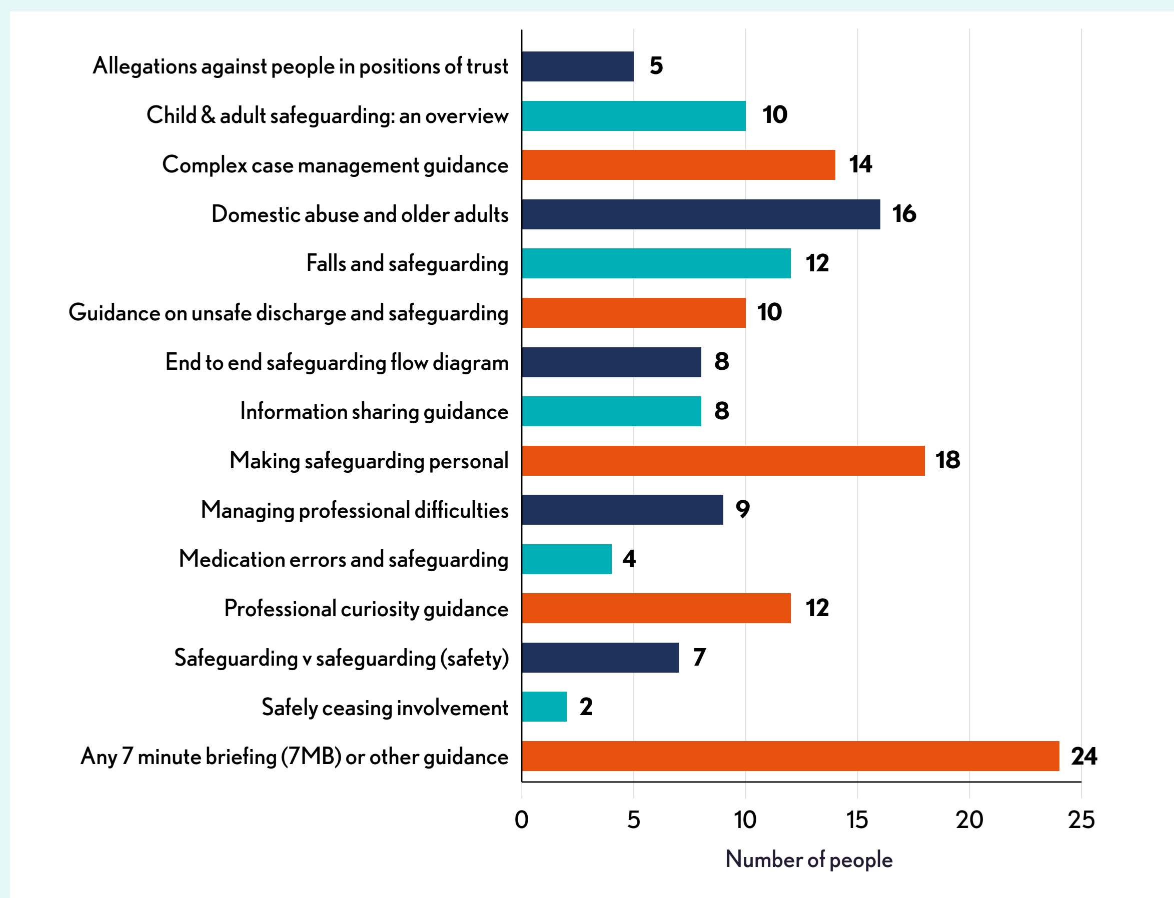
"Used the Herbert Protocol at a fellowship meeting I attend and used the poster on adult abuse to display and show others."

"Some of Healthwatch Norfolk's work relating to services for people with Learning Disabilities has been "born" following work of the NSAB or SARs."

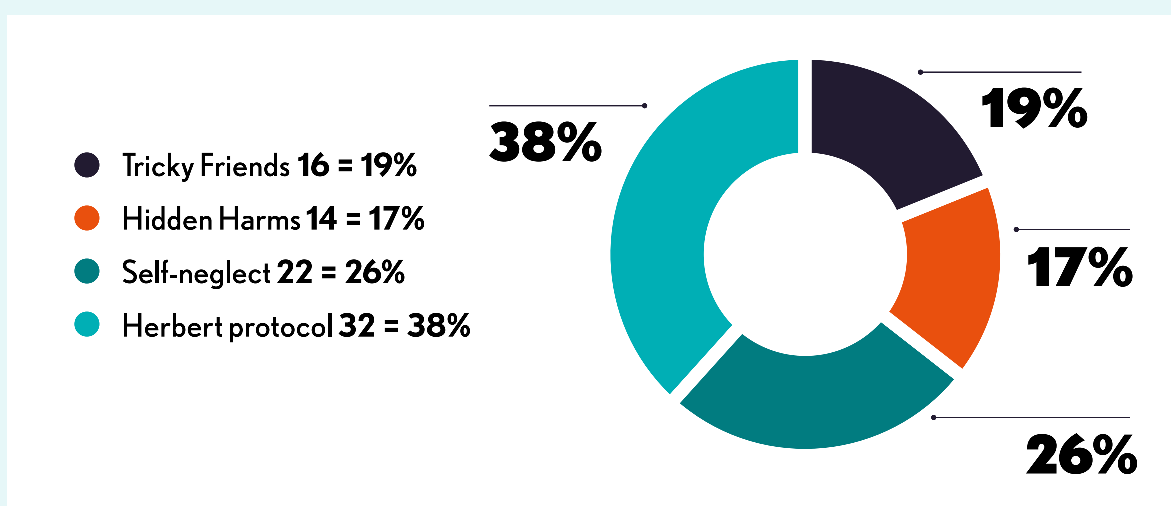
"Our management team will regularly access the website and guidance tools for to further enhance their knowledge and for advice."

"I have shared information on emollient creams and fire risks and use of personal alarms with people who I know are at much greater risk of harm (hopefully contributing to the preventative work of the NSAB)."

Between 1 April 2024 and 31 March 2025, have you used any of our guidance documents?



Between 1 April 2024 and 31 March 2025, have you viewed any of these animations?



We had contact from Age UK who had used the Hidden Harms in an eLearning module and was completed by over 500 Age UK employees. Some of the feedback:

Please tell us what the highlight of the course was for you?

"The animation about the different kinds of abuse. It summarised the key messages well and represented a diverse audience in the visuals."

"This course helped me to think about other forms of domestic abuse, the videos were a good way to explain who could be involved / affected."

"The animated video detailing examples of abuse in practice."

"The hidden harm video along with text."

"The animation."

"The cartoon video, I could imagine using this with an older person."

"The language used in the animation."

