Northamptonshire Safeguarding Adults Board

Annual Report 2025-2026

Contents

Northamptonshire Safeguarding Adults Board

In accordance with the Care Act 2014, it is a statutory requirement for Local Authorities to establish a Safeguarding Adults Board in its area.

The purpose of the Safeguarding Adults Board (SAB) is to assure itself that local safeguarding arrangements are in place, and partners act to protect the welfare of adults who have care and support needs, and who may be at greater risk of abuse and neglect. The Board is committed to preventing abuse from happening, and that safeguarding practice continues to improve outcomes for people in Northamptonshire.

Safeguarding Adults Boards have three core duties under the Care Act 2014:

1. Publish a strategic plan for each financial year and its strategy for achieving its objectives.
2. Publish an annual report including what has been achieved during the year, what it has done to implement the strategy, what members have achieved and findings of reviews.
3. Conduct Safeguarding Adults Reviews in accordance with Section 44 of the Care Act.

Northamptonshire Safeguarding Adults Board (NSAB) is made up of senior officers nominated by partner agencies such as the statutory partners: North and West Northamptonshire Councils, Northamptonshire Police, and NHS Northamptonshire Integrated Care Board. Other members include Acute Hospitals (Kettering General Hospital and Northampton General Hospital), Department of Work & Pensions, Healthwatch North & West Northamptonshire, HM Prisons, Northamptonshire Fire & Rescue Service, Northamptonshire Healthcare NHS Foundation Trust, National Probation Service Northamptonshire, Public Health, and organisations in the Voluntary and Community Sector.

Members have delegated authority to represent their organisation and to make decisions on their agency's behalf.

NSAB's Vision

'Working together to keep people safe'

During the period 1st April 2025 to 31st March 2026, NSAB was supported by the operational Delivery Board and four Subgroups - Communications & Engagement, Learning & Development, Quality & Performance, and Safeguarding Adults Reviews, as well as several dedicated task and finish groups to further support activities from the groups.

There were no new declarations of interest received by members during the year.

Foreword from the NSAB Co-chairs

I am delighted to introduce the Northamptonshire Safeguarding Adults Board (NSAB) Annual Report for 2025-2026.

This year has seen a strengthening in the Board's governance arrangements and strategic leadership with the addition of Michael Murphy joining as Independent Co-Chair in May 2025. Michael's role is to work with myself and the Board to enhance challenge and accountability and align our work with national best practice.

Michael brings a wealth of experience and a different perspective, having worked as a Director of Adult Social Care in many different locations, as well holding several strategic safeguarding roles countrywide. I am sure that our new arrangements will bring stronger independence and objectivity to the Board which is of increasing importance when scrutinising our performance or managing sensitive cases.

We conducted a comprehensive review of our strategic priorities ensuring that widespread consultation has taken place at both strategic and operational levels involving partner agencies and people with lived experience. These new strategic priorities have been agreed and I look forward to them improving our collective response to adults with care and support needs.

From a policing perspective, safeguarding remains at the heart of what we do as set out in the Northamptonshire Police Policing Plan 2025–28 and our Control Strategy. There you will see a key focus on, amongst other things, vulnerability, violence against women and girls (VAWG) and Serious Organised Crime. All of these areas directly relate to the work of NSAB in striving to protect adults with care and support needs from abuse or neglect.

Finally, I would like to thank our partners for their continued commitment, hard work and collaboration. I would also like to specifically reference the tireless efforts of the Business Office; without their support we would not have achieved the results you will read about in this report and our plans would not be so well articulated.

Ivan Balhatchet, Chief Constable, Northamptonshire Police, and Co-chair, Northamptonshire Safeguarding Adults Board

Since joining Northamptonshire Safeguarding Adults Board in May 2025 as an Independent Co-chair, I have met with many dedicated colleagues working tirelessly to prevent abuse and neglect.

I have worked for over 30 years in the Health and Social Care sectors across England, Wales and Scotland. I am a registered Social Worker and have wide range experience of operational management, leadership and service transformation across social care and integrated services. I am also a Safeguarding Adults Review (SAR) author and this work has expanded my commitment to evidencing the impact of SARs.

I am committed to working collaboratively with colleagues to create a positive learning culture, and a trusting working environment to ensure that Northamptonshire is a place where our citizens are safe and can thrive.

As Ivan has mentioned, we reviewed the governance and membership of the Board, and the new arrangements were approved by the four statutory partner Chief Executive Officers in February 2026.

We also held a multi-agency strategic planning workshop in September 2025 to review the existing plan for 2023-26 to support the development of a new plan for 2026-29. The updated plan was approved by statutory partner Chief Executives in February 2026. Further details can be found on page 8.

Following evidence from local SAR referrals, the Board agreed to prioritise self-neglect as a key theme. A summit was held in June 2025, facilitated by an independent facilitator. The event involved colleagues from many different organisations. Further details can be found in the report at page 10.

We participated in the Care Quality Commission (CQC) Framework Inspections for North and West Northamptonshire Councils in the summer. Both local authorities received an outcome of Requires Improvement. Improvement plans will be developed by the local authorities who will have ongoing communication with the Department of Health & Social Care (DHSC). The CQC inspection outcome reports can be found here via this link.

I look forward to working with the safeguarding partnership during the year ahead and to achieving NSAB's key priority objectives.

Michael Murphy, Independent Co-chair, Northamptonshire Safeguarding Adults Board

Annual Report Overview

The Annual Report provides an overview of NSAB's achievements against the Strategic Plan 2023-2026. For the period 1st April 2025 to 31st March 2026, the Strategic Board unanimously agreed to retain the existing three priorities: Prevention, Quality and Making Safeguarding Personal (MSP).

The Strategic Plan (the Plan) is aligned with the six key principles as outlined in the Care Act:

Empowerment

People are supported and encouraged to make their own decision and informed consent.

Accountability

Accountability and transparency in delivering safeguarding.

Prevention

It is better to take action before harm occurs.

Protection

Support and representation for those in greatest need.

Proportionality

The least intrusive response appropriate to the risk presented.

Partnership

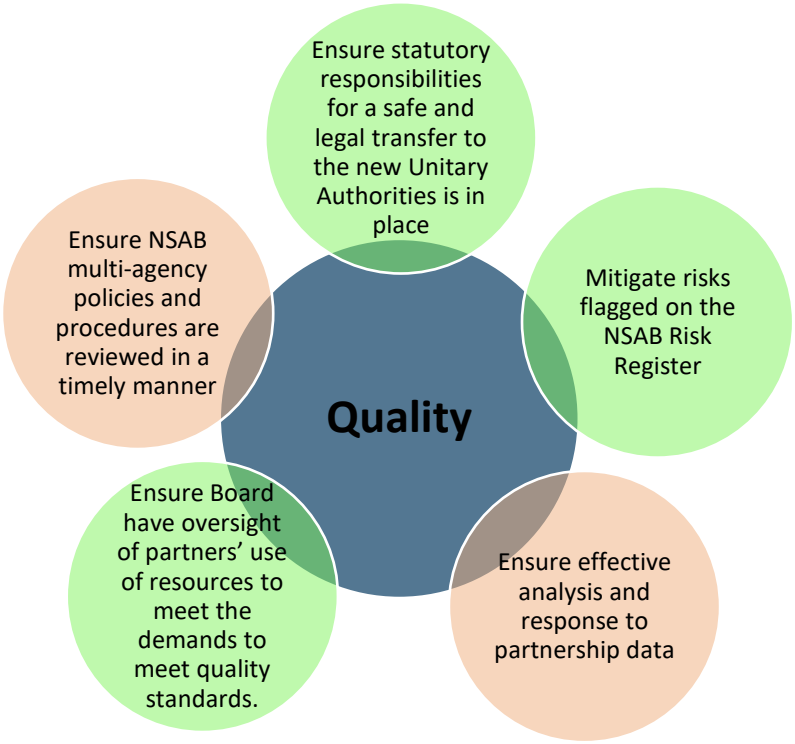
Local solutions through services working with their communities.

Strategic Plan 2023-2026

Board priorities for 2023-2026

1. Making Safeguarding Personal
2. Prevention
3. Quality

Achievements against the three priorities are highlighted below - green denotes achieved and amber denotes ongoing activity:



At an in-person development workshop with partners at the Guildhall, Northampton in September 2025, the strategic plan 2023-2026 was reviewed in detail and development of a new strategic plan for the period 2026-2029 began. Throughout the development process for the new strategic plan, there was robust consultation with partners with priority objectives and assurance agreed at the Strategic Board in January 2026. Agreement for the new priority framework was also agreed by the Chief Executive Officers from the four statutory partners in February 2026. The eleven objectives in the Strategic Plan 202-26 are detailed below:

Strategic Plan 2023-2026 continued…

Eleven Strategic Objectives Underpinning NSAB's Three Strategic Priorities in 2023-2026		
Seek assurance that the Making Safeguarding Principles (MSP) are embedded in practice	Ensure the partnership continues to promote the importance of multi-disciplinary meetings including the Adult Risk Management (ARM) process	Seek assurance that the use of the Mental Capacity Act 2005 (MCA) and its five principles are embedded in practice
Ensure the partnership has mechanisms in place to capture the voice of people with lived experience involved in the safeguarding process	Seek assurance that robust transitional safeguarding arrangements are in place to support young adults with care and support needs moving into adulthood. Also, adults transitioning from services such as mental health, and prison continue to have their needs met once back in the community	Seek assurance that the workforce recognises when a person has been affected by a traumatic event, and where this has a lasting, adverse effect on their mental and physical well-being, that they take a holistic view to their presenting circumstance
Work together as a Board to provide local leadership to safeguard adults from risk and abuse	Deliver a targeted preventative approach based on data and intelligence to help recognise emerging safeguarding themes	Effectively manage and publish Safeguarding Adult Reviews (SARs) and reflect on learning from local and national statutory reviews and good practice
Seek assurance that the system workforce is knowledgeable and confident in the application of their safeguarding duties and responsibilities	Develop a data and intelligence led approach to safeguarding to include a robust dashboard to help inform Board and partners of emerging safeguarding issues	

Strategic Board & Strategic Planning for 2026-2029

The Strategic Board was Co-chaired by Ivan Balhatchet, Chief Constable of Northamptonshire Police and Independent Co-chair, Michael Murphy. All meetings were held quarterly in-person at various locations across the county. Five Strategic Board meetings were held during the year, including the strategic planning workshop in September 2025. We are pleased to advise that there was 100% attendance from all four statutory partners at all meetings. To ensure agency representation, some senior colleagues deputised for substantive Board members. The topics noted below were discussed in detail with presentations provided by partners.

Presentation / Topics Discussed at Strategic Board	
Operational delivery plan progress made against strategic plan 2023-2026	Review of the strategic plan 2023-2026 and development of the new plan for 2026-2029
NSAB Governance including membership review	Self-neglect and summit feedback
St Andrews Healthcare Assurance	NHS England Reforms and ICB impact and restructure
Modern Slavery and Human Trafficking	Suicide Prevention including real time surveillance data
North Northamptonshire Council Safeguarding Practice Review Overview and Outcome	Mental Health, Learning Disability and Autism Collaborative
Care Quality Commission Local Authority Framework Inspection status for North & West Northamptonshire Councils	North and West Northamptonshire Asylum Seekers, contingency hotels and houses of multiple occupancy
Safeguarding Adults Reviews (SAR) quarterly briefing	Approval of SARs 026/035, 033, 051 and 056/062

St Andrews Healthcare Northampton

During the course of the year, and as documented in the national media, serious concerns were raised about the safety of patients and the quality of care being given at St Andrews Healthcare in Northampton. St Andrews Healthcare Northampton is the largest mental health hospital in Europe, with many different organisations involved with diverse roles and responsibilities.

Numerous safeguarding concerns were received by West Northamptonshire Council and the Board were notified of two police investigations in relation to serious abuse with arrests being made in relation to an investigation regarding sexual abuse. In addition, a death in February 2025 resulted in a section 42 Safeguarding Enquiry being undertaken which uncovered additional concerns resulting in a Large-Scale Enquiry being opened in relation to care on four wards.

On 14th July 2025, the Care Quality Commission took urgent enforcement action by imposing a condition on St Andrews Healthcare registration to keep service users safe by restricting new admissions. A number of other conditions were imposed on 10th November 2025 requiring the provider to make improvements to the safety and quality of care provided relating to staff, ward environments, blanket restrictions, risk management, observations, incident management, governance, systems and processes[1].

Members of NSAB are active participants in the NHS quality oversight process and West Northamptonshire Council continues to have strong operational safeguarding links. NSAB sought assurance from key partners regarding patient safety including at Strategic Board meetings and will continue to support, as well as seek assurance in 2026-27.

