National Network for Chairs
of Safeguarding Adults Boards

National Survey for Safeguarding Adults Board Chairs

2024/25

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The Local Government Association with the Association of Directors of Adult Social Services are Partners in Care and Health (PCH). PCH helps councils to improve the way they deliver adult social care and public health services and helps Government understand the challenges faced by the sector. The programme is a trusted network for developing and sharing best practice, developing tools and techniques, providing support and building connections. It is funded by the Department of Health and Social Care and offered to councils without charge.

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National Survey of Safeguarding Adult Board Chairs 2024/25

Summary

This is the fifth survey since implementation of the Care Act 2014. Report of the fourth survey can be found on the National Network for Chairs of Adult Safeguarding Boards website (https://nationalnetwork.org.uk). The fourth survey collected data between November 2023 and January 2024. This survey has collected data between October 2025 and January 2026.

This survey once again has provided an opportunity for Safeguarding Adults Boards (SABs) to complete a temperature check and appreciative enquiry on their performance, achievements, and challenges – their effectiveness in meeting their statutory duties and in seeking assurance about the effectiveness of adult safeguarding through data collection and analysis, member assurance reports, and learning from the involvement of people with lived experience. Accordingly, there are sections that cover SAB performance and planning, membership, and funding.

Data on housing demonstrate the increasing recognition by SABs that homelessness, insecure or temporary housing and poor quality accommodation are adult safeguarding concerns. There are sections on adult safeguarding enquiries (section 42 Care Act) and safeguarding adult reviews (SARs) (section 44) since these are key barometers of the effectiveness of adult safeguarding. The data on section 44 builds on the findings of the second national analysis of Safeguarding Adults Review (SARs) and provides currently the only comprehensive picture of the types of abuse and neglect (including self-neglect) that feature in these human stories.

The survey offers SAB reflections on their engagement with prisons and with concerns surrounding accommodation for people seeking asylum. Finally, the survey has included reflections on the process and outcome of Care Quality

Commission (CQC) Assessment Framework for local authority assurance visits. PCH continues to provide consultation and service development input for local authorities, especially those where safeguarding has been assessed as requiring improvement or inadequate. From free text comments in the survey, this injection of support has been found to be valuable. The National Network of Safeguarding Adult Board Chairs (NSCN) has already fed back to CQC observations about the process of assessment and the quality of reports, and will continue to do so in order to inform the next round of visits to local authorities.

Key findings from the fifth SAB Chairs Survey 2025/26

Joint Governance Arrangements – there is strong confidence in shared governance arrangements with other partnerships.
Reviewing SAB performance – there is increasing confidence in evaluating performance but often work is underway to further improve the capture of the outcome of strategic plans. Experiences of CQC assessment visits were variable.

SAB Chair & Membership responses continue to indicate a requirement for greater diversity in recruitment to SAB Chair roles; and whilst statutory partners hold key membership, there is considerable variability in membership from other sectors. There is evidence that SAB and sub-group membership reflects the breadth of adult safeguarding, with increasing numbers of SABs reporting representation from DWP and housing/homelessness. Common SAB subgroups remain those focused on performance and quality, SARs, and learning and development.

Involvement of People with Lived Experience – Compared with previous surveys there is evidence of increased involvement and variety in how SABs seek to hear and respond to the voices of lived experience. However, finding effective approaches to involvement remains a challenge.

Seeking Assurance from Provision of Safeguarding Data – most data continues to come from adult social care. Respondents continue to cite challenges in getting appropriate data from all statutory partners. Lack of capacity and expertise to analyse data is also reported as a concern. Criticism of the annual SAC return is once again expressed.

Mechanisms for Referral of Safeguarding Concerns – SABs expressed variable levels of confidence in how agencies understand and implement Section 42 Care Act 2014. There appears to be increasing focus on organisational abuse.