"They commented 'the impact of the animation will no doubt have a ripple effect and improve the responses by staff working with older people, so I wanted to say thank you.' "

Self-neglect and hoarding event October 2024

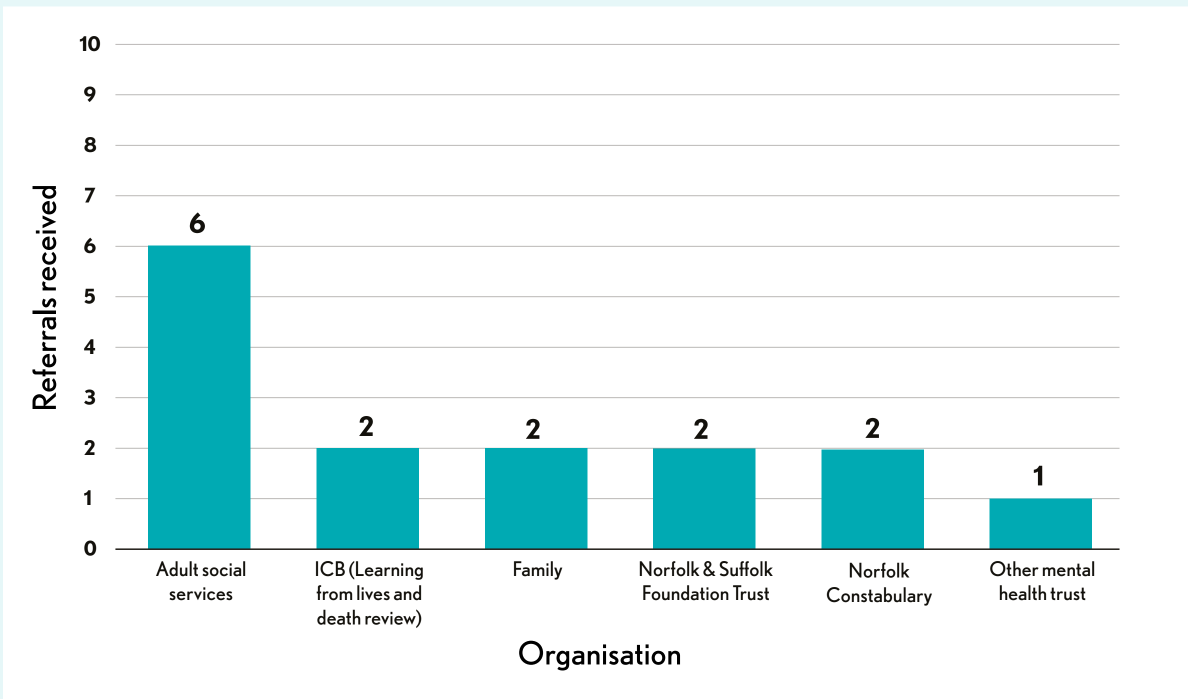
Safeguarding Adults Reviews

Section 44 of the Care Act determines when Safeguarding Adults Boards must carry out a SAR. The Safeguarding Adults Review Group (or SARG) is a subgroup of NSAB who meet monthly to discuss referrals received and decide whether they meet the criteria to explore further and whether the criteria under s44 is met. Reviews are undertaken in cases of harm or death of an adult with care and support needs, where there's a suspicion of abuse or neglect **and** there is concern that partner agencies could have worked together more effectively to protect the adult.

The goal is to identify learning from these cases, map to the NSAB overarching strategy and implement changes to prevent similar harm in the future. The membership is drawn from the three statutory partners (local authority, police and health) supported by a senior solicitor, the NSAB board manager and deputy manager, co-opting other agencies, as appropriate. The SARG chair presents an update at each NSAB meeting where enquiry, comment and challenge is encouraged.

Organisation submitting SAR referral

Referrals received between April 2024 to end of March 2025

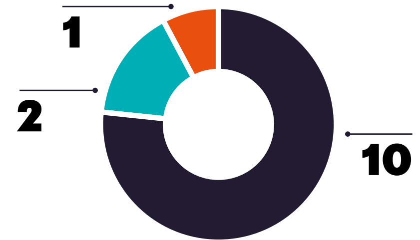


Gender

● Male – **11** ● Female – **4**

Referral outcomes

- Did not meet criteria / no further action – **10**
- At stage 2 – **1**
- SARs commissioned – **2**

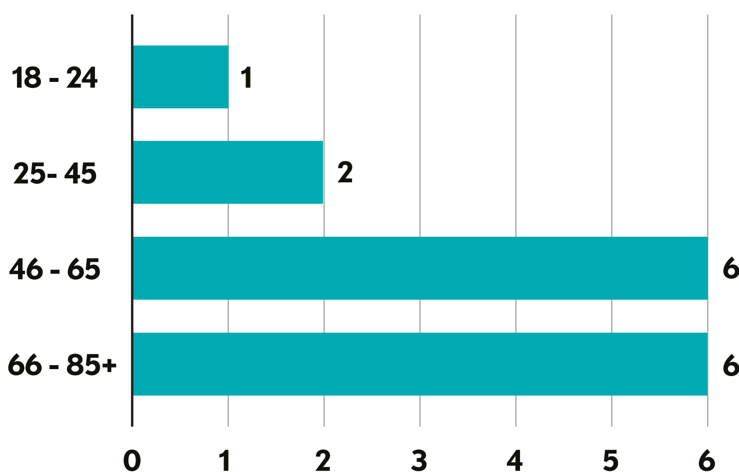


Stage 2 refers to where further information is requested from relevant agencies so that the group are better able to decide whether the case meets the criteria for a SAR. The two SARs commissioned comprise two referrals each.

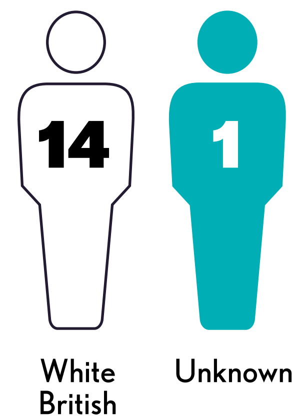
Types of abuse

● Neglect / self-neglect and acts of omission – **14** ● Domestic – **1**

Age range



Ethnicity



Reviews concluded in the reporting period = 4

SAR Adult R: published 6 June 2024

Adult R, aged 82, died in hospital in August 2021. Three months earlier she had been hospitalised following a stroke and after treatment had returned home, in line with her wishes, where she received bed-based care. The review focused on hospital discharge, equipment provision, pressure ulcer care, escalation pathways, complex bed-based care, interagency communication and mental capacity assessments.