Governance and Strategic Planning

A review of the Board's governance arrangements were undertaken with a number of recommendations made, including:

- **Membership (voting and non-voting members)** – voting members to formally approve policy and practice matters.
- **Chair's term of office** – proposing the extension from two to four years to give a higher degree of stability and consistency to cover the life of NSAB's planning cycle of three years.
- **Oversight by statutory partners** – to ensure the effectiveness of the Board, two executive meetings should be held each year with the Chief Constable and the three other statutory partner Chief Executives. The autumn meeting will consider the Independent Co-chair's assurance report on progress made against the strategic plan.
- Opportunity to briefly consider the alignment of the priorities and plans of the county's other strategic partnerships.
- Expectations of NSAB members:
    - To ensure consistency and continuity, member organisations (voting members) should confirm their nominated representative (ideally Director level) and a named deputy. It is anticipated that the nominated representative will attend all quarterly meetings and the named deputy by exception.
    - To ensure an effective governance process for Safeguarding Adults Reviews (SARs), once approved by the NSAB Co-chairs, the statutory partners will be expected to respond to the SAR Subgroup's referral recommendations within 14 days from the date of the request from the NSAB Business Manager.
    - Member organisations will be expected to review/comment/approve SAR reports when requested by the NSAB Business Manager to enable the sharing of the report to aid wider learning for the partnership.

The recommendations were approved by the Chief Executive Group at the inaugural meeting on 25th February 2026.

[1] Care Quality Commission website – St Andrews Healthcare Northampton

Progress, Achievements and Impact continued…

Strategic Priorities – Prevention, Making Safeguarding Personal, Assurance

Strategic Objectives and Assurance Underpinning NSAB's Strategic Priorities in 2026-2029

Priority Objectives

Rebalancing the System – Tier 1	Rebalancing the System – Tier 2	Rebalancing the System – Tier 3
Maximise early intervention and prevention People with needs for care and support are assisted by information and/or informal services before accessing more formal interventions	Strengthening inter-agency processes to enable better multi-agency responses to need at an earlier stage to reduce volume of safeguarding referrals, ensuring alternative pathways to safeguarding are utilised	For people where services struggle to support the most Review the self-neglect and Adult Risk Management (ARM) pathways, the use of care reviews and section 117 aftercare
Impact from Safeguarding Adult Reviews (SARs) In line with national analysis and experience, our SARs evidence several consistent themes that tend to be repeated despite being identified as issues in previous reports. An example is self-neglect. The work will focus on two areas: 1. The Board will work with the SAR Subgroup to review how the impact of learning from SARs is monitored 2. The Board will establish a Self-neglect and Hoarding Subgroup to implement robust systems for this area of practice	**Data Led Priority Setting and Assurance** The Board's priorities for new and improvement actions are informed by benchmarked shared data which identify where issues are arising and gives assurance where existing measures are in place. Utilise the Police Observatory and relevant Joint Strategic Needs Assessments (JSNAs)	**Co-production and inclusion of People who use Services** NSAB will seek assurance from partner agencies that there are mechanisms in place to ensure strategies, policies and procedures consider the voice of adults with care and support needs

Priority Objectives - Assurance

Transitional Safeguarding	Prison Release Process
To ensure that young people with care and support needs who are moving into adulthood receive appropriate support and that safeguarding action is taken where necessary	To ensure that services to support vulnerable prisoners are optimal

Exploitation and Modern Slavery

To ensure that all partner agencies are briefed on the threat and risk to vulnerable people from organised criminal exploitation

Priority Objective - Solution

Multi-Agency Safeguarding Hub (MASH)

A Multi-Agency Safeguarding Hub (MASH) to process safeguarding enquiries is recognised as national best practice. This arrangement is known to improve information sharing, partnership working and outcomes for adults with care and support needs

A decision is required as to whether we continue as a system without an integrated MASH, knowing that this is a barrier to improving safeguarding outcomes

Progress, Achievements and Impact continued…

A robust consultation process was put in place to ensure all partners had the opportunity to contribute to the development of the new plan.

Strategic Plan 2026-2029 - Consultation and Implementation Timetable	
September 2025	Partner Strategic Planning Session - partners to review existing strategic priorities and objectives and identify new (if appropriate) objectives. Agencies should take into account their own capacity to work collectively to address the Board's priorities/objectives
October 2025	Update initial thoughts and findings to Strategic Board
December 2025	Update Delivery Board - subject to analysis by Police Tasking Group and a Public Health approach, to create a prioritised list which aligns with capacity
January 2026	Extraordinary Strategic Board workshop session, to analyse and agree the proposal
February 2026	Development of the operational delivery plan and assurance framework
March 2026	Partners to approve the delivery plan
1st April 2026	Implement the new delivery plan and assurance framework

Delivery Board

The purpose of the Delivery Board is to oversee the progress made against the NSAB Strategic Plan, and the operational Subgroup activities that support the plan's key priorities and objectives. The operational delivery plan's progress, barriers and evidencing impact was discussed at every meeting. The Subgroups are instrumental in delivering the core actions, and the Business Office in managing and progressing the activities.

Joseph Banfield (Joe), Detective Superintendent with Northamptonshire Police continued to Chair the Delivery Board highly effectively. Joe was instrumental in developing the Strategic Plan for 2026-29 with the Independent Chair, Michael Murphy and the Board Business Manager, Suzanne Binley.

Five Delivery Board meetings were held during the year including the Self-neglect summit in June 2025.

Presentation / Topics Discussed at Delivery Board		
Standing Agenda Items		
Subgroup Chair updates	Partner Emerging Themes	Risk Register Review
Homelessness and housing updates from North & West Northamptonshire Councils	Strategic Planning consultation and updates throughout the year	
Other Presentation / Topics Received		
Public Health - Suicide Prevention and Real Time Surveillance		
Northamptonshire Fire and Rescue Service – Community Risk Management Plan – Fire Fatality Trends and Prevention Strategy		
East Midlands Ambulance Service - Prevention of future deaths report – Janet Springall – National Case		
Probation Service Changes including IMPACT and Accredited Programmes and the Probation Sentencing Review		

Self-neglect Summit

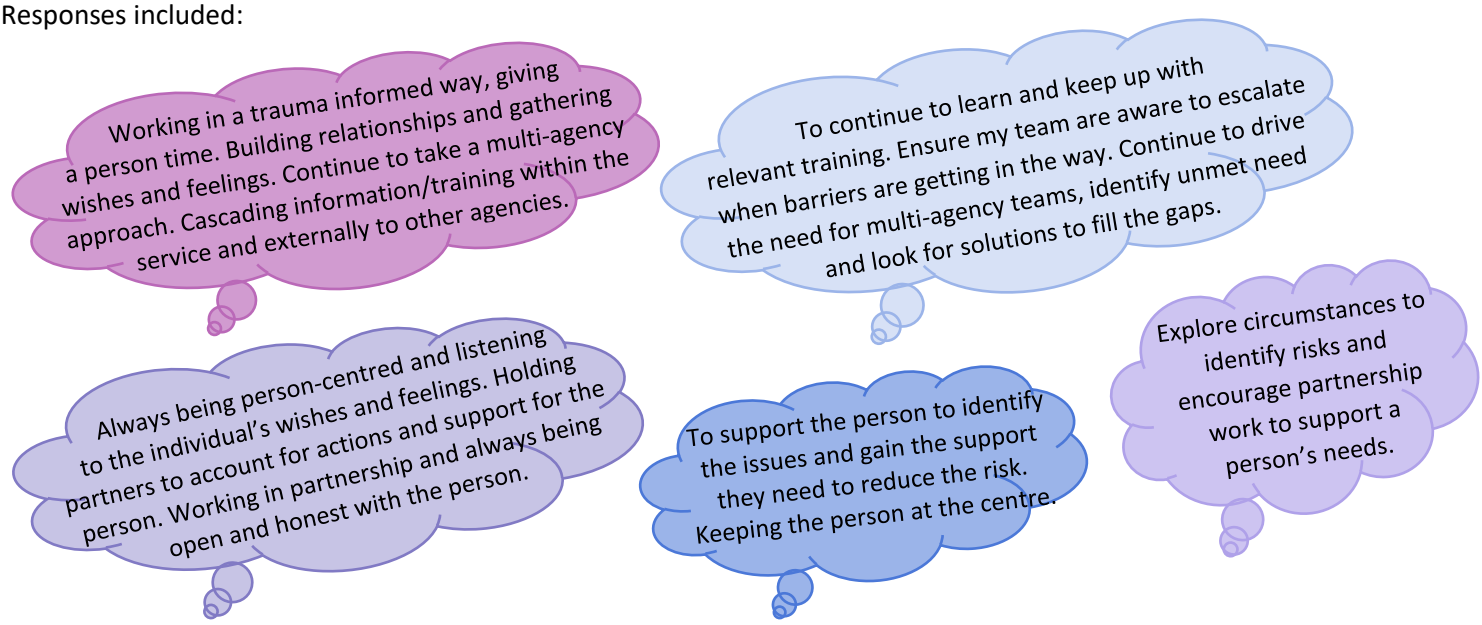
In light of the themes highlighted in Safeguarding Adults Reviews (SAR) referrals and agreement by the Board to prioritise self-neglect, a summit was held at the Guildhall in Northampton in June 2025, chaired by independent facilitator, Heather Roach. We welcomed 69 colleagues from across the County. The summit had four main objectives: to focus on key themes that were evident locally and nationally, learn about what support is available to practitioners dealing with people who self-neglect, identify what works well in these situations and help shape the future safeguarding response to self-neglect across the county.

The summit highlighted the support available across the county from Northamptonshire Fire and Rescue Service, Northamptonshire Police's Vulnerability Board, Substance to Solution Service, Kettering Mind's virtual Hoarding Support Group and the Adult Risk Management (ARM) process. Case studies were shared to help identify gaps and good practice. Feedback from the summit was very positive and provided an opportunity to connect with colleagues from a wide range of organisations and discuss what was needed in the system to support adults experiencing self-neglect. The event enabled open discussion, shared knowledge and experience. Practitioners identified the following key themes to help improve practice and improve the safeguarding system:

Key themes to help improve practice	Key themes to improve the safeguarding system
Improving professional knowledge around self-neglect and the pathways	Development of a multi-agency safeguarding hub (MASH) or similar
Building effective and consistent engagement with individuals and taking time to build relationships	Improved information sharing between agencies
Understanding and accessing available support and resources	Centralised referral pathways – having one clear route for a practitioner or member of the public
	The response to people who do not meet statutory thresholds

The outcomes from the summit were considered by the NSAB Strategic Board and have fed into the development of NSAB's Strategic Priority Framework for 2026-2029 as outlined in the report above.

Practitioners were asked to complete an evaluation form at the end of the summit. 57 completed evaluations were received highlighting: 87.7% practitioners found the session informative and helpful to their role and 89.5% were confident to share their views during the multi-agency table discussions. 89.5% practitioners agreed that the learning from the summit would support their future practice. 78.9% had a clear understanding of what is in place locally to support practice and 94.5% stated they understood the importance of multi-agency working and how it can help adults who self-neglect. Practitioners were asked 'What is your personal commitment to support adults who self-neglect?.' Responses included:



Prison & Probation Partnership

Whilst prisons are responsible for safeguarding in their estate, not the local authorities, NSAB wanted to help develop stronger working relationships between local prisons, the Probation Service and other key partners including housing, to support better joined up working to support prison release and support in the community. Terms of Reference were agreed, and there was agreement to meet at least twice a year on an informal basis. We noted challenges facing prisons and the Probation Service in light of the prisoner early release scheme. Moving forwards, assurance will be sought on the effectiveness of prison release and the transition for prisoners back to the community. Assurance on safeguarding will also be requested.

Homelessness and Rough Sleeping

The Delivery Board continued to be supported by housing colleagues from North and West Northamptonshire Councils, with quarterly updates discussed at each meeting. The quarterly homelessness and rough sleeping update reports include the following information:

- Number of rough sleepers (including comparative data from previous years)
- Details of the target priority group (TPG)
- Details of any deaths and light touch reviews undertaken
- Initiatives to support and prevent homelessness
- Accommodation update including temporary accommodation and single homelessness accommodation pathway (SHAP)
- Severe Weather Emergency Protocol (SWEP)
- Safeguarding concerns

The level of work being undertaken to support adults faced with homelessness and rough sleeping is extensive, with many different initiatives in place.

In North Northamptonshire, the Rough Sleeping Team host a monthly 'EmpowerHER' drop-in session which supports vulnerable women experiencing rough sleeping/at risk of exploitation or homelessness. Partners involved in the drop-in include Public Health, Sexual Health, midwifes, domestic abuse support, and the Rough Sleeping Treatment Team (RST). The Complex Lives group provides practitioners with the opportunity to discuss individuals with complex needs who don't meet the threshold for a s42 safeguarding enquiry or the Adult Risk Management (ARM) process. The RST have undertaken prison in-reach sessions to deliver wrap-around support for individuals who have been recalled or sentenced.