Safeguarding Adult Reviews - Data on types of abuse/neglect continues to indicate that self-neglect and neglect/ acts of omission feature most commonly in reviews, followed by domestic abuse. This repeats the finding in the second national analysis of SARs. Rates of referral are increasing with reported concerns about the impact on resources available to SABs and partner agencies. Challenges continue to be reported, for example with commissioning reviewers, managing parallel processes and ensuring the quality and impact of reports. There is good evidence of the use of SCIE quality markers and of how SABs have responded to the findings of the second national SAR analysis.

Funding – SABs have identified this as a major concern, especially because of the impact of ICB reforms and local government reorganisation. Local authorities are often the principal funders.

Multi-Agency Policies and Procedures – Data here reflect the breadth of adult safeguarding.

Learning and Development – There is strong evidence for how SAB chairs are meeting their obligation to remain up-to-date and for how SABs are using resources to support their work.

Recommendations from the fifth SAB Chairs Survey 2025/26

Recommendation One: The NSCN executive will need to consider how to follow up with those SABs that did not complete the survey.
Recommendation Two: NSCN should continue efforts to improve the diversity of its membership.
Recommendation Three: The work of the NSCN task and finish group should continue to disseminate examples of how SABs have effectively engaged with people with lived experience of adult safeguarding.

Recommendation Four: NSCN should consider the development of a minimum data set for SABs when seeking assurance about the effectiveness of adult safeguarding.

Recommendation Five: NSCN should use this survey to continue the discussion with DHSC about improving the data collected through the SAC return.

Recommendation Six: NSCN should continue to identify specifically the impact on SABs of policy decisions relating to ICBs and generally the weak clause in the care and support statutory guidance on ensuring that SABs have sufficient resource to comply with their statutory duties and mandates.

Recommendation Seven: NSCN should undertake a research project on the different leadership and scrutiny approaches adopted by SABs to ensure compliance with statutory duties and mandates.

Outcomes of Recommendations from the Fourth Survey

Recommendation One: *The network should consider how to improve the diversity of its membership.* This remains a priority for the NSCN. Data presented in this fifth survey report indicates the need for further progress.

Recommendation Two: *Network members should consider how wider membership of SABs can be improved in respect of*:

- *following DHLUC guidance, how strategic housing may be represented*. NSCN conducted a survey of how SABs had responded to the joint ministerial letter on homelessness and adult safeguarding. This has been reported in NSCN annual reports, published on the network's website. As the data shows, there is now much greater engagement by SABs with housing and increased focus on homelessness.
- *following the recently implemented Memorandum of Understanding (MoU) with the Department for Work and Pensions (DWP), how local DWP can be better represented*. Data presented in this survey reports on stronger DWP engagement with SABs. The MoU is due for review in 2027.
- *in respect of prison services, how representation on SABs may improve wider engagement with prisons, particularly to support preventative safeguarding for those prisoners with health and care needs and also those who are preparing for release.* A NSCN task and finish group has collated and disseminated data on how SABs are engaging with prison staff and how partners are seeking to ensure that prisoners' health and social care needs are met whilst in custody and on release. This work has been shared with those working in and with the Ministry of Justice (MoJ) on health and social care.
- *regional consideration given to having a Lead SAB in the region, and having the main Ambulance Service representation (in the*

area where a local ICB is the main regional commissioner for the Ambulance Service). Several regions have this arrangement in place, for example London and the South West.

- *similar consideration given to CQC which covers wide regional areas, to be supported by regular CQC attendance at the regional SAB Chairs' Network*. A protocol is being developed between NSCN and CQC. CQC attendance at SAB and regional meetings has been encouraged.

Recommendation Three: *The network should continue with the task and finish group activity that was commenced as a priority following the previous survey, with a particular focus on collating examples of good practice in involving people with lived experience.* The task and finish group continues to meet and NSCN annual reports provide an update. The data in this survey indicates that this must remain a strategic priority.