SAR Adult S: published 11 July 2024

Adult S was a 72 year old male, who lived alone. He had no known family network and younger adult acquaintances used his flat as a place to meet, leading to concerns that he was being exploited. He requested relocation to sheltered accommodation but he was considered low priority for a move. After being discharged from hospital following a second suicide attempt, Adult S was discovered deceased in his home by his neighbour, in March 2022. The review focused on cuckooing and exploitation, housing, multi-disciplinary team meetings, mental health and mental capacity.

SAR Eric: published 27 February 2025

Eric was a male, aged 62 when he died. He had a recorded but informal diagnosis of Korsakoff's dementia. He was moved to residential care due to self-neglect and was placed in a number of different care homes all of whom struggled to meet his needs.

He attempted suicide in October 2021 and died via suicide in November 2021. The review focused on mental health, mental capacity availability and suitability of residential beds.

SAR X: published 13 March 2025

This SAR focused on a male, aged in his early 80s at the time of the referral, who shortly after being discharged from a Norfolk prison to an approved premises entered one of the acute hospitals in the county.

He was under the supervision of another county's multi-agency public protection arrangements which caused difficulties in his case management, particularly when it was felt his care needs had increased and the approved premises felt no longer able to meet them.

SAR X was commissioned as a discretionary SAR under section 44(4) of the Care Act with a focus on addressing:

- clarity regarding agencies roles and responsibilities, statutory and legal duties.
- consideration of mental capacity, and how it was assessed.
- was the multi-agency plan clear and understood by all agencies involved.
- practice and policy issues.
- an ageing prison population and their care and support needs.

Reviews ongoing and to be published in 2025 / 26

SAR Douglas

A young male who took his own life.

Key lines of enquiry include caring responsibilities, his own care needs and transitioning into, and preparing for, adult life.

SAR Holly

A young woman who resided in 24 / 7 residential care and received 1:1 support by day and night and later died from breathing complications related to her weight, triggered by epilepsy.

Key lines of enquiry include weight management, activities of daily living and maintaining her safety whilst living in a care home and consistency of mental capacity assessments.

Thematic SAR

Joint review into the death of two men who were awaiting the availability of acute mental health beds.

Key lines of enquiry include understanding the scale of the issue, the impact of unavailability of beds, maintaining a focus on the individual and whole system support.

SAR 001

Review into two males with care needs who were living in a family care setting where there was ongoing domestic abuse.

Key lines of enquiry include commissioned care oversight, staff understanding of domestic abuse, risk of 'groupthink', role of advocacy and review of 'Persons in a position of trust' protocols.

SAR 002

Review into a gentleman with complex healthcare needs who died and where it was unclear if agencies had worked effectively to meet those needs.

Key lines of enquiry currently being scoped.

What we have done / are doing to implement the findings of reviews

SAR Adult R

- In seeking assurance that discharge arrangements consider the night-time care needs of a person leaving hospital, NSAB work includes collaboration with a range of health leads, reviewing and considering case studies and summaries of changes that have been made since Adult R died. NSAB to be assured that system wide pathways are also understood.
- Norfolk Community Health & Care pressure ulcer response has been revised and strengthened and has been shared with NSAB. It is reviewed regularly.
- All practices have a safeguarding lead GP who oversees reviewing / updating of policy. Guidance provided by the Care Quality Commission on significant event analysis shared with all GP practices in June 2024.
- Review of mental capacity guidance to be undertaken and guidance relaunched.
- Provider audits are conducted to ensure accuracy of related record keeping and administration of medicines. The Integrated Care Service disseminated a guidance note on this to all care providers.
- Norfolk learning event held in September 2024 and a workshop planned for the National Association of Equipment Providers Conference in June 2025.
- Communication charter to be produced and promoted by NSAB.

SAR Adult S

- NCC Adult Social Services guidance sets out when Care Act assessments need to take place. These are reviewed when care and support plans are signed off and there is a system audit of the quality of this. Casework checks are also made during staff supervisions and there is a systemic audit process that reviews the appropriateness of the allocated worker.
- Ongoing promotion of NSAB's 'Complex case management' and 'Managing professional difficulties' guidance documents. These documents can be found on norfolksafeguardingadultsboard.info
- A countywide exploitation group has been set up which has been asked to undertake a viability study of creating a vulnerable adult risk assessment conference.
- Norwich City Council safeguarding policy has been reviewed to include a section reminding officers that they have a responsibility to escalate concerns and including a link to the NSAB complex case guidance.
- Norwich City Council Home Options team delivered a learning session to their early help hub partners in February 2024. Nineteen different agencies attended with a total of 55 participants, and a further session took place in November 2024. This presentation was shared with colleagues from the Norfolk Housing Alliance.

SAR Eric

- NCC, with assistance from other relevant agencies, will conduct a scoping exercise to understand the impact of the lack of placements for adults of all ages presenting with complex needs.
- NSAB secured funds to create a new consultancy role across the partnership in support of awareness / upskilling agencies without a Mental Capacity Act or Deprivation of Liberty Safeguards specialist.
- Briefing tool to be created and disseminated to assist professionals in understanding the terminology and criteria for the Mental Health Act and Mental Capacity Act.
- The relevant care home to undertake an audit on its admission and risk assessment processes, including training for its staff and to share with NSAB.

SAR X

- Norfolk Adult Social Services prison lead to work with HM Prison and Probation Service (HMPPS) to map Norfolk prison residents.
- NSAB to write to the Ministry of Justice, HMPPS and Department of Health and Social Care to make a request to identify the cohort currently in prison who will require care and support on release, to understand the projected need and proactively plan.
- Norfolk Adult Social Services prison lead to undertake local options review on feasibility of social care staff being placed in prisons, but also to receive referrals for pre-release planning earlier.
- A Memorandum of Understanding between Norfolk probation and the Norfolk acute hospital safeguarding teams to be agreed to ensure that information about a prisoner who has been released, with ongoing involvement with the probation service and any risk, is shared in a timely manner.
- NSAB to write to the Ministry of Justice and the Department of Health and Social Care to publish clarifying guidance to address the longstanding issue of 'Ordinary Residence rules'.
- Norfolk Adult Social Services to strengthen closer joint working with Suffolk County Council Adult Social Services to ensure a smooth and timely process for the release of prisoners from HMP Norwich L wing.