In West Northamptonshire, a Supported Accommodation Multi-Agency Panel is in place to co-ordinate a person centred, multi-agency response to provision of housing with support for individuals experiencing/at risk of rough sleeping. St Johns supported accommodation offers support from 08:00 to 20:00, seven days a week including practical and emotional support, skills training, housing assistance and help accessing healthcare and community services. There is a Homelessness Treatment Team in providing substance use treatment and support to individuals experiencing rough sleeping and homelessness. The service provides a pro-active outreach model focusing on early identification, harm reduction, housing support, transition into structured treatment and recovery pathways, reducing drug and alcohol-related harm and improving physical and mental health outcomes.

NSAB would like to congratulate colleagues from North Northamptonshire Council's Housing Solutions Service for being shortlisted as a finalist in the MJ Awards under Best Council Service. We wish them every success.

Target Priority Group

NSAB's oversight following the ministerial letter in May 2024 was reviewed in relation to the arrangements for the Government's Target Priority Group (TPG). We are pleased to confirm that:

- NSAB already had named Board members for housing and homeless teams from North and West Northamptonshire Councils.
- NSAB continued to consider undertaking Safeguarding Adults Reviews for rough sleepers with care and support needs. It should be noted that NSAB, with the support of housing colleagues, initiated a Light Touch Review (LTR) process a number of years ago, and this remains in place.

NSAB Subgroups

The Strategic Plan's objectives direct the priorities and focus for all Subgroups. Where there were cross-cutting issues, the Business Manager ensured these were tabled at other Subgroups, for example, the publication of Safeguarding Adult Reviews (SARs) and findings from Quality & Performance impacts on the Communication & Engagement and Learning & Development Subgroups.

It is noted that some members found it difficult to attend all meetings, or to find representatives to participate.

Communications & Engagement Subgroup

In May 2025, the Subgroup welcomed a new Chair, Clare Bell, Service Manager, Quality and Assurance, West Northamptonshire Council. We would like to thank Vicki Rockall, Head of Community Safety, Engagement and Resettlement, West Northamptonshire Council, for her support over the years of Chairing the group. The Subgroup met four times over the course of the year.

Engagement and Feedback

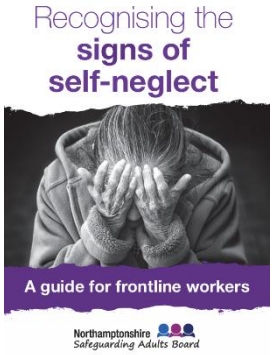
General Engagement

Partnership mapping activity was undertaken to understand the opportunities for co-production activities and engagement with service users across the partnership where members will share key messages at events and forums.

It had been suggested by a previous West Northamptonshire Council Director of Social Services, that the quality of safeguarding could be determined by the number of complaints received in relation to the service provided. In this regard, colleagues were asked to ascertain the number of complaints relating to safeguarding practice – the results were reassuringly low. Whilst the number of safeguarding concerns relating to self-neglect were low, members acknowledged the impact on individuals is high and agreed to focus on a new campaign to raise awareness of self-neglect. Throughout the course of the year, the Subgroup developed a Communications Plan to detail the key self-neglect messages to share with different groups.

Self-neglect leaflet

To support the priority of self-neglect, a leaflet was developed to help raise awareness of self-neglect with frontline practitioners including information relating to what self-neglect is, causes and signs of self-neglect, risks of living with self-neglect, how to respond and how to help an individual who may be self-neglecting. The leaflet can be accessed via this link on the NSAB website.



Printed copies of the leaflet are also available for sharing with colleagues and at events. Please contact the NSAB Business Office via nsab@westnorthants.gov.uk if you would like to collect leaflets.

Cuckooing Animation

A new animation dedicated to cuckooing and home takeover highlights the signs and indicators of cuckooing, why people might be reluctant to report concerns, where concerns can be reported to, and where to go for advice was personalised.

We would like to thank Newcastle Safeguarding Adults Board for granting their permission to adapt the animation.

The animation can be found via this link on the NSAB website.

Progress, Achievements and Impact continued…

Sharing Positive News – Service User Voice

On a rotating basis, members presented a good practice case study at each meeting to ensure the voice of service users was heard – some really positive practice was shared – see examples below:

Service User Voice - Case Studies - Impact
West Northamptonshire Council Community Safety, Engagement and Resettlement team shared a case regarding the support given to a vulnerable adult regarding their homelessness and poor mental health during a visit at Northampton Library Welcoming Space. The support given resulted in a Duty to Refer referral. By taking the time to listen to the adult, and the action put into place, the outcome facilitated the adult being housed. The adult revisited the library to update the staff member on her positive change in circumstance and to thank them for their support.
West Northamptonshire Council Adult Social Care shared a case involving a 53-year-old woman, previously unknown to them, who was referred by a district nurse due to her mental health struggles and not taking her medication. A home visit revealed additional issues including financial hardship, lack of food, tenancy concerns, and unmanaged diabetes. The individual was 'open' to support, and with a multi-agency, person led response focusing on the individual's preferred outcomes, she was supported with her medication, wound care, memory concerns, food access, and finances. Despite complex family dynamics, adult social care remains involved as her health needs are addressed.
West Northamptonshire Council Adult Social Care shared a case in relation to a 90-year-old Romanian woman who had come to Northampton to support her granddaughter but wished to return home after a period of time when her support was no longer needed. When a social worker became involved, the lady was a patient at Northampton General Hospital after the police had found her wandering in the street. There were initial concerns about her mental capacity. The social worker assessed her mental capacity to make decisions and determined that she had capacity to do so. The social worker advocated her wishes and raised safeguarding concerns. She had a valid passport; however, her family had hidden this from her and were preventing her from accessing her documentation to return home. She agreed to a temporary care home placement while her passport was retrieved. After six weeks and a further hospital admission at Northampton General Hospital visit, she expressed her distress about not returning to Romania. Through collaborative work with health services, the police, and social services in Romania, the social worker successfully retrieved her passport, arranged her a flight, and safe return home. She expressed deep gratitude upon receiving her travel documents and kissed the social worker's hand (a gesture of gratitude in Romanian culture). It was later confirmed that she was happily settled back in her community. The case highlighted the importance of cultural awareness and multi-agency working in achieving person-centred outcomes.
North Northamptonshire Council Adult Social Care shared a case in relation to a 19-year-old male, who had a diagnosis of autism, verbal and communication challenges where concerns were raised by his parents about possible neglect and physical/psychological abuse by his care provider. The parents also contacted the Care Quality Commission (CQC). A Section 42 safeguarding enquiry was initiated immediately, resulting in a same-day visit. The individual agreed to meet with a duty worker, supported by his carers. No immediate risks were identified, but the investigation continued due to the number of concerns raised. An advocate was involved to support communication, and a person-centred approach was used including visual tools and gestures to help the individual express his feelings. The care manager viewed care records, spoke with the registered manager, and gathered additional views, including from a personal assistant. Regular updates were provided to the parents throughout the process. The enquiry found no evidence to support the allegations of abuse and concluded that the concerns were more likely linked to parental anxieties. It was also identified that the individual lacked peer support, which was addressed by the social worker.

NSAB Newsletter

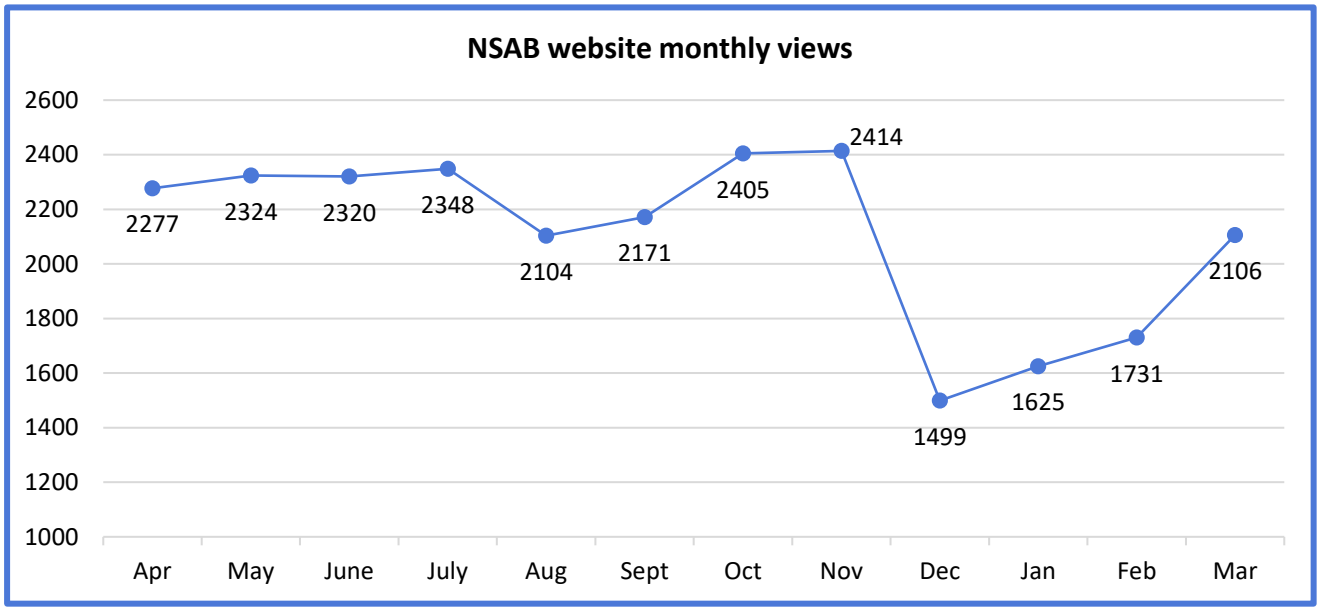
During the year, two newsletters were published; one in September 2025 and the other in March 2026. Collectively, the newsletters received almost 900 views.

Newsletter Articles	
Business Office staffing and structure update	Introduction to the newly appointed Independent Co-chair, Michael Murphy
Details of the Self-neglect summit and resources	Publication of Safeguarding Adult's Reviews
Details of the Drug and Alcohol Related Death (DARD) reviews	Home fire safety visits and using emollients safely
Healthwatch North and West Northamptonshire's annual report	All age Mental Health and Suicide Prevention training framework
Falls prevention	24-hour mental health text messaging service
Promotion of the NSAB website	Practitioner forums
The Adult Risk Management process and toolkit	Feedback from the NSAB week of learning
Publication of new resources	The Forcer Protocol
Changes to the drug and alcohol services across North and West Northamptonshire	Partner campaigns including 'Ask Me' and 'it's not love, it's abuse'
North Northamptonshire's Complex Lives Panel	Breaking the chains of addiction
Advocacy services	Smoking cessation services

Copies of all the NSAB newsletters can be found via this link to the NSAB website.

NSAB Website

The graph details the number of monthly website visits between April 2025 – March 2026. A total of 25,324 views were recorded to the NSAB website during this time. The Subgroup will continue to raise awareness of the website and a poster will be developed for sharing on office noticeboards. Note, the publication of SARs correlates with spikes in the number of views in May 2025, November 2025 and March 2026.



NSAB Website Access – Evaluation

As part of the evaluation from the Week of Learning in November 2025, colleagues were asked to provide their feedback on their use of the NSAB website. 54% of colleagues stated that they had accessed the NSAB website within the last 3 months, a 6% increase from the November 2024 Week of Learning of 48%.

Learning & Development Subgroup

Sarah Morris, Chief Principal Social Worker, North Northamptonshire Council continued to Chair the Subgroup very effectively. The group met seven times during the year including three extraordinary meetings to discuss the NSAB Week of Learning and Self-neglect Practitioner Forums. Engagement from partners was good. Gaps in membership were identified and colleagues in North Northamptonshire Public Health, West Northamptonshire Public Health and West Northamptonshire Learning and Development were approached to join the Subgroup.

New NSAB Resources

Bite sized learning and guidance documents

Three practitioner guides were developed and added to the NSAB website: 1. Managing Difficult Conversations, 2. Closed Cultures, and 3. Safely Ceasing Involvement. A further bitesize video regarding information sharing was also published in April 2025 and received 169 views during the course of the year. The documents and video can be found here on the resources page of the NSAB website.