Recommendation Four: *SABs should review the Safeguarding Adults Collection (SAC) returns annually as part of their data analysis and performance review. The network should use the free text comments from the survey as a springboard to collate tools to support the collection and analysis of performance data.* NSCN has yet to develop tools to support the analysis of performance data.

Recommendation Five: *The network should engage in discussion with DHSC and ADASS with a view to strengthening national data collection about adult safeguarding, and potentially building on the Client Level Data approach in place for adult social care activity reporting.* This was also a recommendation to DHSC from the second national analysis of SARs. NSCN continues to engage with DHSC on how to progress this recommendation.

Recommendation Six: *The network should continue to engage in discussions with DHSC on policy and practice regarding section 42.* This too was a recommendation from the second national analysis of SARs. NSCN continues to engage with DHSC on how to progress this recommendation.

Recommendation Seven: *The national network and individual SABs should address the improvement priorities from the second national analysis of SARs and report on changes to policies and practice, including quality assurance, in their annual reports.* NSCN established four workstreams in collaboration with the national network of SAB business managers (NBMN). These workstreams have produced briefings on best practice across the domains of SAR analysis (direct practice, team around the person, organisational support for practice, governance and the national context), on good practice for disseminating and tracking

the outcome of SAR learning, and an analysis of the Care Act 2014, ten years after its implementation. A briefing of SAR best practice has also been produced. All this work has been published on the NSCN website (https://nationalnetwork.org.uk) and will be formally launched at a conference in May 2026.

Recommendation Eight: *The network should disseminate to partners, including government departments, the outcomes of the work of the task and finish group on prisons, probation and adult safeguarding*. This work, as covered in NSCN annual reports, has been shared with DHSC, Home Office and Ministry of Justice. NSCN attends meetings of the MoJ National Partnership Social Care Board.

Recommendation Nine: *The network should collate from members concerns about accommodation provided for people seeking asylum, after-care when a right to remain is granted, and provision to meet their health and social care needs, to be shared with the Home Office.* Concerns have been shared at NSCN scheduled meetings with Home Office civil servants.

Introduction

The National Network for Safeguarding Adults Boards (NSCN) conducts a survey of its members every two years. The survey is used to inform the network's priorities. On this occasion, the questions asked in the survey were co-produced by network members and in consultation with our partners in the Department of Health and Social Care, the Home Office, Partners in Care and Health (PCH), and ADASS. The survey was sent, where known, to the chairs of safeguarding adults boards who were asked to complete the survey with their Board business managers. Where known, the survey was also sent to SAB business managers through their national network (NBMN).

Methods

All known chairs of safeguarding adult boards (SABs) were sent a link to the online questionnaire via email in October 2025. In an attempt to ensure that SABs without a current known chair were covered, SAB business managers were also sent a bespoke link to the online questionnaire, again where known. This meant that 134 of the 136 SABs received the online questionnaire. A total of 111 completed surveys were received, giving a response rate of 83 per cent. This is an improvement on the 75% completion rate for the 2023 survey. Where possible the questions from the 2023 survey were repeated for comparative purposes and trend analysis. A

copy of the survey questionnaire is shown in Annex A of this report.

Region of SAB	Number of invitations sent	Number of responses	Response rate (%)
East (ADASS Region)	10	8	80%
East Midlands (ADASS Region)	7	7	100%
Greater London (ADASS Region)	29	24	83%
North East (ADASS Region)	9	8	89%
North West (ADASS Region)	23	18	78%
South East (ADASS Region)	15	13	87%
South West (ADASS Region)	13	11	85%
West Midlands (ADASS Region)	13	9	69%
Yorkshire and Humber (ADASS Region)	15	13	87%
Total	**134**	**111**	**83%**

Among the SABs that did not complete the survey, six had yet to replace an independent chair who had resigned, and five had a statutory partner as chair.

Recommendation One: The NSCN executive will need to consider how to follow up with those SABs that did not complete the survey.