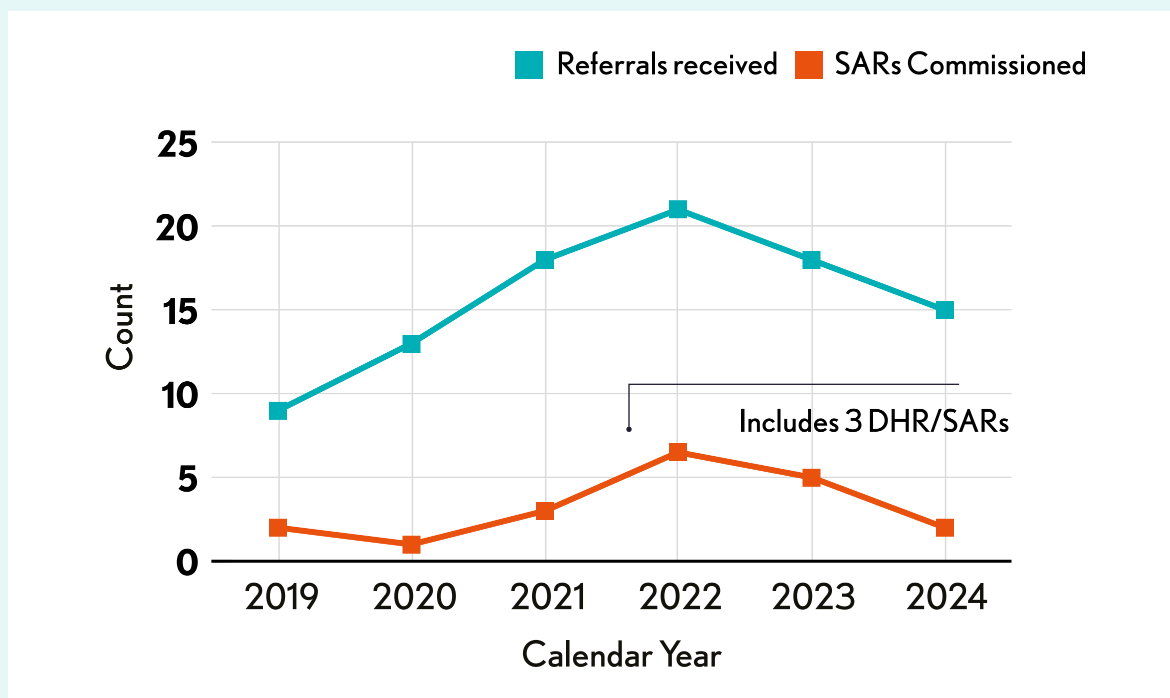
Occasionally professionals request to observe a SARG meeting. We received some wonderful feedback from one such observer:

"Attending this meeting has been an incredibly valuable experience, further deepening my passion for safeguarding. Seeing first-hand how learning is translated into real, actionable change has reinforced my belief in the importance of this work. The rigorous and thoughtful approach taken by the group has left me feeling both inspired and motivated. It has also given me much to reflect on, particularly in terms of the vulnerabilities associated with certain care arrangements and the role I can play in addressing these issues.

This experience has undoubtedly influenced my thinking about my future career direction, and I am eager to explore how I can contribute more actively to safeguarding initiatives moving forward."

The graph below shows the number of SAR referrals received by NSAB over the past five calendar years, and the number that go on to be SARs.

Referrals and SARs Commissioned (2019 – 2024)



The statutory guidance indicates that wherever possible a SAR should be completed within six months; this is not always possible due to the complex nature of reviews. They can sometimes take more than a year to complete and publish, so the numbers will overlap each year. You will see that there are some that fall into the Domestic Homicide Review (DHR) – now referred to as Domestic Abuse Related Death Review (or DARDR) and SAR category.

Contributions from our three statutory partners

Adult Social Services

The Adult Social Services department welcomed Ian Wake as its new executive director in October 2024, and Ian has joined NSAB's Executive Group.

We have emphasised NSAB's strategic intention around **learning lessons and shaping future practice** this year, commissioning a new safeguarding training contract for the next three years. All courses have been rewritten and training methods refreshed to include a strong focus on accessibility, supporting inclusion and best learning outcomes for all delegates. All our courses have a thread of professional curiosity and incorporate learning from new SARs / Domestic Abuse Related Death Reviews (DARDRs). We have been pleased to see a big increase in the uptake of our safeguarding training this year.

We have made great progress in our MSP work, gathering feedback from adults who have experienced abuse and neglect. Feedback continues to illuminate the value of relationships and connections with others in supporting people to feel safe.

This learning helps us develop our preventative safeguarding agenda by promoting informal support networks and community connections to combat loneliness. It has generated rich insights into the impact of abuse and neglect on the lives of adults with care and support needs. The most notable theme this year is the length of time that adults continue to experience anxiety and distress about the abuse that happened to them. We used this learning to promote trauma-informed practice with our staff group.

Identifying a group of individuals we struggle to hear from (people who lack mental capacity, those who have experienced trauma and those where it may not be safe to interview them as part of the feedback project), an appreciative inquiry was carried out to vicariously capture the experiences of this group using stories told by the practitioners who worked with them. The stories shared clearly illustrated emergent outcomes through lives changed because of relational safeguarding interventions by practitioners.

There has been a particular focus on exploitation within our department this year following the publication of SAR Adult P and learning from DARDR / SAR Doris (awaiting publication following Home Office review). Our exploitation course was recognised as meeting a notable gap in the county's training provision and has been picked up by the Community Safety Partnership and offered out to all partners. One of our quarterly OWL briefings focused on exploitation in relation to these SARs, emphasising the **preventative aspects of safeguarding** by supporting our practitioners to spot the signs of cuckooing or other forms of exploitation at an early stage, enabling early, multi-agency intervention. We have also had a focus on domestic abuse and older people, with two of our OWL briefings focusing on this topic. We have made good progress to take forward actions from SAR Adult X to strengthen partnership work with Norfolk's prisons and SAR Eric to examine the availability of care providers for adults with complex needs.

Since detailed scrutiny in 2023 / 24, we have improved risk management processes, strengthened our indicators and their application and have strong oversight of decision making and casework. The introduction of a new portal for the receipt of safeguarding or quality concerns from our provider market has contributed to NSAB's strategic intention around managing and responding to concerns and enquiries about abuse or neglect. The portal is helping us to manage the high volume of concerns we receive more effectively and has opened a conversation with our provider colleagues about quality versus safeguarding concerns.

Norfolk Constabulary

Norfolk Constabulary is a statutory partner and plays a core role within the Norfolk Safeguarding Adults Board, led by Temporary Assistant Chief Constable Chris Balmer at executive level and supported by detectives at each rank up to and including chief superintendent. The constabulary is an active contributor, providing group members and chairs to assist with efficient and effective delivery of the NSAB strategy 2023-2026.

We continue to work on all three NSAB priority areas, focussing on delivering exceptional service to victims and potential victims of crime while recognising their individual needs and ensuring these do not present barriers to service. Examples of this include our close work with partner agencies to improve the response for vulnerable adults in Norfolk through the Right Care Right Person program and an ongoing review of the Multi-Agency Safeguarding Hub (MASH). This work aims to ensure that the most appropriate agency, who is best able to assist the individual in their context, receives the referral and provides the right service to the public.