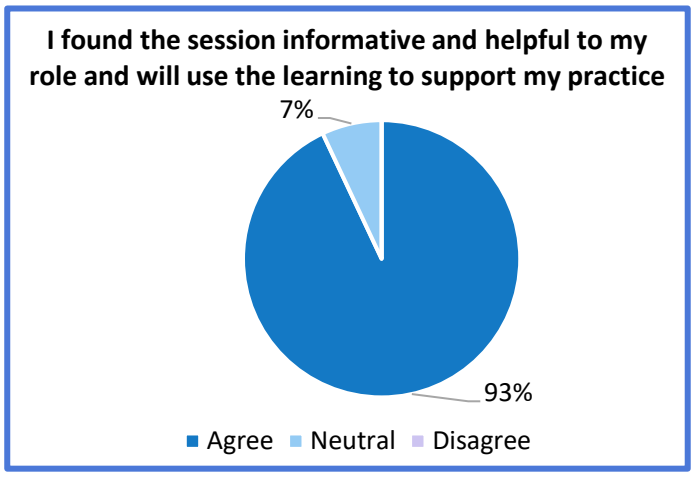
Learning Events

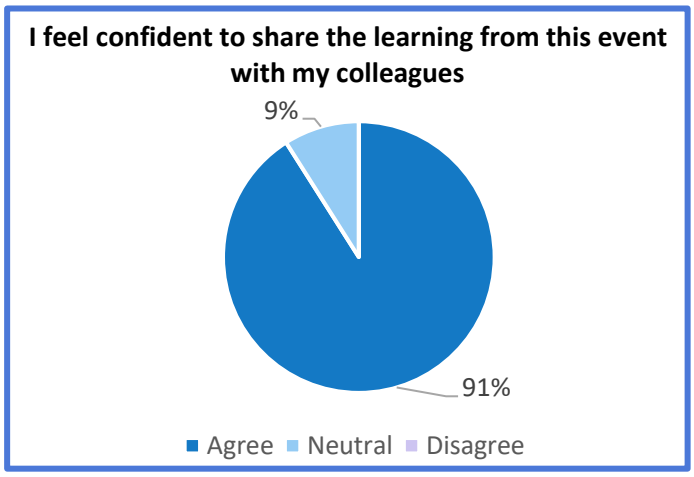
The Subgroup continued to develop and offer a range of multi-agency learning events to support the safeguarding partnership. These were delivered both virtually and in-person. Sessions related to themes from Safeguarding Adults Reviews – see further details under the headings below.

Week of Learning – November 2025

A Week of Learning was held in November 2025 to coincide with National Safeguarding Adults Week. Five sessions were held, including an in-person Mental Capacity Act Workshop. All other sessions were held virtually via Microsoft Teams. 371 registrations were received and 227 (61.2%) colleagues attended across the week. The detail below provides a breakdown of the sessions held virtually. Feedback from the Mental Capacity Act Workshop can be read further on in the report. In return for a completed evaluation form, certificates of attendance were provided to attendees. The evaluation form consisted of two sections: One in relation to the events, and two regarding the use/knowledge of the NSAB website.

Event	No. of Attendees	No. of Evaluations Received
Self-neglect – hearing from those with lived experience (Monday session)	65	37 (56.9%)
Sharing Good Practice (Tuesday session)	39	28 (71.8%)
Trauma Informed Practice and Reflective Practice Framework (Wednesday session)	45	27 (60%)
Cyber and Fraud Awareness (Thursday Session)	29	22 (75.9%)





Progress, Achievements and Impact continued…

178 colleagues attended the virtual sessions with 114 (64%) evaluation forms received. Feedback was very positive with 108 (93%) saying the sessions were informative, helpful to their role and would use the learning to support their practice. 105 (91%) colleagues said that they felt confident to share the learning from the events with their colleagues.

Practitioners were asked "What have you learnt from the training and will you use in your working practice?" Responses included:

Barriers for people accessing support services, how to combat these and what we can do more as a service to ensure we are doing the best we can. Not just accepting excuses such as simply due to "lack of engagement". MCA information regarding who can undertake, how to carry them out and where to get support from.

That there isn't one specific individual responsible for undertaking mental capacity assessments and that even though capacity is key; safeguarding is not only for people who lack capacity. Anyone can request an ARM meeting.

I will make the individuals I am working with aware of the different types of scams and how to protect themselves against the risks.

The session gave insight into what works best for those with lived experience in terms of support and what is not so helpful. It has helped to improve my knowledge of self-neglect and local pathways.

I gained a deeper understanding of self-neglect as a complex safeguarding issue, not just a sign of "refusal" or "non-compliance." The lived experience accounts were especially powerful in highlighting how trauma, mental health, neurodiversity, and past experiences with services can influence a person's ability to engage.

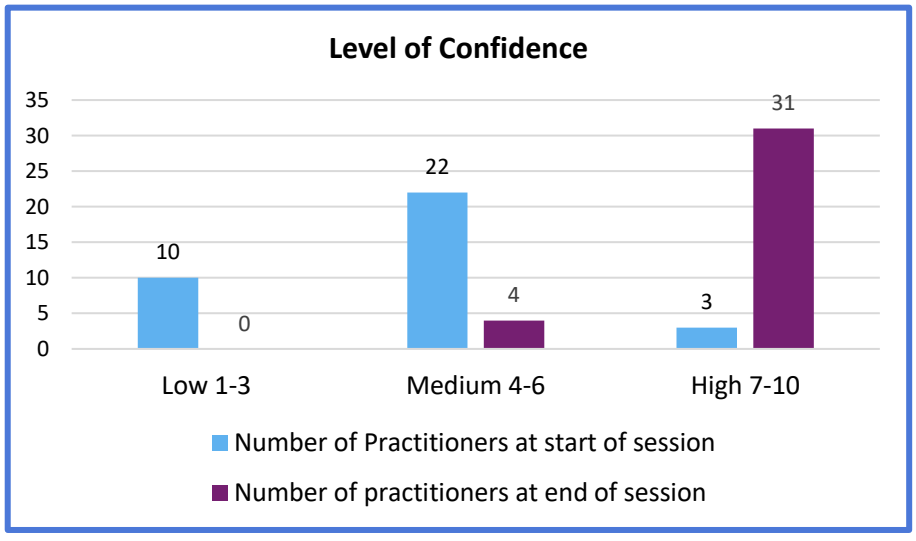
Mental Capacity Act Training

Following the positive feedback for the in-person Mental Capacity Act (MCA) workshop in November 2024, a further session was delivered as part of the Week of Learning. 76 practitioners registered with 49 attending on the day (64%).

Practitioners were asked their level of confidence in using the MCA at the start and end of the workshop on a scale between 1 (not confident at all) to 10 (very confident). 35 (71%) responses were received.

Responses were categorised into low (between 1-3), medium (between 4-6), and high (between 7-10).

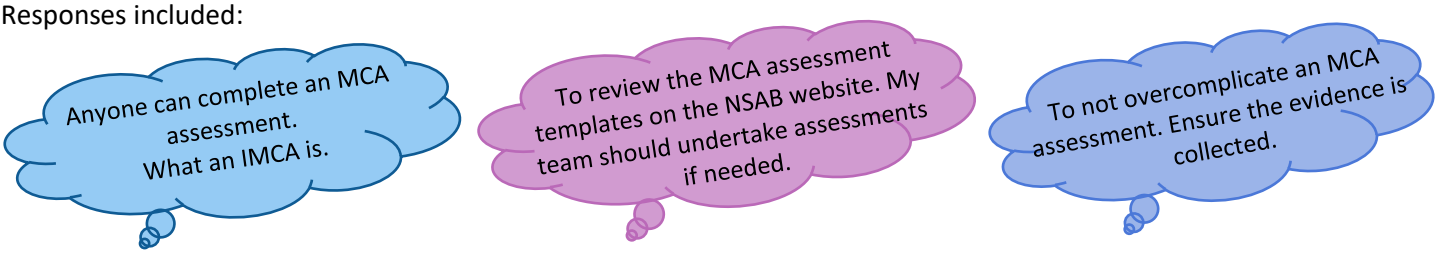
The graph shows an increase in confidence between the start and end of the session. Confidence for two practitioners did not increase. Of these, one reported a 9 out of 10 confidence level at the beginning of the session.



43 (87.75%) evaluation forms were received. 100% practitioners found the session informative and helpful to their role, 93% felt confident to share the learning with their colleagues and 88% were confident to share their views during table discussions. 93% stated the training increased their understanding of who can undertake an MCA assessment and 90% stated the session improved their confidence to apply and use the MCA in practice. 97% have greater understanding of what to consider when undertaking an assessment.

Progress, Achievements and Impact continued…

Practitioners were asked "What have you learnt from the training and will use in your working practice?"
Responses included:



Frontline Practitioner Feedback Forum

A frontline practitioner feedback forum was held in April 2025 to hear firsthand how the learning from both the Week of Learning events and Mental Capacity Act Workshop, held in November 2024, had supported practitioner's practice. 17 colleagues from a range of organisations attended. Practitioners were asked to consider what learning they had implemented into their working practice, how their practice had improved since attending the session(s) and what outcomes have been achieved for service users. Examples are noted in the table below:

Practitioner Feedback – Impact
Northamptonshire Fire and Rescue Service colleague – I attended the Trauma Informed Practice (TIP) during the week of learning and the MCA training. Following the sessions, I attended additional Tier 1 and 2 TIP training and was looking to implement a train the trainer type approach for the fire service. Safeguarding training packages were reviewed to provide better outcomes for customers. The same colleague said the MCA training was fantastic and they found the multi-agency case discussion of scenarios really helpful to their practice. Their confidence in undertaking assessments increased, as has calling ARM meetings.
Northampton General Hospital Stoke Community Team colleague - advised that the MCA workshop improved their confidence in challenging decisions. The MCA paperwork at NGH was reviewed to make this more appropriate to the team's needs. The team have seen an increase in self-neglect/hoarding cases and training has given the team the confidence to determine whether a safeguarding referral should be made or not.
Northamptonshire Healthcare Foundation Trust colleague - I attended the Trauma Informed Practice (TIP) and PiPoT sessions during the week of learning. Since attending, I have facilitated TIP training for Kettering Mind. Learning from the PiPoT session was rolled out to providers and they were asked to evidence how this is used in practice.
St Andrews Healthcare colleague – I attended a variety of the week of learning sessions. Level 3 Safeguarding training was reviewed in light of the learning to ensure the correct content was covered. The Decision-Making Framework (DMF) was embedded into the Datix reporting system to allow for correct reporting of safeguarding concerns. The PiPoT policy was also reviewed. The self-neglect session was really helpful in supporting a response to the increase in self-neglect on the wards.
West Northamptonshire Council colleague - advised that they really enjoyed the MCA training and liked having the opportunity to build connections with professionals from other agencies. ARM training has been invaluable and having the oversight panel in place is really supportive for practitioners. The resources on the NSAB website are really helpful and the Making Safeguarding Personal bitesize video has been implemented into training.
West Northamptonshire Council colleague – I attended the Decision-Making Framework week of learning session which was helpful to understand that decision making is at the centre of what practitioners do. The training provided confidence to discuss risks with an adult they worked with and obtained consent for a referral to the Falls Team to be made.

Self-neglect Practitioner Forums

To build on the learning from the Self-neglect summit held in June 2025, members agreed to utilise the frontline practitioner forums for wider self-neglect discussions. Two meetings were held in-person rather than virtually to encourage greater multi-agency discussion and networking. The sessions focused on learning from Safeguarding Adults Reviews published during the year (this format will continue in 2026-27). The first two forums were held in March 2026 and focused on SARs 026/035 and SAR 033. Further details on the next page.

Self-neglect Practitioner Forum – SARs 026/035 and SAR 033 - Attendance		
Event	**Registered**	**Attended**
Thursday 19th March - Northampton	56	42 (75%)
Friday 27th March – Corby	41	34 (82.9%)
Total	**97**	**76 (78%)**

Evaluation from the forums focused on impact of potential learning on practice. 92% evaluation forms were received with very positive feedback and 100% of practitioners stating they found the session informative, helpful to their role and would apply the learning within their practice. 98.6% felt confident to share the learning with their colleagues and 100% felt confident to share their views during table discussions. 94.3% stated they gained a thorough understanding of the learning from the cases and 91.4% said the session increased their confidence to support individuals with similar circumstances. Practitioners were also asked free-text questions – example responses below:

1. What is the key learning from the session that you will implement into your practice immediately?

- How important it is to consider cultural intricacies when supporting individuals.
- Partner mapping. Escalation policy around professional challenge if outcomes are not achieved.
- Use Ecomaps. Follow up on referrals to other services and agencies.

2. Which part of your practice do you feel will benefit from this training?

- My approach to multi-agency working. My approach when supporting service users will be more sensitive.
- Identifying, questioning and challenging safeguarding concerns.
- Have the confidence to take the lead when working with vulnerable people.

3. Give an example of how you'll apply what you have learnt from today's session into your practice.

- Use of Section 6 of The Care Act 2014.
- Not taking information at face value. Asking more questions to dig deeper. Will follow up with teams and on referrals to ensure that support remains in place.
- Use of ecomaps will enable discussions with service users to understand what other services they are in contact with or receiving support.