SAB Performance and Planning

The survey began by asking about confidence in the effectiveness and/or strength of the joint governance arrangements between the SAB and different partnership organisations. 106 SABs answered the main components of this question. Overall, levels of confidence in their partnerships were high for the majority of SABs but with some variation when compared with the 2023 survey. The strongest levels of confidence were seen in the partnerships with community safety (74% fairly confident or very confident in the effectiveness/ strength, up from 65%) and safeguarding children (70%, down from 73%). Confidence in cross-boundary

arrangements into other local authority areas showed a decline from 72% to 60%.

	Very confident	Fairly confident	Somewhat confident	Not at all confident	N/A
Safeguarding Children Partnership	40%	30%	19%	3%	8%
Community Safety Partnership	37%	37%	11%	6%	9%
Health and Wellbeing Board	24%	29%	33%	8%	6%
Cross Boundary arrangements into a separate local authority area for Safeguarding Adults	27%	33%	19%	3%	18%
Voluntary / independent sector groups in your area	25%	31%	33%	1%	9%
Other (n=33)	36%	30%	21%	0%	12%

Confidence in arrangements with the Health and Wellbeing Board and with voluntary/independent sector groups was not included in the 2023 survey. The breadth of partnership working was shown by the 33 responses that gave information on “other” governance arrangements. Mention was made of partnerships or boards covering domestic abuse, suicide prevention, public health, learning disability, autism and homelessness. There were also references to scrutiny committees, chief executive assurance meetings, criminal justice agencies and faith groups.

Free text comments demonstrate a variety of arrangements and relationships, and a focus on review and development.

“We have good governance arrangements between the SAB and SCP which are facilitated by the existence of the safeguarding Executive Board. We also have a combined business unit which sits across both and monthly meeting between the chairs of both the board and partnership, strategic leaders and independent scrutineer. The CSP is represented at the safeguarding Executive Board and the SAB as is the VCSE sector. We also have regional ADASS and safeguarding leads meeting ...”

"Regional working is a strength - with joint policies and procedures, shared training, shared safeguarding week, shared conferences and events as well as informal networking between Business Managers, Multi-Agency Trainers, and Board Chairs. Other forums such as Trauma Adversity and Resilience are addressed at a regional level and we are working together to be Trauma Informed by 2030. There is a joint Communications Group which tackles [regional]-wide topics."

"Governance arrangements with the SCP, CSP and HWB are laid out in the SAB Constitution and in practice we have processes in place where there are regular meetings held with the SCP and CSP and we are all members of a joint exploitation subgroup. The Annual Report is presented to the HWB each year and the Chair of the HWB has previously been a member of the SAB full board, although with a recent change this isn't currently the case."

"The SAB has a subgroup focusing on the voluntary/independent sector with selected representatives from this also part of the full SAB."

"There isn't joint governance arrangements with any of the above, however, the SAB has strong relationship and close working relationship with Children Partnership, Community Safety Partnership, Health Wellbeing Board, other SABs across [the region]."

"During the 2024–25 reporting period, SAB has continued to prioritise strengthening connectivity across the safeguarding landscape. This work is essential to ensure that governance structures are robust, communication channels are clear, and that safeguarding intelligence is shared effectively across all relevant bodies."

"Cross partnership working is a priority area for the Board and, whilst still in embryonic stages, there has been a significant shift towards development of a joint governance framework over the past year."

An effective and accountable SAB is one that reviews, at least annually, its compliance with its statutory duties. SABs have reported an increase from the 2023 survey in confidence in evaluating their performance and both the content and outcomes of their strategic plans. The question on the outcome of local authority CQC assurance visits was added for this survey and most local authorities had not received final reports by the time the survey closed.