Significant work continues with examples such as:

- Neighbourhood policing teams working closely with NSAB and Norfolk CSP partners to focus on 'cuckooing' offences, identifying and taking coordinated action where individuals may be suffering exploitation in their home.
- Operation Engage, providing tailored support to the most vulnerable service users who require a different approach to provide their best possible evidence.
- Working with City of London Police and the National Economic Crime Victim Contact Unit to ensure that the most vulnerable victims receive the additional support they require, from the most appropriate partner.
- A focus on high-harm fraud through Operation Radium – a Norfolk Constabulary operation which uses specialist police digital investigators to identify offenders and coordinate regional enforcement.

Norfolk Constabulary has been instrumental in assisting NSAB to concentrate their work in the most impactive areas by co-chairing NSAB Business Group and working, through this group, to involve partner agencies in delivering continuous improvement.

The year 2025 will see Norfolk Constabulary remaining as an active NSAB partner and seeking to improve our service to vulnerable victims and striving to deliver exceptional policing to Norfolk residents.

Norfolk and Waveney NHS Integrated Care Board

This year, the Norfolk and Waveney Integrated Care Board (ICB) appointed into a new head of safeguarding role to provide leadership to the designated safeguarding teams for children and adults. This strategic leadership role has been instrumental in progressing towards an all-age safeguarding model. The aim is to strengthen safeguarding responsibilities across the life course, ensuring a more joined-up approach to protecting babies, children, young people, adults and older people.

The designated safeguarding teams have continued to provide strategic oversight and leadership across the health system. This includes coordinating health sector engagement in statutory reviews, supporting the analysis of both quantitative and qualitative data to inform the evolving NSAB safeguarding data dashboard, and embedding safeguarding considerations into ICB commissioning and contracting processes. Safeguarding remains a golden thread throughout all aspects of health provision across Norfolk and Waveney.

In alignment with NSAB priorities, the ICB has supported work to build confidence and competence in the application of the Mental Capacity Act. This has included promoting learning from Safeguarding Adults Reviews, facilitating discussion groups across the county, and creating opportunities for shared learning and best practice. NSAB has also actively participated in health-led forums to support co-production and strengthen cross-sector collaboration.

Recognising the importance of transitional safeguarding, the ICB has invested in a dedicated designated professional role to lead this work. This post is focused on bridging the gap between children's and adults' safeguarding within the health system. The aim is to improve outcomes for young people transitioning into adulthood and to reduce health inequalities through more coordinated, multi-agency working.

The ICB remains fully committed to the NSAB's strategic priorities. It continues to provide leadership and direction for the health sector's contribution to safeguarding, ensuring alignment with wider ICB goals such as reducing health inequalities and improving the quality of care. Through ongoing partnership with NSAB and other agencies, the ICB is working to ensure that safeguarding responsibilities are met and that healthcare services contribute to safer, more resilient communities.

Locality Safeguarding Adults Partnerships (LSAPs)

There are five LSAPs in Norfolk, meeting bi-monthly and covering north, south, east, west and central Norfolk. The partnerships are made up of a range of local organisations, agencies and individuals who work with adults at risk and / or have responsibility for safeguarding adults within their role.

These local networks support NSAB work within those communities, building a culture that does not tolerate abuse, working together to prevent harm, with confidence to know what to do when abuse happens. Deputy board manager Becky supports all the meetings including planning and collating relevant material.

"I think the South safeguarding meetings are very collaborative, inclusive and informative and help me to gain knowledge and network about good practice across the locality / place."
Katie St John-Clarke, TMOT South OP / PD.

These links between strategic and operational safeguarding continue to support NSAB's evidence-based approaches, with updates from the LSAPs to board and vice versa, each set of meetings.

It's been the first year in a long time that we have had a full complement of LSAP co-chairs, especially in the west! Huge thanks as always to the steady leadership and support of Steven and Liam (SLSAP), Lucy (who makes very nice cakes for our face-to-face meetings – pictured below) and Alicia (CLSAP), Jo and Lynn (ELSAP), Pete and Charlotte (WLSAP) and Sam and Ruth (NLSAP).

From Lynn (co-chair) "I really enjoy the eastern LSAP meetings. It is a chance to connect with colleagues from my locality and share information and learning. I love the spontaneous conversations and reflections. The meetings restore my spirits and often leave me feeling energised to continue in the ever-changing safeguarding arena, to offer the learning and support as required in my job role."

We have continued to hold two meetings each year face to face for all the LSAPs to come together – these are in May and November, held at Aldiss Park in Dereham. It is a great opportunity to network, learn more about each other and hear from guest speakers too. In May 2024 the topic was financial / economic abuse, and we had Reg Burrell (Director of Operation Repeat) talk to us about doorstep crime and scam prevention; also, Sarah-Jane Niles (Modern Slavery & Human Trafficking Co-ordinator) gave a presentation and handouts on labour exploitation and cuckooing in the county. Output from a group exercise on what financial abuse and exploitation might look in day to day practice and how to tackle it is now on our exploitation webpage Exploitation | Norfolk Safeguarding Adults Board.

At our November meeting, with a focus on risk assessment and multi-agency working) we had a number of new attendees from the Department for Work and Pensions, which brought a valuable new element to the group work we did, using a fictional case study about 'Monica' and Marco' to hold multi-agency meetings in the different LSAP groups. The exercise got people thinking about the different information that different people and agencies might hold, and that every voice is important to hear, including that of the adult themselves; and how not having one piece of a jigsaw can make such a difference to the overall view of a scenario. We also had a member of our ELSAP, police sergeant Dan Smith (pictured), talk to us about work to tackle anti-social behaviour in partnership with the borough council and other partners, a more collaborative and potentially preventative approach.

Some feedback we have had on the meetings:

"Thank you for keeping safeguarding high on stakeholders' minds!"

"I liked the discussion about concern v risk – food for thought during safeguarding cases / referrals."

"Really helpful to network with other agencies and develop my understanding."

"Excellent learning opportunities and great environment for discussion – thank you."

"This is the second one I have attended. Both have been so informative and I have made important links with other professionals."

"Extremely interesting and beneficial. Thank you."

"Excellent; informative speakers. I learnt a lot. Please continue to have guest speakers."