4. How will this session influence the way you collaborate with colleagues and partners?

- Reinforced the importance of information sharing and multi-agency working, calling ARMs and using the escalation process.
- Reinforced the importance of communication to understand who is doing what to support individuals.
- Pick up the phone to colleagues to discuss

Assurance Activities

Partner Training Assurance

Partners were asked to complete the biennial training assurance return to advise what percentage of staff, at each level, were trained across three specific areas: Safeguarding Adults, Mental Capacity Act (MCA) and Prevent. A benchmark of 85% was previously agreed by the Subgroup. NSAB recommended that all safeguarding adult related training should be measured against the national competency framework. 25 organisations were asked to complete the return and 17 responses were received. The Department for Work and Pensions (DWP), North Northamptonshire Public Health and West Northamptonshire Public Health were unable to provide data as there is no requirement for staff to complete the training. No responses were received from HMP Peterborough, North Northamptonshire Housing, St Matthews Healthcare and West Northamptonshire Housing, and Northamptonshire Police were unable to provide a response. *Whilst training is undertaken, the Competency Framework highlights what the training must include, and if one element is missing, accurate figures based on the criteria set out cannot be provided.*

It was agreed that the assurance return request should be reviewed to ensure the request is achievable and information provided to NSAB is meaningful moving forwards.

Partner Training Assurance - Responses
Change Grow Live – Good compliance across Safeguarding Adults and MCA training. Work was being undertaken to improve Prevent compliance.
East Midlands Ambulance Service – Safeguarding Adults compliance at level 2 had improved by 10%. There was good compliance for level 2 and 4 MCA training, whilst level 3 had decreased by 7% but remained close to the benchmark. Prevent compliance was close to the benchmark.
Healthwatch North and West Northamptonshire – Safeguarding Adults compliance sat at 100%.
HMP Five Wells – Safeguarding Adults and MCA compliance sat below the benchmark. Prevent figures couldn't be provided.
HMP Onley – Prevent compliance sat at 100%. Safeguarding Adults and MCA compliance was poor.
HMP Rye Hill - Compliance for level 1 Safeguarding Adults and Prevent sat at 100%. Compliance at all other levels was poor.
Kettering General Hospital – Compliance at all levels sat above the benchmark.
North Northamptonshire Council Adult Social Care – Level 2 Safeguarding Adults compliance was the only area that sat above the benchmark. Numbers had to be produced manually. Additional internal safeguarding training was being planned and there are opportunities for self-directed learning which will not be captured within the return.
Northampton General Hospital – Safeguarding Adults at level 4 sat under the benchmark. Compliance in all other areas sat above or close to the benchmark.
Northampton Probation Service – All areas sat above the benchmark. There had been an increase in compliance for Safeguarding Adults and Prevent training.
Northamptonshire Domestic Abuse Service – Compliance for Safeguarding Adults training sat at 100%.
Northamptonshire Fire and Rescue Service – Compliance sat above the benchmark for all areas.
Northamptonshire Healthcare Foundation Trust – All areas sat above the benchmark and there had been a significant increase in compliance for Safeguarding Adults at level 3.
Northamptonshire Integrated Care Board – Safeguarding Adults compliance sat at 66%. We were advised that there was a plan in place to improve compliance in this area. MCA and prevent compliance sat above the benchmark.
St Andrews Healthcare – Compliance sat above the benchmark for all areas.
VOICE for Victims and Witnesses – All areas sat above the benchmark and there had been a significant increase in compliance for Safeguarding Adults training at all levels and for MCA training at level 1.
West Northamptonshire Council Adult Social Care – Compliance across all areas sat below the benchmark. There are opportunities for self-directed learning which will not be captured within the return. There isn't specific safeguarding level 2 training, but there are several courses that meet this requirement. There will be colleagues who have completed some of the modules, but not all, which effects the figures.

Quality & Performance Subgroup

Michael Murphy, the new NSAB Independent Co-Chair took over the role Chairing the Subgroup following his appointment in May 2026. Six Subgroup meetings including two task and finish groups were held. The task and finish groups discussed the NSAB dashboard. Member attendance was good, however, Northamptonshire Police sent apologies to one meeting.

Assurance Activities

During the course of the year, the Subgroup continued to adopt an assurance-based model rather than audit. A set of specific questions were asked of partners to provide NSAB with added assurance regarding specific topics.

Whistleblowing and Complaints Assurance

Assurance was sought to ensure robust processes and management were in place to deal with complaints and whistleblowing[2] safeguarding issues. Responses highlighted that there were robust policies and processes in place across the partnership, including corporate complaints and whistleblowing policies in all organisations. Northampton Probation Service did not respond to this request. Some key highlights following the exercise include:

Whistleblowing and Complaints Assurance – Responses
Health services have a Freedom to Speak Up Policy to support staff who want to raise concerns.
Northamptonshire Police complaints are managed by a specialist department within the Office of the Police, Fire and Crime Commissioner (OPFCC) or Northamptonshire Police Professional Standards Department. Colleagues can report anonymous concerns about other staff members via the Integrity App.
Northamptonshire Fire and Rescue Service (NFRS) have a Service Information Team and an OPFCC Complaints Team responsible for dealing with complaints.
POhWER have robust policies and processes in place for complaints and whistleblowing to ensure lessons are learnt and training is provided for all staff.
West Northamptonshire Council have a dedicated Complaints Manager to coordinate the process, ensuring responses are robust and delivered in a timely manner. Learning is implemented through an assurance framework.
Local authorities are responsible for commissioned services such as St Andrews Healthcare and St Matthews and are moving towards more robust frameworks. If a non-contracted provider is used, desktop monitoring is undertaken and if there are safeguarding concerns, visits are undertaken.

Person in Position of Trust Assurance

Assurance was sought regarding the arrangements that were in place for Persons in a Position of Trust (PiPoT)[3] following publication of the revised policy in December 2024. There were relatively low numbers of 'PiPoTs' across the County. Northamptonshire Healthcare Foundation Trust (NHFT) had seven during the period. The local authorities had a similar number of PiPoTs received for an individual in another organisation – 17 in North Northamptonshire Council and 15 in West Northamptonshire Council. Members felt it would be useful to receive benchmarking data, however, when this was raised regionally, not all Safeguarding Adults Boards collect data, so this was not possible. Northamptonshire Police were unable to provide information due to a processing issue. Members noted that the revised policy has improved people's understanding and they are now more confident and engaged in the process.

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2 Whistleblowing – Reporting of information which relates to suspected wrongdoing at work, including possible unlawful conduct, fraud, risks to the public or malpractice.

3 PiPoT is a framework that is used to handle allegations or concerns about professionals or volunteers who work with adults with care and support needs where concerns arise about their behaviour, that may pose a risk to adults at risk. This may include being accused of the abuse/neglect of a child or adult family member in their personal life, accused of grievous bodily harm or behaved in a way which puts into question their ability to perform their professional role.

Demographic Data Assurance

Partners were asked to quality check their demographic data to ensure all relevant information is being captured. Assurance was received from organisations as below. Healthwatch North and West Northamptonshire, Northampton Probation Service, St Andrews Healthcare and St Matthews Healthcare did not respond to this request.

Demographic Data Assurance - Responses
Northamptonshire ICB - GP practices collect and record demographic data in relation to age, gender, race and ethnicity which is held on the clinical system. Staff are trained on how to accurately collect and manage demographic data. The data supports where improvements are needed in respect of healthcare delivery.
North Northamptonshire Adult Social Care – Missing ethnicity data was identified, and work was undertaken to resolve the issue. Teams reviewed records and added the missing information where ethnicity could be identified from notes.
Northamptonshire Fire and Rescue Service – Demographic data is collected as part of their internal Scorecard. A new recording system was in the process of being implemented to provide greater insight. The data is used to support the most vulnerable people.
Northamptonshire Healthcare Foundation Trust – SystmOne (electronic patient record), has in built templates to collect demographic data. Audits are undertaken which include details of demographics whereby actions for improvement can be created and monitored through internal assurance processes.
Northamptonshire Police – Office of National Statistics (ONS) data is used understand the demographic of the communities they police. Data is captured when engaging with the community that assists with analysis of demand and informs risk identification and opportunity. The personal data collected is on a voluntary basis which can create situations where analysis will show gaps in information.
POhWER – Key monitoring information and demographic data is collected to support reporting functions. This is checked through regular file reviews and if gaps are identified, staff are supported to gain this information to complete records.
West Northamptonshire Adult Social Care – Demographic information is captured to inform statutory returns. A process of data verification is undertaken to ensure all mandatory information is completed, including demographics. Throughout the year, data reports identify where information is missing and officers review and include the required information.
University Hospitals Northamptonshire – Demographic data is captured and maintained centrally.

Partner self-assessment audit

Following the completion of the remaining organisations' action plans in June 2024, assurance was sought that all elements of the self-assessment audit were still in place. The audit covered: governance and partnership; policies, procedures and protocols; commissioning; human resources and workforce; quality, assurance and monitoring; and making safeguarding personal.

Healthwatch North and West Northamptonshire, Kettering General Hospital, Northamptonshire Healthcare Foundation Trust, North Northamptonshire Council, Northamptonshire Carers, Northamptonshire Fire and Rescue Service, Northamptonshire Police, Northamptonshire Probation Service and West Northamptonshire Council provided assurance that all elements of the self-assessment were still in place.

Whilst Northamptonshire Integrated Care Board provided assurance that all elements were still in place, they did not have a Named Nurse for Safeguarding Adults in post, and this work was being covered by the Head of Safeguarding and Named Professional for Children's Safeguarding and Children in Care.

Northamptonshire Domestic Abuse Service noted that three areas had since moved from blue (complete) to green and two areas had moved to amber.

Northampton General Hospital noted that one area had moved from blue (complete) to green.

St Andrews Healthcare and VOICE did not respond to the assurance request.

Dashboard

The data dashboard continued to be developed and reviewed at all quarterly meetings. There were discussions about what the data was telling us, and this will be explored further in 2026-27.

Summary of Key Points Discussed
West Northamptonshire Council (WNC) saw a peak in the number of safeguarding concerns received in June 2025, attributed to St Andrews Healthcare.
Assurance was provided from North Northamptonshire Council (NNC) that in order to support consistency of triaging a centralised safeguarding team would be created.
The most prevalent types of abuse across the county are neglect and acts of omission. Self-neglect was also high.
There were a significant number of individuals in West Northamptonshire with 5+ safeguarding concern referrals across the year. Work was being undertaken to review complex case panels to ensure these are utilised appropriately and that protection plans are put in place to reduced/remove risk.
Adults placed out of county and awaiting review was added to the dashboard, with wait times for a review requested.
The number of individuals who were not asked for their outcomes decreased for both local authorities.
Advocacy data was reviewed throughout the year with attention paid to waiting times. Wait times increased for WNC in Quarter 1 due to higher demand for St Andrews Healthcare (SAH) no longer having internal advocacy provision.
NNC provided data relating to concern and enquiry timescales. WNC will provide from 2026 – 2027 onwards.
Where care homes had a high number of concerns, assurance was received that the homes were on internal risk registers and monitored regularly by the respective Quality Board.
Members agreed that the dashboard was local authority loaded and data from other partners will be explored.
The following changes to the metrics were agreed and will be implemented from April 2026: • Triaging outcomes – source of referral will be split between key partners and other top referral sources; number of concerns will be provided as a count and number of enquiries will be presented as count and percentage. For concerns where threshold for enquiry is not met, data will be provided for where an assessment/review is required, there are appropriate measures in place, or there are quality issues or a compliant. • ADASS[4] benchmarking data will be provided on one slide with regional and national benchmarks. Data will also include the mean days to triage a concern and mean, median and mode timeframes to complete an enquiry. • Deprivation of Liberty Safeguards[5] data will include number of new cases, percentage of urgent and standard cases, number of closed per month, number awaiting assessment, authorisations, number granted/not granted, mean timeframe from referral to authorisation and longest wait time. Data will be split into those waiting in acute hospitals and those in care homes.

[4] ADASS – Association of Directors of Adult Social Services

[5] Deprivation of Liberty Safeguards – Legal framework that protects vulnerable adults who lack the mental capacity to consent to their care, and who require restrictive measures, such as continuous supervision or locked wards, in hospital or care home to keep them safe.

Patient Safety Incident Response Framework (PSIRF)

A representative from Northamptonshire Integrated Care Board attended the Subgroup to provide awareness on the Patient Safety Incident Response Framework (PSIRF) which outlines how providers should respond to patient safety incidents for the purpose of learning and improvement. PSIRF supports a shift in safety culture and prompts a move to a more proactive approach to achieve effective learning.

There are four sections within PSIRF: compassionate engagement and involvement of those affected by incidents; application of a range of system-based approaches to learning; considered and proportionate responses; and supportive oversight focused on strengthening response, system functioning, and improvement.

The Learning from Patient Safety Events (LfPSE) system is a national NHS service for recording and analysing patient safety events. LfPSE captures a wide range of data including issues relating to medication, vaccination concerns, disruptive behaviour, equipment concerns, and diagnostic errors. Compliments are also captured. A demonstration of the LfPSE dashboard was provided which allows filtering by area, safeguarding concern, ethnicity, age, etc. Monthly meetings are held with the ICB safeguarding team to discuss safeguarding related incidents. It was agreed that a separate meeting will be organised with the local authorities to cross reference data against safeguarding incidents to identify patterns and repeat concerns. Outcomes from this meeting will be detailed in the 2026 – 2027 annual report.