A member of our ELSAP, police sergeant Dan Smith

In our virtual meetings, an example of one of the topics covered – **Prevention themes from SARs** – some key points from the discussions included:

- Wider thematic learning is harder to embed in frontline practice especially without enough context for the individuals – in practice, most staff (at all levels) are bombarded with information / emails while trying to manage large workloads
- Time is the most common barrier to learning – few people have time to read a whole SAR – especially if your sector / organisation is not directly involved
- SAR learning can also feel repetitive, or it comes out long after the original event when things have already changed or moved on – it needs to feel relevant
- Safeguarding leads / champions have a valuable role in contextualising SAR information and learning and sharing this in accessible ways / forums
- NSAB material including short briefings / website, newsletter, learning events were all considered helpful – but could be more individualised / sector specific / quick and easy to digest to enhance context / make it relevant to different people.

The meetings also included overviews and learning from some of our Norfolk SARs published in this period. We also held some more webinars in 2024 / 25, covering Prevent, modern slavery and exploitation, and an update on the refreshed Neighbourhood Watch scheme.

A final comment from one of our LSAP members:

"LSAPs are perfect to help us reset, remember and recharge, to take and use partnership knowledge and experience into our practice" Steve, Prevention & Early Help Manager & Safeguarding Operational Lead, Great Yarmouth Borough Council.

Self-neglect and hoarding event October 2024

Self-neglect and Hoarding subgroup

The subgroup continues to draw on a range of research and approaches to help continuously improve its approach to supporting Norfolk people experiencing self-neglect and / or hoarding issues. The group includes representatives from a range of partner organisations who bring many years of experience and expertise.

Highlights from this year include:

- Further review of the NSAB self-neglect and hoarding strategy and practitioner guide and other resources added to the NSAB website
- An in-person conference attended by over 130 people from multiple organisations to:
  - Learn more about innovations in service delivery in some of Norfolk's localities.
  - Meet providers of services supporting people with self-neglect and hoarding needs.
  - Hear about research from Dr David Orr into multi-agency working which Norfolk partners participated in.
  - Networking and working together to understand more about safeguarding pathways and the challenges for professional partnerships.

Dr David Orr's research analysed 273 SARs and interviewed practitioners and people with lived experience. Self-neglect is the single biggest category of abuse and featured in 60% of all the SARs from local authorities across the country.

Key findings recognised the challenges of inter-agency working and encouraged:

- inter-professional curiosity and collaboration
- seeing the person and situation in the round – keeping the person at the centre
- trauma aware practice
- importance of relationships and engagement and continued curiosity regarding the person's focus and motivation for change
- awareness of neurodiversity
- assessment of mental capacity

The feedback from participants was extremely positive and a further online / in person event is planned for later in the coming year.

Quality and Assurance subgroup

The Quality and Assurance subgroup of NSAB continues to be well supported by Norfolk County Council's insight and analytics team, with regular attendance from the three statutory partners and Healthwatch.

This year the group was allocated a recommendation from SAR Adult R to carry out a review of discharge processes across the acute and community hospitals in the county and take subsequent action dependent on the findings. The group has set up a further working group to take this forward, pulling in relevant partners involved in discharge processes. This is a complex piece of work and will continue into 2025 / 26. Next steps will be to review case studies about people in similar circumstances to Adult R, from each of the hospitals and an audit of the equipment service. These will be considered in relation to changes that have been made to hospital discharge since Adult R's death.

Alongside this, the group has developed a set of 'assurance measures' for the board which assess performance using data from the Adult Social Services department's case management system, against the three pillars of the board's work: prevention; management and responding; learning lessons and shaping future practice. The group's analyst has developed a dashboard where the assurance measures can be viewed. Once these have been presented to board, board members will be offered access to view the dashboard independently. The group has used the data from the dashboard to propose a deep dive into the abuse type 'neglect and acts of omission' as this is the county's most prevalent type of abuse. This work will begin in 2025 / 26.

Coalition for Change (C4C)

It has been a year of mixed fortunes for C4C, with staffing changes. The chairperson retired from the role at the end of March 2024 and the new chair was elected by the core group, accepting the role on a voluntary basis. Funds from the previous chair role that remained unspent were rolled over to 2024 / 25 and with financial support from Norfolk County Council the project remained viable and the contract for the project coordinator was extended. Unfortunately, the coordinator had to retire from the role in January 2025, so several aspirations from the C4C business plan were not achieved.

Although work started in earnest in the first part of 2024 / 25 to recruit new members to the core group and to continue with areas of work relating to the Cawston Park Safeguarding Adults Review recommendations, this was only partially successful. Despite having identified an appropriate structure within which C4C could become independent this was not completed.

Jerome Mayhew MP, along with Dr Margaret Flynn, has continued to pursue the Law Commission recommendation related to accountability in criminal law of directors and owners of services found to be unsafe. The general election paused this work and the resulting change in government means building a new network of support. This work will continue.

Norfolk Adult Social Services and the ICB instigated the development of the Real Care Deal for Norfolk, an inclusive process to determine a framework for ethical commissioning. The process included extending the principles to all vulnerable adults requiring care and support. C4C was commissioned to undertake a 'deep dive' exercise into the outcomes for a group of individual clients nominated by the Transforming Care Partnership. Work commenced on this in December 2024 and the report of findings with recommendations was circulated to the commissioners and presented to an NSAB meeting on 11 March 2025.

The core group has decided that it wishes to remain as an informal voluntary interest group who will seek out examples of good practice in the interests of people with learning disabilities and / or autism; continue working on accountability under criminal law, which is supported by the Law Commission but requires government approval and to share learning in Norfolk and nationally.

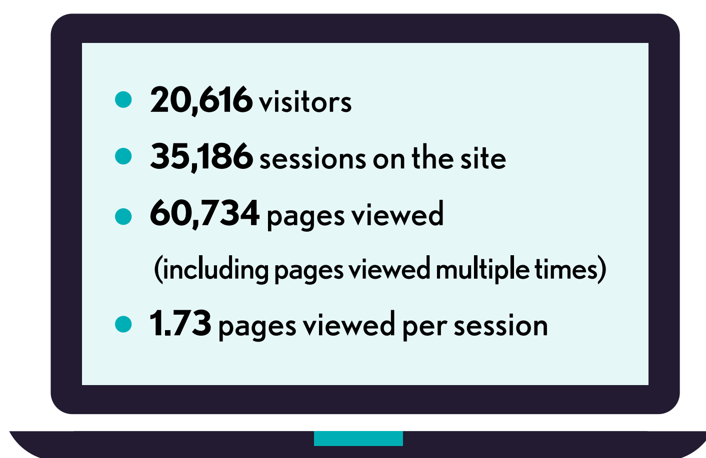
Read more about the Coalition for Change, including who the core group are, on the NSAB website.

Our website, social media, and comms

It has been four years since our website was refreshed and we are so pleased that it continues to receive a lot of recognition, not just from users in the Norfolk area, but also more widely. Our training providers tell us that they regularly refer course participants to guidance and information on our website.