Policies and Procedures

As part of the Quality & Performance remit, three policies and procedures were reviewed and refreshed across the course of the year:

- Inter-agency Safeguarding Policy and Procedures – Published May 2025
- Complaints Policy – Published June 2025
- Escalation Policy – Published October 2025

Safeguarding Adult Review Subgroup

Matthew Jenkins, Director Care Markets, Provider Services, Safeguarding and Improvement, North Northamptonshire Council, Chaired the Subgroup. Meetings continued to be held monthly to ensure new referrals for consideration of a SAR were dealt with in relative real-time. Eight meetings were held across the year including an extraordinary meeting to discuss the learning from a referral detailing concerns relating to exploitation. 100% attendance was received from statutory partners.

The Safeguarding Adults Review (SAR) Subgroup has responsibility for considering whether referrals meet the criteria for a review and there is learning for the wider partnership. The NSAB Business Manager, manages the SAR process with support from colleagues in the Business Office. The Subgroup has strong links with other NSAB Subgroups to ensure published SARs are communicated effectively and there are learning opportunities for colleagues. The Chair of the Subgroup is responsible for keeping Strategic Board updated on the progress of SARs activities.

The volume of Safeguarding Adult Review (SAR) activity remained high, see details on page 25 below.

SAR Quality Assurance

In line with the agreed quality assurance process for SARs, the Independent Co-Chair and Business Manager met with partners between December 2025 – March 2026 to seek assurance on the progress of their agency actions for SAR 026/035 – published in May 2025. At the end of March 2026, whilst progress had been made, a number of actions remained in progress. Outstanding actions will be followed up by the Business Office.

SAR Methodologies and Information Scoping

To support more timely learning from incidents, the SAR Subgroup revisited SAR methodologies, and agreed to take a more proportionate response rather than more traditional routes.

In addition, the partner SAR scoping template was revised by adding additional columns to encourage increased reflection. Partners are now being asked about the quality of intervention (highlighting good practice as well as areas for improvement), to reflect on what has changed, and detail changes to practice since the incident. The updated chronology allowed the group to identify and highlight areas of learning more easily. Whilst it's early days, it was good to see partners provide additional information in the revised scoping template. This will continue in 2026-27.

Cross Boundary SARs

Working in partnership with the East Midlands Board Managers' Network, the Cross-boundary SAR guidance was reviewed and adapted for the region. The updated guidance was published in March 2026 and is available on the NSAB website via this link.

National SAR Analysis

A number of working groups from the national Safeguarding Adults Board Managers' Network were created to support a number of actions from the 2nd National SAR Analysis published in 2024. The Board's Independent Co-chair and Business Manager supported some of these activities including the development of the first national Safeguarding Adults Board Conference 'Recognising ten years of positive impact - and looking at what is next for Safeguarding Adults Boards and the wider sector' in May 2026. At the conference, the results of the working groups will be shared. These include:

- National SAR Analysis – Domain Outcomes
- Improving and Measuring the Impact of Safeguarding Adult Reviews (SARs) – Toolkit, CLEAR Framework and Essential Guide to Safeguarding Adult Reviews

Care Act 2014 – Section 44 – Safeguarding Adult Reviews

The Safeguarding Adults Board (SAB) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The SAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

Criteria for a Safeguarding Adult Review

1. A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs); if –

   (a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult; and
   (b) Condition 1 or 2 is met.

2. Condition 1 is met if:

   (a) The adult has died; and
   (b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

3. Condition 2 is met if:

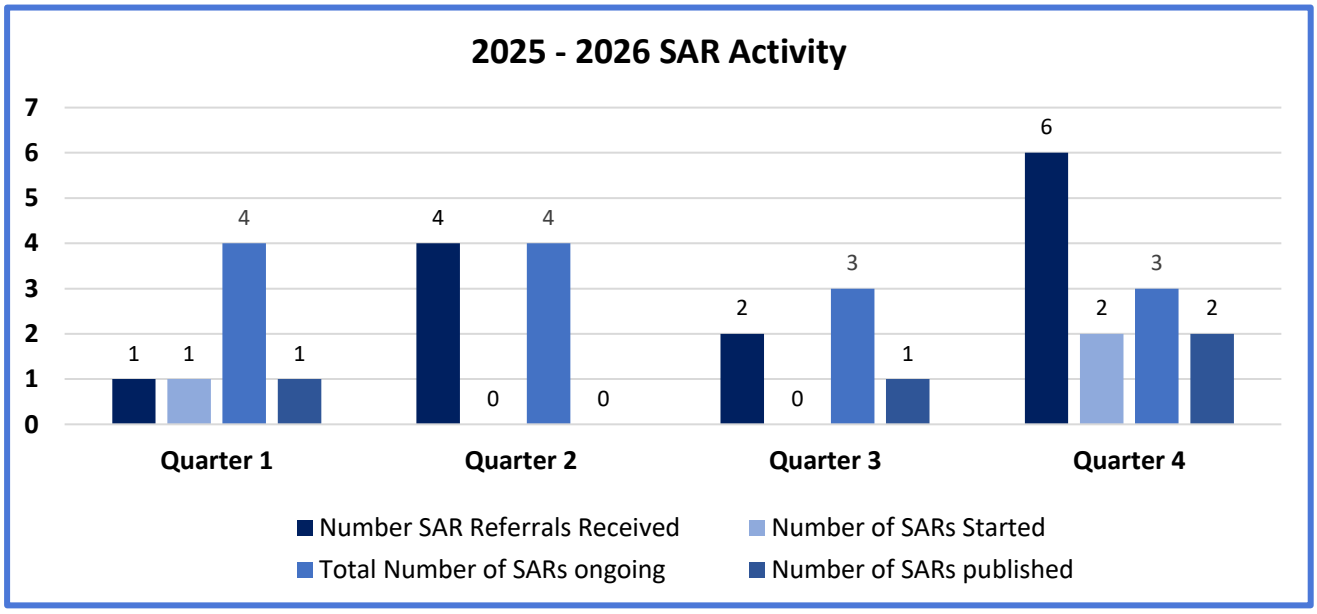
   (a) The adult is still alive; and
   (b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

4. A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

5. Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

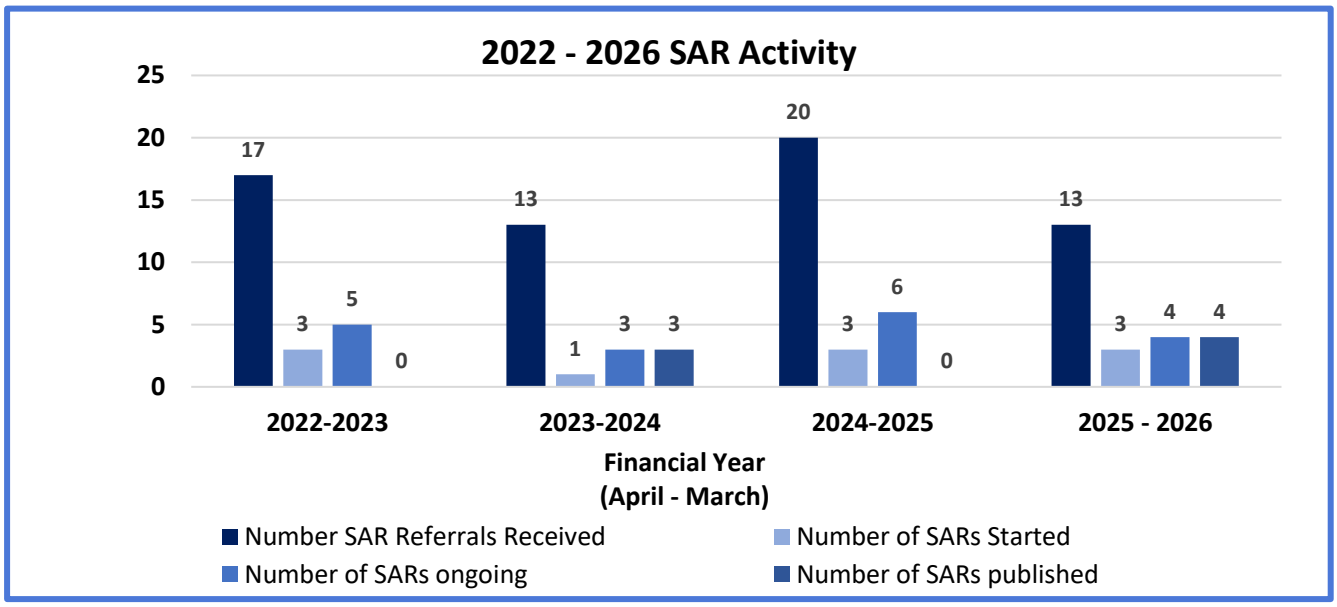
   (a) Identifying the lessons to be learnt from the adult's case; and
   (b) Applying those lessons to future cases.

The graph below details SAR activity between 1st April 2025 and 31st March 2026 by each quarter. A total of 13 SAR referrals were received during the financial year (April to March) leading to initial information scoping with partner agencies to aid decision-making and discussion at SAR Subgroup. The number of ongoing SARs in each quarter reflects both the number of SARs started during that quarter and those continued from the previous quarter/year.



Care Act 2014 – Section 44 – Safeguarding Adult Reviews continued…

The below graph details cumulative SAR activity dating back to financial year 2022 to 2026.



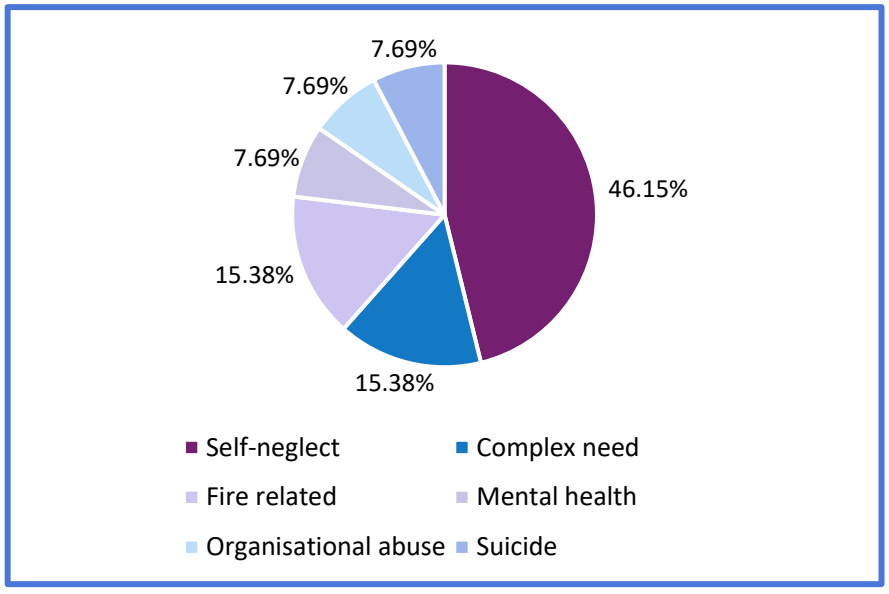
Key Themes from SAR Referrals

The graph shows a breakdown of the key referral themes. Of the 13 referrals received, 6 related to self-neglect (46.15%), 2 (15.38%) detailed complex need and 2 (15.38%) related to fire related deaths.

Mental health, organisational abuse and suicide were each a key theme in one referral (7.69% each).

The high level of referrals relating to self-neglect supported the need for this to be a key objective in the 2026 -2029 Strategic Plan.

The fire related death referrals both noted use of emollient creams and as a result, it was agreed that an emollient use and fire risk guidance would be developed.



Approved / Ongoing SAR Activity

Reference	Reason for referral	SAR criteria	Commenced	Published
026 & 035	Males - homelessness (thematic review)	026 S44 (4) 033 S44 (1)	January 2023	May 2025
033	Male - self-neglect	S44 (3)	November 2023	November 2025
051	Female - mental health	S44 (3)	August 2024	February 2026
056 & 062	Males - self-neglect (thematic review)	S44 (1)	October 2024	March 2026
057	Female - medical neglect	S44 (1)	November 2025	Ongoing
059	Male - self-neglect	S44 (1)	November 2025	Ongoing
060	Male - neglect - physical health	S44 (2)	March 2025 (joint review with NSCP - NSAB leading)	Ongoing

SAR Publications

Four Safeguarding Adults Reviews were published during the year relating to six individuals.