The relaunch of the Herbert Protocol (working alongside the Suffolk Safeguarding Partnership and Norfolk / Suffolk Constabulary) introduced an informative animation which brought a lot of traffic to our website particularly during September and October, as well as many requests from other local authorities around the UK who wished to borrow and rebadge the animation.

In the reporting year we have had:



4:17 minutes is the average time a user spends on our website, each visit (last year's average was 3:25 minutes)

11,474 resources have been downloaded

We published two SARs in the summer of 2024, Adult R in June and Adult S in July. Those SARs had the most viewed pages during the summer months.

The national Safeguarding Adults Week takes place in November, and the information that we shared about the events that we were hosting in that week was seen by a high number of users.

SAR Eric was published at the end of February and that SAR webpage had the highest number of users for March. All of our SARs can be found on our website.

Walter's blog always draws in a high number of readers and particularly so in February this year, where he talked about his need to do more exercise, and the physical challenge that he has set himself for 2025. He also talked about what we need to be alert to in adult safeguarding.

The most downloaded documents from the website include:

- Our See something, Hear something, Say something A5 leaflet
- the SAR report in respect of Joanna, Jon and Ben
- the NSAB self-neglect and hoarding strategy
- NSAB multi-agency procedures
- NSAB multi-agency policy

Interestingly, this was not that dissimilar to the most downloaded documents in the reporting year 2023 / 24.

We still use X on an occasional basis. Our number of users has dropped by 100 since the previous reporting year and fewer followers interact with us when we do post, none of which is perhaps surprising. The board is considering switching to a different platform and has sought views of other SABs to see whether they're still using X.

The feedback provided shows that there is very little use of X, or other social media, generally as SABs don't have the time or resource to monitor / update it.

Safeguarding Matters newsletter

The newsletter drives a lot of traffic to our website and over 1,000 people have signed up to receive it directly into their mailbox.

APRIL **2024**

April 2024 the newsletter had **1,008** recipients

MARCH **2025**

March 2025 had **1,062** recipients

We appreciate that our readers are generally very busy with their day to day jobs and don't always have time to read every newsletter that they've signed up to, but word of mouth and the data that we have been provided shows that what we put out there is helpful to some, so that's very reassuring for us!

The newsletter in this reporting year that received the highest number of interactions was in April. This was the month that we shared our annual survey and news about the second SAR analysis which was about to be published. The most interactions were with Walter's blog (about the human element in adult safeguarding), our annual survey and the James Paget University Hospital's safeguarding conference.

Safeguarding Adults Collection Return 2024 / 25

Counts of Individuals by Age Band	18-64	65-74	75-84	85-94	95+
Individuals involved in Section 42 safeguarding enquiries	940	318	538	497	80

There was a 20% decrease in those aged 95+, and an overall increase in working age adults being subject of a concern or enquiry. This follows a pattern seen across social care data generally.

Counts of Individuals by Gender	Male	Female	Not known
Individuals involved in Section 42 safeguarding enquiries	918	1,454	1

Individuals involved in Section 42 safeguarding enquiries by ethnicity:

Ethnicity	Numbers in 2024 / 25	Percentage change compared to 2022 / 23
White	1,896	-11%
Mixed / Multiple	14	-26%
Asian / Asian British	22	83%
Black / African / Caribbean / Black British	13	-35%
Other Ethnic Group	15	-29%
Refused	12	50%
Undeclared / Not Known	401	9%

Total safeguarding contacts received and numbers which progressed to a Section 42 safeguarding enquiry:

Type	2022 / 23	2023 / 24	2024 / 25
Contacts	5,904	6,385	7,026
Section 42	1,956	3,069	2,769
% converted	33%	48%	39%
'Other' safeguarding	-	-	171
Total % converted	-	-	42%

The number of safeguarding concerns received has increased by 10%. This year there were **7,026** and last year there were 6,385. In August 2024 NCC moved to progressing safeguarding enquiries where the individual has died from 's42' to 'other safeguarding'; this means there is a significant rise from 19 cases recorded as 'other' in 2023 / 24 to 171 – an increase of 795%. This meant there was a relative decrease in the number of 's42' enquiries, from 3069 in 2023 / 24 to 2769. Overall, 42% of safeguarding concerns raised in 2024 / 25 progressed to either a Section 42 or 'other safeguarding' enquiry, a small increase compared to 2023 / 24.

Location of abuse (s42 enquiries)	2022 / 23	2023 / 24	2024 / 25
Own home	1,417	1,095	1,200
Residential care home	951	1,170	826
Hospital – acute	116	163	133
Hospital – mental health	168	133	92

Location of risk – enquiries where the location was 'own home' (increase of 11%) is now greater than 'care home – residential' (which saw decrease of 29%). This is a return to the pattern of data in 2022 / 23, so we will be looking at 2025 / 26 data with interest, to see if 2023 / 24 was unusual. All health and social care locations saw a decrease from 2023 / 24 to 2024 / 25, while 'In the community (excluding community services)' saw an increase.

Type of abuse (s42 enquiries)	2021 / 22	2022 / 23	2023 / 24	2024 / 25
Physical	689	715	851	734
Sexual	152	215	231	252
Psychological	410	458	475	512
Financial	365	432	497	597
Discriminatory	6	6	9	9
Organisational	95	87	91	93
Neglect & acts of omission	875	1,055	1,547	1,132
Domestic abuse	210	322	274	324
Modern slavery	3	3	6	9
Self-neglect	24	10	68	66

Looking at types of abuse reported, there was a 26% decrease in neglect and acts of omission, although this is still the most common type of risk identified in safeguarding enquiries. The second most common type of abuse, physical abuse, also decreased by 12%. We will be taking a closer look at what lies beneath that decrease.

There were some types of abuse that increased in numbers, such as domestic abuse (21%) and financial or material abuse (23%) – these were the third and fourth most common types of abuse. In 'other safeguarding' enquiries, 55% related to neglect and acts of omission – these are commonly cases where the adult was in 24 hour or similar care and have passed away either before the enquiry or during it. Modern slavery still has very low numbers who have needs for care and support under the Care Act but increased threefold from 2023 / 24 (from 3 to 9).

For further information, please see Safeguarding Adults – NHS England Digital

Financial summary 2024 / 25

Income source	General funding	Contribution to deputy board manager post
NCC	133,030	10,000
ICB	22,500	10,000
Norfolk Constabulary	20,000	10,000
Other partners		
- District councils x 7 (£5K per District council)		35,000
- Norfolk & Suffolk Foundation Trust	3,000	
- Norfolk Community Health & Care	3,000	
- Queen Elizabeth Hospital	3,000	
Income from Train the Trainer	3,824	-
Income from NICHE project	5,000	-
Income for self-neglect / hoarding event	2,300	-
Total	**195,654**	**65,000**

Costs Breakdown – General budget	Cost (£)
Total staffing	
- Independent chair(s)	40,018
- Board manager (incl. oncosts)	75,418
- Deputy manager (incl. oncosts)	66,047
- Executive Support Assistant, 1.5 FTE (incl oncosts)	56,418
Consultant – NICHE project, LD Provider Event	10,020
Contribution to NSCP LELE	1,500
Design and publicity costs (incl animation)	564
Miscellaneous (venue hire, catering, IT equipment, etc)	1,655
NSAB website costs	1,416
Training costs (incl. Train the Trainer)	4,194
Total	**257,250**
Total income	**260,654**
Total expenditure	**257,250**
Carry forward to 2025 / 26 (To be transferred to SAR budget)	**3,404**

SAR costs	Cost (£)
Balance brought forward in 2023 / 24 from general budget	30,324
Transfer from general budget 2024 / 25	3,404
SAR reports and related costs 2024 / 25	16,218
Current SAR commitments	15,809
Remaining SAR budget for 2025 / 26	**1,701**

Strategic plan 2023-26

The 3 highlighted priorities have been our focus in 2024 / 25

Preventing abuse & neglect	Managing and responding to concerns and enquiries about abuse and neglect	Learning lessons and shaping future practice
To enable safer communities who can recognise abuse and neglect, take action to protect themselves as well as giving confidence to others to respond in a way that prevents, reduces, or removes the risk of harm.	To promote and improve confidence in reporting safeguarding adult concerns; to be confident that risks are identified and appropriately managed; to develop a more accurate evidence base to identify key safeguarding themes and issues.	To improve future practice, by understanding what has worked well as we ll as what lessons have been learnt, using learning that links back into prevention. To share good and best practice, supporting our workforce to deliver better quality services across Norfolk, in turn reducing risk and harm in our communities.
3 Priorities	**6 Priorities**	**7 Priorities**
We will:	**We will:**	**We will:**
Coordinate partnership activities using an evidence-based approach, using language and material that is relevant and accessible, that: • raises safeguarding awareness amongst the people of Norfolk • targets safeguarding awareness for particularly vulnerable groups, using an evidence-based approach • promotes engagement with the resources of NSAB and its subgroups.	Develop a framework that ensures confidence in, and consistency of, reporting of safeguarding concerns, giving us evidence to demonstrate proportionate responses to individual incidents incorporating the wishes of the adult (Making Safeguarding Personal) – in line with the LGA / ADASS framework.	Develop a way to ensure that the findings from Safeguarding Adults Reviews, and other key areas of practice improvement, are implemented promptly and the impact measured.

Preventing abuse & neglect	Managing and responding to concerns and enquiries about abuse and neglect	Learning lessons and shaping future practice
Promote good quality and effective training across the partnership which includes, wherever possible, the voice of lived experience.	Promote equity of access / consistent pathways within organisations, supporting positive approaches to reporting and responding to safeguarding adult concerns.	Develop a way to ensure that the findings from Safeguarding Adults Reviews, and other key areas of practice improvement, are implemented promptly and the impact measured.
Encourage and support our partners to have robust safeguarding awareness within their recruitment processes and throughout their working practice to build a quality workforce delivering safe practice in Norfolk.	Recognise the different needs and barriers to access which vary across our communities and aim to be inclusive in all aspects of safeguarding.	Produce/share relevant insights and guidance across our multi-agency partnership.
-	Value and respect those who raise a safeguarding concern and expect partners to support the delivery of appropriate and timely feedback.	Collaborate with other partnership boards to identify any recurring themes, to develop and share approaches/ material where learning can be applied more widely.
-	Seek evidence and assurance to demonstrate that people who use safeguarding services have been fully involved in what happens, following the principles of Making Safeguarding Personal.	Ensure that actions taken are influenced and advised by the experience of people who have been or may be at risk of harm as well as those communities whose voice is seldom heard, including carers.
-	Use the information we gather as a feedback loop to improve practice and promote co-delivery / co-production with partners.	Build our knowledge of the diversity of Norfolk's people, ensuring that our engagement is inclusive and respectful.
-	-	Exercise our power to challenge when safeguarding needs are identified and not met; ensure safeguarding outcome measures effectively capture the adult's views and wishes, as well as clearly demonstrating the impact of safeguarding interventions.

How we will measure success:

Prevention	Managing	Learning
Develop ways to gather and collate feedback from people providing and using services to measure their confidence / understand their experience.	Develop multi-agency audit processes to identify both qualitative and quantitative data to monitor the reporting of safeguarding concerns and MSP.	By asking partners to demonstrate how they have implemented actions / learning Developing a way to evidence the impact of learning from SARs etc.
Number / percentage of people who define what outcome they want at the beginning of a s42 enquiry.	Examination of s42 conversion rates – in each abuse type.	All action plans developed from SAR recommendations will now have an "impact" column added which will require feedback from partners evidencing the implementation of actions / recommendations and timeframe.
Number / percentage of people whose identified outcome was met.	Tracking the safeguarding process – time taken to complete s42 enquiry.	SARG to identify past recommendations / actions to revisit and request partners provide evidence of changes / improved practice.
Access to advocacy.	Monitor the number of repeat safeguarding concerns reported.	All NSAB training / awareness events to have evaluation forms / feedback to demonstrate improved practice.
Proportion of people who feel safe after the safeguarding intervention.	Regular multi-agency audit to examine safeguarding themes – dip samples.	NSAB annual survey – including examples where something NSAB has done over the year has impacted on the person's practice – compare year to year.
Use partnership data to monitor and review the numbers of safeguarding concerns and enquiries in relation to volume, types, key themes and consistency.	Develop a process of feedback from service users that examines whether feedback is timely, useful and appropriate.	-

Prevention	Managing	Learning
Current data gathered by Q&A subgroup for presentation to board is currently adequate and is considered alongside SAC return.	Question asked through follow up by local authority at the end of an enquiry – number of people at risk informed of outcomes and percentage of people at risk satisfied with outcomes.	-
-	Question asked of referrers at conclusion of enquiry.	-
-	Use qualitative data to understand the lived experience of those supported by the safeguarding process.	-
-	NCC MSP work; potential thematic analysis of cases.	-

Contact Details

Tel: 0344 800 8020
Email: nsab@norfolk.gov.uk

Original Document Name

Norfolk Safeguarding Adults Board Annual Report 2024 / 25

Version Control

1

Date of publication

03 September 2025

Availability

Hard copy on request. Please email nsab@norfolk.gov.uk or at norfolksafeguardingadultsboard.info

www.norfolksafeguardingadultsboard.info