SARs 026 & 035 – Homelessness Thematic Review – regarding Adults BA and CE

Following the publication of SAR 019 'Jonathan' in March 2021, NSAB received two new referrals regarding two men who had experienced multiple exclusion homelessness (MEH). NSAB wanted to understand if similar issues had been experienced by the two men, and whether there was new learning following their deaths. The thematic review commenced in 2023 and looked at two men, from diverse backgrounds (one was white British, and the other was of Polish origin). They had dissimilar causes of death, were both rough sleeping at the time of their deaths, used alcohol and substances, and had contact with many different agencies. An independent reviewer was commissioned for the review, but additional information was added to the report and finalised by the SAR Subgroup Chair which resulted in delayed publication.

A copy of the report can be found on the NSAB website via this link - SAR 026 & 035 - Homelessness Thematic Review - published 2nd May 2025

SAR 033 - Self-neglect - Adult C

SAR 033 related to Adult C, a man in his late thirties, of South African heritage, who had lived in Northamptonshire for a number of years. He has a diagnosis of paranoid schizophrenia and had a number of admissions to hospital under the Mental Health Act due to his deteriorating mental health. In late 2021, Adult C had no electricity, water or gas in his flat, no access to money and had no contact with services. He started a fire in his flat to keep warm and was subsequently detained under Section 2 of the Mental Health Act. Before this, he was unmedicated, poorly housed, living in poverty, and unsupported, despite having needs for care and support. In late 2020/early 2021, Adult C spent two months in prison. Throughout his time in prison, staff encouraged Adult C to take his depot medication which he initially declined, but in December 2020, he accepted his medication and received fortnightly depot injections. However, no medication was prescribed by the GP after Adult C's release, as responsibility had transferred to the Community Mental Health Team (CMHT). A Multi-agency Case Audit was held in November 2023 and meetings with Adult C and his social worker to share the initial draft report were scheduled between April and June 2024, but Adult C did not attend. Finalisation of the report was delayed further at the end of 2024/beginning of 2025 following further points of clarification as part of the review and governance process. In June 2025, at the request of Strategic Board members, an addendum was added to the report regarding what had changed in practice since the incident – this delayed publication.

A copy of the report can be found on the NSAB website via this link - SAR 033 - Report - published 11th November 2025

SAR 051 - Self-neglect - Adult D

Adult D is a white, north European female in her early forties. Adult D has a history of self-harm and depression, and at the time of the incident, had a diagnosis of Emotionally Unstable Personality Disorder (*the diagnosis has since changed to Complex Personality Disorder)*. Adult D was well-known to mental health and emergency services and had been a frequent attender at the hospital accident and emergency department. Adult D had been placed on Mental Health Act (MHA) 1983, and Section 136 (s136) orders on a number of occasions, had been detained under Section 3 of the MHA, and had a number of informal admissions to mental health hospitals. There were a number of incidents of self-harm and threats of suicide that led to an incident on 13th September 2023, where sadly, Adult D suffered life changing injuries following lack of mental health hospital bed space. It must be noted that Adult D has made a remarkable recovery physically following the incident in September 2023 and has been living independently since she was discharged from hospital. She actively participates in community group activities and therapeutic sessions, and enjoys cooking healthy meals for herself, walking and shopping. Adult D is very close to her family and enjoys spending time with them.

There were a number of reiterations of the final draft report following input from Adult D's family. The comments referred to complaints made by Adult D and her family to NHFT that were not referenced in the report. With input from the family and NHFT, the report was approved and publication delayed.

A copy of the report can be found here on the NSAB website via this link - SAR 051- published 16th February 2026

Care Act 2014 – Section 44 – Safeguarding Adult Reviews continued…

056/062 - Thematic Review – Eddie and Frank

The thematic Safeguarding Adults Review (SAR) was commissioned to review the circumstances surrounding the lives of two males, Eddie and Frank (not their real names), to identify key themes and areas for improvement for services supporting individuals with similar profiles. Concerns were raised that whilst known and supported by several agencies, there had not been a co-ordinated approach to support the men. Eddie and Frank were white British, middle-aged men who died in their own homes, and did not appear to have been missed by family or professionals.

Eddie was only found at his home following a warrant to complete gas checks. Frank wasn't missed for around three weeks and his body was only discovered when family alerted the police. Both men had long-term alcohol dependency and various physical and mental health issues, including anxiety, depression and paranoia, and one of the men regularly self-harmed and often required admission to hospital. The other had mobility issues and other health conditions. There was a significant level of involvement of both statutory and non-statutory services with both men which included emergency services, police, ambulance and fire services and many health and social care professionals. What appears to have been lacking was response to their complex needs, co-ordination, multi-agency working and ownership, both to manage the level of complexities they presented with and a resilience in attempting to keep them engaged in the process.

A copy of the report can be found on the NSAB website via this link – SAR 056 & 062 – Eddie and Frank – Self-neglect Thematic Review – Published 13th March 2026

NSAB have a robust governance process in place when a SAR is published. Every SAR has an agency action plan in place which is reviewed quarterly as part of the SAR Quality Assurance Process. Partners are asked for evidence and impact of any action taken.

Working in Partnership - Our Key Statutory Partners

NSAB continues to work closely with its statutory partners; NHS Northamptonshire Integrated Care Board (ICB), North Northamptonshire Council (NNC) Northamptonshire Police, and West Northamptonshire Council (WNC). All statutory partners are represented on the Strategic Board, Delivery Board, and all four Subgroups, and we are grateful for their support and ongoing commitment to keeping adults safe in Northamptonshire.

For achievements made in 2025-26 noted in last year's report, we have asked partners to RAG rate. Any outstanding achievements will be followed up with statutory partners.

NHS Northamptonshire Integrated Care Board (ICB)		
Achievements in 2025-26	**RAG**	**Evidence to Support**
The 2025/26 Domestic Abuse health coordinator work plan outlines how we can enhance domestic abuse (DA) response within the Northamptonshire health economy with a focus on primary care and NHFT mental health services. There will be a strong focus on simplifying risk assessments, improving referral pathways, integrating the "domestic abuse health toolbox" to ensure long-term sustainability, and strengthening the Domestic Abuse Network. Practical tools such as Tea Break Guides, asking and responding will be developed to improve accessibility and engagement for busy professionals. Regular updates through the "Network News" newsletter which will maintain momentum and communication across healthcare teams.		During 2025/26, significant progress has been made in strengthening primary care's role in identifying and responding to domestic abuse, supported by the implementation of the "Ask Me" approach to promote routine enquiry and safer disclosure. Practitioner support has been enhanced through weekly drop-in sessions offering reflective practice, peer support, and specialist advice, alongside regular Sway newsletters providing updates, learning, and resources. A one-page referral form introduced within NHFT has increased referrals to NDAS, with plans for wider rollout across primary care and the health system. A Domestic Abuse Toolkit has also been launched, with broader dissemination planned. The SPECCS risk assessment tool has been embedded across training, ensuring a consistent approach to identifying and responding to risk. **Conference and Recognition -** The Northamptonshire Domestic Abuse Health Conference received highly positive feedback and was recognised by the Domestic Abuse Commissioner, Nicole Jacobs, who identified Northamptonshire as a "pathfinder" area. **Impact -** This work has resulted in: Increased practitioner confidence, Improved risk identification and referrals, Stronger multi-agency collaboration and greater embedding of reflective safeguarding practice across the system
System wide Health safeguarding sufficiency – Statutory responsibilities and assurance.		The ICB has continued to strengthen its approach to ensuring system-wide safeguarding sufficiency, with a clear focus on meeting statutory responsibilities and providing robust assurance across all commissioned health services. The ICB has maintained oversight of safeguarding arrangements through established governance structures, including safeguarding committees and quality assurance reporting.
Working with health system partners to ensure all safeguarding referrals adhere to the NSAB decision making framework and that other routes for embedding learning and improving delivery are properly considered e.g. Risk Management and Quality improvement.		The ICB has worked with system partners to improve the quality and consistency of safeguarding referrals in line with the NSAB decision-making framework, supporting a more proportionate and person-centred approach. Strong assurance is provided through Named and Designated Safeguarding Professionals, supported by strategic oversight via the Strategic Health Safeguarding Forum and engagement with the NSAB Quality and Governance Performance Group. Operationally, provider "catch-up" meetings support shared learning, improve referral quality, and promote consistent application of the framework. A key focus has been strengthening practitioner confidence and decision-making to ensure appropriate use of safeguarding referrals and alternative responses where needed.

NHS Northamptonshire Integrated Care Board (ICB) continued		
Achievements in 2025-26	**RAG**	**Evidence to Support**
To embed the recently created Standard Operating procedure for the role of the ICB in adult safeguarding enquiries where there is a health and or clinical concern.		During 2025/26, the ICB has prioritised the embedding of the newly developed Standard Operating Procedure (SOP) which sets out the ICB's role in adult safeguarding enquiries where there is a health and/or clinical concern. The SOP provides clarity on roles, responsibilities, and expectations, ensuring a consistent and coordinated response across the health system. It supports practitioners and safeguarding leads to understand when and how the ICB should be involved in safeguarding enquiries, particularly where clinical input, oversight, or escalation is required.
To bring the work of the NSAB and NSCP closer together in the area of commissioning and conducting reviews either where there are transitional safeguarding issues or where there are both adult and children's safeguarding learning identified in the referral and information gathering.		During 2025/26, the ICB has strengthened alignment between NSAB and NSCP, promoting a coordinated "think family" approach to safeguarding where cases involve both adult and child concerns. This has improved information sharing, supported joint discussions, and increased the use of aligned reviews, particularly for transitional and complex cases. Learning from SARs and CSPRs is now more consistently shared, supporting system-wide improvement across health services.

Areas for development in 2026-27

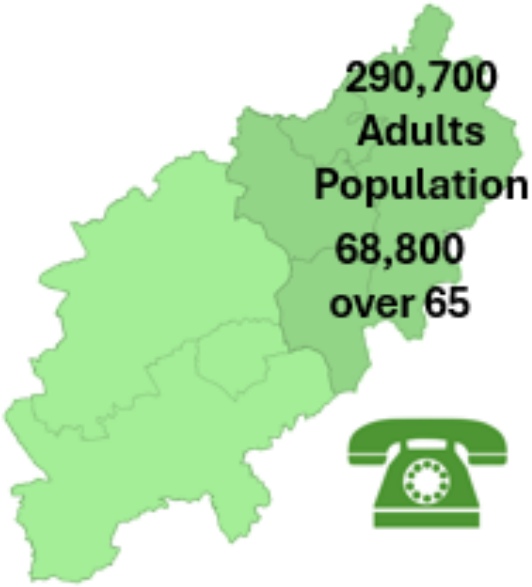
1. We will work collaboratively with system partners to strengthen inter-agency processes and maximise prevention and early intervention. Through neighbourhood-based models of care, we will improve timely access to support, information, and alternative pathways to safeguarding. This will reduce unnecessary escalation, improve outcomes, and support independence and wellbeing.
2. We will prioritise strengthening how learning from Safeguarding Adult Reviews is embedded and monitored, working collaboratively with our providers, primary care, and system partners. As a committed member of the SAR Subgroup, we will continue to actively contribute to its work and fully engage with the development of a new multi-agency subgroup on self-neglect, mental capacity and hoarding to improve consistency, early intervention and outcomes.
3. The ICB will support Northamptonshire Safeguarding Adults Board (NSAB) in seeking robust assurance that partner agencies have effective mechanisms in place to ensure the voice and lived experience of adults with care and support needs are central to strategy, policy, and practice. We will promote co-production, strengthen feedback mechanisms, and ensure that learning from service users meaningfully informs service design, delivery, and improvement.
4. Working collaboratively with system partners to ensure robust transitional safeguarding arrangements are in place, providing assurance that young people with care and support needs are appropriately supported as they move into adulthood. This includes ensuring timely planning, continuity of care, and that safeguarding action is taken where risks are identified, to promote safe and positive transitions.
5. In 26/27 the Domestic Abuse Health Co-Ordinator will continue to strengthen the system response to domestic abuse by improving workforce capability, awareness, and trauma-informed practice. We will deliver targeted training, enhance referral pathway awareness, and develop the Domestic Abuse Champions network across providers and primary care. Through this, we will improve early identification, coordinated responses, and outcomes for individuals affected by domestic abuse.

North Northamptonshire Council - Adult Social Care		
Achievements in 2025-26	**RAG**	**Evidence to Support**
A safeguarding improvement plan has been created following a focussed review on safeguarding. Workstreams will address the following:		
1. The creation of a Safeguarding Team to oversee concerns and enquiries for anyone not allocated to a worker. This will develop a specialist, skilled team to address concerns in a timely fashion, meeting timescales for safeguarding and providing a consistent, quality service.		A single Safeguarding Team has been created for the management of all concerns and enquiries with the exception of where our locality teams are already supporting a person and they have an allocated worker. This team is aligned to a new Head of Service post that leads our Provider Quality, Safeguarding and Care Home Review Team.
2. Working with providers to re-launch the Decision-Making Framework (DMF) and give confidence in what concerns should be referred under safeguarding and where risks can be managed by the provider themselves.		The DMF was relaunched with our provider market and internally with our Safeguarding Adults Teams. A dashboard has been developed to identify providers with low conversion rates following the submission of a Safeguarding Concern with enhanced support offered to providers by our Quality team to support their confidence in apply the DMF consistently where low conversion rates are identified.
3. Assurance – involving the perspective of people within the safeguarding audit so that we get feedback. We are developing a scenario-based workshop to give colleagues the opportunity to reflect on the various stages of a safeguarding concern and enquiry: what we should be considering and asking, what the legislation says and how we should be recording our decision making.		Four safeguarding workshops were provided for front line managers, and these will be rolled out across teams. Following the workshops, updates have been made to the Eclipse system to simplify recording and the capture of data. We also utilised internal audit capacity to assess our safeguarding practice and pathways. We will use the findings of our Internal Audit in our review of our safeguarding practice audit and consider, with experts by experience, how we capture the perspective of people within this.
Areas for development in 2026-27		
1. Planning Self-neglect workshops and learning sessions to all ASC Teams commencing with our Safeguarding Adults and Access Teams. This will increase the confidence across teams in working with people who may struggle to engage with services. These sessions will also advertise the NSAB resources and our new 'Supporting People to Engage with ASC' guidance.		
2. Co-production - through the Councils 'Together for Care' forum we will work to engage with people who draw on services to better understand the lived experience of safeguarding processes. This will include a review of our Safeguarding Practice Audit tools with the Together for Care forum to ensure it is effective in capturing people's lived experience to support our practice development.		
3. Mental Health Strategy - aligned to NSAB priority objective to rebalance the system we are co-producing a Mental Health strategy, to communicate a vision of the offer from ASC for people experiencing mental ill health. Part of this work will be to develop colleagues' understanding of our role and responsibilities under the Care Act when working with people with mental health issues. We have met with NHFT managers and are sharing information about structures and roles to support better joint working and confidence within our workforce. This work aims to ensure that people receive the most appropriate support early, reducing the numbers coming to ASC in crisis, requiring involvement through a safeguarding enquiry or ARM.		
4. Embed the significant changes we have made throughout 2025/26 and maximise the benefits, learning and impact from our Safeguarding Adults Team, Access Team and new ways of working to improve our practice and the experience of people who draw on services.		
5. Aligned with our SEND Priority Action Plan, we will work to have a greater focus on Transitional Safeguarding and how people are supported as they transition into adult social care in a way that recognises their rights as adults but also supports an effective transition that focuses on people's safety and quality of life that supports their journey to greater independence and positive risk taking.		

Northamptonshire Police		
Achievements in 2025-26	**RAG**	**Evidence to Support**
Implement the findings of the Force's Rape end to end review which was recently commissioned following the success of the DA End to End review. This review will address the areas for improvement identified by the Operation Soteria Transformation Plan.		All recommendations from the Rape End to End review are encompassed in our Operation Soteria Transformation Plan. Senior leads from various parts of the organisation now have responsibility for driving the change required under the Op Soteria Pillars. The Operation Soteria Transformation plan has been approved by Chief Officers and was recently submitted for National Feedback.
Violence Against Women and Girls (VAWG) will continue to be a matter of priority for Northamptonshire Police. The national Framework for Delivery 2024-2027 was publicly launched in March 2024. Using the principles of a 4P plan (Prepare, Prevent, Protect, and Pursue) throughout the framework means that policing will focus on outcomes that make a real difference to tackling the epidemic of VAWG related crime. The 4P approach is well used in developing policing strategy. It ensures a focus on preparing for VAWG offending, protecting individuals, families, and communities, pursuing perpetrators, and preventing crime. There is a requirement for Northamptonshire Police to complete a self-assessment against the 4P approach and this is due to be submitted in September 2024.		The force continues to prioritise VAWG and recently launched a VAWG Independent Advisory Group. The IAG is collaborative, safe space where women from all backgrounds can engage in open and constructive conversations. We want the group to influence how Northants Police tackles VAWG in the future, it meets quarterly focussing on the 4 P's: **Preparation** – enhancing our readiness to address VAWG **Prevention** – Stopping VAWG before it happens **Protection** – Supporting and safeguarding those affected. **Pursuit** – Bringing perpetrators to justice The group is open to all women regardless of whether you have direct experience of VAWG or simply want to contribute to make the force response more effective, inclusive and impactful.
Implementation of the Adult Safeguarding Working Group in force. This is chaired by the Head of PVP (Protecting Vulnerable People) and ensure Chief Officer strategic governance, it will report into the force Vulnerability Board, chaired by ACC Emma James. The meetings will have Senior Leader attendees from police and internal partners providing scrutiny and delivery at a force level. The meeting agenda will include: • Safeguarding Adult Reviews (SARs) • Individual action plan and thematic learning • National and local learning events		The Adult Safeguarding Working Group has been running for 12 months now and the remit of the group has expanded to ensure we improve the Police response to Mental Health and scrutinise our decision making under the RCRP banner. Members of the group recently had constructive conversations organised by NSAB, with a number of partners to improve our counties response to those in mental health crisis where emergency powers are required to detain and safeguard them.
Areas for Development in 2026-27		
1. Improving our safeguarding response to Sex Workers. A roundtable event for partners will be organised by the OFPCC and the Chief Constable. Governance of our response will be managed via the Adult Safeguarding Working Group; we are seeking to improve our response in line with NPCC guidance as a part of our focus on VAWG.		
2. We will map the process for the ARM pathways with a view to improving uptake, governance and output. Our focus will also be on identifying the cohort of individuals that requires most multi-agency support and ensuring their needs are met under objective 1C.		
3. We will seek to use victim and survivor voices to shape our safeguarding response, particularly to VAWG, using our recently formed IAG.		

West Northamptonshire Council - Adult Social Care		
Achievements in 2025-26	**RAG**	**Evidence to Support**
1. To develop a tool for ensuring that safeguarding issues and risks are referred through the appropriate pathway.		The online SA1 form integrates the Section 42 (1) criteria with advice given when the criteria hasn't been met. For example this could be a care and support need.
2. To challenge continued poor practice with organisations where referrals do not meet the criteria or standards acceptable for safeguarding.		Dashboards have been developed using Power BI and Excel to identify key themes and trends, such as cases recorded as 'not a safeguarding.' These themes are being monitored by designated link workers, who meet with providers to provide appropriate challenge, alongside targeted training and advice. This approach also applies to providers who have not raised any safeguarding concerns over a 12-month period. These instances are flagged and followed up by link workers, who will visit services to review practice. In addition, the team provides clear feedback to referrers through outcome emails or letters where identified standards fall below expectations. Where necessary, concerns are escalated via link workers to safeguarding leads or Registered Managers.
3. To improve the Making Safeguarding Personal practice to ensure that all people who can respond and are willing are asked for their outcomes.		This has been added to the audit tool to ensure people who are able to are being spoken to gain their views, wishes and outcomes. As part of Safeguarding training MSP is discussed to ensure that we are involving and engaging people so that their voices are heard.
4. To develop and implement a transitional safeguarding pathway with Northamptonshire Children Trust (NCT) and North Northamptonshire Council (NNC).		Due to OFSTED inspection there was a hold in progression. However, this remains a strategic priority for both WNC and NNC; we are committed to working together with NCT to develop a plan and systems that can be embedded in our practices to ensure a safe and clear pathway.
5. To complete the DoLS development plan and celebrate improvements in practice.		Most areas of the development plan have been met; however, some areas are on hold due to the need to consider the impact of LPS and Supreme Court NI judgement (Northern Ireland legal challenge on Deprivation of Liberty Safeguards (DoLS) and consent).
6. Embed the front door process in the safeguarding hub and the integration of community safeguarding to improve outcomes and practice.		This remains an ongoing area of work. A consistent screening process has been established, ensuring clarity and consistency in decision-making and providing teams with robust rationales for considering safeguarding enquiries. The community safeguarding function acts as a second line of review, allowing for enhanced challenge and assurance across cases.
Areas for development in 2026-27		
1. To develop and implement a transitional safeguarding pathway with Northamptonshire Children Trust (NCT) and North Northamptonshire Council (NNC).		
2. To complete the DoLS development plan and celebrate improvements in practice.		
3. Embed and strengthen the front door process in the safeguarding hub and the integration of community safeguarding to improve outcomes and practice.		
4. Review self-neglect and Adult Risk Management pathways.		
5. Consider development and implementation of a Multi-agency Safeguarding Hub (MASH) model of practice.		
6. Determine S117 Aftercare escalation and funding split.		

North Northamptonshire Council

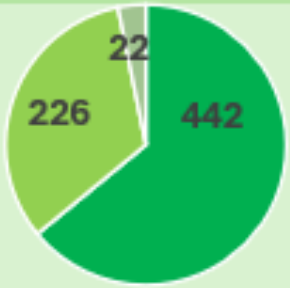


4,999 concerns raised

4,321 (86%) remained Alerts

678 (14%) became Enquiries

64% (422) of enquiries had Provider as the 'Source of Risk'



Other options - Known to Individual 33% and unknown to Individual 3%

44% Male

56% Female

The enquiry subject was most frequently of the female gender

Subject age band of the enquiry

18-64	65-74	75-84	85-94	95+
41%	13%	20%	23%	3%

36% of abuse types recorded for enquires was Neglect and Acts of Omission

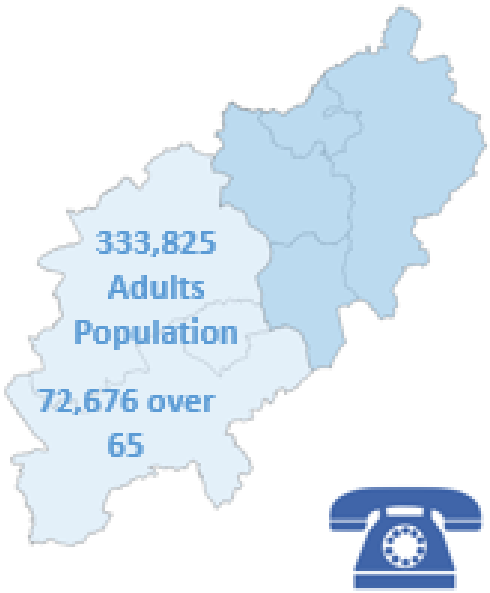
Risk Remains	Risk Reduced	Risk Removed
8%	58%	34%

Following investigation, **92%** identified with risk had their risk removed or reduced

*Adults population based on ONS 2024 mid-year estimates ages 18+.

*Based on concerns received during the reporting period and enquiries completed during the period

West Northamptonshire Council

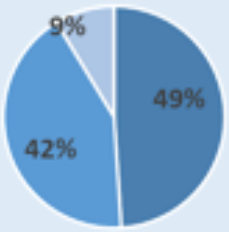


5052 concerns raised

4130
82%
remained
Alerts

922
18%
became
Enquiries

49% (617) of enquiries had Provider as the 'Source of Risk'



Other options- Known to Individual 42% and Unknown to Individual 9%

47%
Male

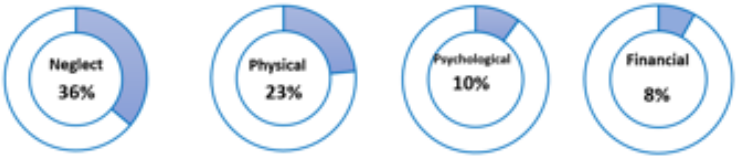
53%
Female

The enquiry subjects were most frequently female

Subject age band of the enquiry:

18-64	65-74	75-84	85-94	95+
45%	14%	19%	18%	4%

36% of abuse types recorded for enquires were Neglect and Acts of Omission.



Risk Remains	Risk Reduced	Risk Removed
6%	71%	24%

Following investigation, **95%** identified with risk had their risk reduced or removed

*Adults population-based Census 2021 estimates that classify usual residents in England and Wales by sex, and by age. The estimates are as at Census Day, 21 March 2021.

Income and Expenditure 2025-26

Statutory partners contribute financially to NSAB's operating expenditure as well as providing 'in kind' resources such as meeting venues and their officers' valuable time and expertise.

Income	2024-25 £
Carry forward from 2024-25	47,170
NHS Northamptonshire Integrated Care Board	41,000
North Northamptonshire Council	41,000
Northamptonshire Police	41,000
West Northamptonshire Council	41,000
Total Income	**211,170**

Expenditure	2025-26 £
Staffing	153,109
Independent Scrutineer and Co-chair	19,375
Safeguarding Adult Reviews (SAR) Reviewer costs and legal costs	5,727
Events and office costs	2,273
Total Expenditure	**180,484**

Northamptonshire Safeguarding Adults Board

North Northamptonshire Council

West Northamptonshire Council

NORTHAMPTONSHIRE POLICE
Fighting Crime. Protecting People.

NHS Northamptonshire Integrated Care Board

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