Change since 2023	To a great extent	To a moderate extent	To some extent	Not at all
Its own performance	51%	41%	7%	1%
The content of its strategic/business plan	69%	27%	3%	1%
The outcomes of its strategic/business plan	55%	38%	6%	1%
The outcome of the local authority CQC adult social care assurance visit in relation to Theme 3 on safeguarding and other relevant areas	61%	22%	9%	9%

Methods of reviewing the SAB's own performance continue to rely heavily on peer or external assessment/review, self-assessment, audits and surveys, challenge events and development days. Free text comments also referenced the use of sub-groups for performance analysis and scrutiny, the completion of audits and surveys, and occasionally use of independent scrutineer reports.

"Through its quarterly performance data and reports from the QPP subgroup which link to the priorities in the Business Plan with occasional deep dives as requested by the SAB."

"Annual Report. Health & Wellbeing board Scrutiny. Scrutiny from Chief Executive and Regional Police. Scrutiny from local Elected Members. Regular development days for the Board and all subgroups. Periodic Peer Review. Regular supervisions and development sessions with back office staff."

"A Local Government Association review of the SAB was initiated in 2024 at the behest of the DASC to assess the effectiveness of the board. This resulted in a number of recommendations in regard: governance / culture / strategic direction / scrutiny and assurance. The majority of recommendations have been completed leading to a strengthened partnership with clear accountability and scrutiny of safeguarding-related activity. A new strategy for 2025-28 supported by a work programme provides the ability to track performance at board meetings."

"The SAB chair undertakes annual conversation with every board member. In developing our new strategic plan, several sessions have been held with stakeholders and members of the community to discuss the performance of the SAB. We intend to strengthen this further next year in having independent scrutiny of annual performance."

The same methods were being used to develop the SAB's strategic plan and to review its outcomes. Development days were prominent here, being used to identify themes and priorities. The compilation of annual reports was also prominent, again as an opportunity to consult with partners, to monitor data and to collate outcome evidence, for example from audits. Once again, free text comments referenced reporting by sub-groups to Board meetings.

"This is reviewed by the Independent chair and business manager regularly and is a standing agenda item for each meeting. The plan is reviewed thoroughly annually."

"This is linked to self-assessment and the SAB annual report. This is carefully tracked and monitored throughout the year via Business Unit Team Meetings, and updates to the SAB."

"The SAB has developed a strategic plan and accompanying work programme for 2025-28 which reflects areas identified from local SARs, a thematic analysis of SARs between 2020-2023 and feedback from practitioners and Board members. Accountability for progress against actions is provided through the independent chair scrutiny and oversight."

"Outcomes are planned and monitored through a summary dashboard that tracks delivery of the workplan linked to each strategic priority. This provides a clear view of progress, impact, and areas where additional focus is required."

"Via various audits, themed survey audits, and the SAPAT (safeguarding adults partnership audit tool). A tracker is also managed and monitored by all subgroups and the Executive. Outcomes are reported in the annual report."

In this survey, rather than challenges in strategic planning being reported, there were occasional references to work in progress to capture outcomes.

"We get some information on what difference we are making but will do more with the new strategic plan monitoring and put in outcome measures."

When completing the survey, not all SABs had received the outcome of the CQC assessment visit. Plans were clearly in place to discuss the outcome. SABs also commented on how they had been involved in preparations for assessment visits.

"The inspection has only recently been conducted. A presentation on it will occur at the next board and the SAB will monitor and receive assurance/data on the action plan."

"This will result in an action plan discussed at and overseen by the SAB, working closely with the Local Authority."

"Regular updates to the SAB and sharing of information. Partners involved in inspection preparation work and inspection itself."

"The CQC Inspection process has just concluded locally and Adult Social Care will be requested to present to the board on the report and actions being undertaken in response to the findings."

"Regular updates from DASS prior and post assessment visit. The SAB Chair was involved in the assessment visit and was interviewed by inspectors. Learning from the review has been incorporated into the SAB governance and assurance framework and will be incorporated into the refresh of the strategic plan. The SAB has considered how it can monitor any areas of development for the LA."

"The outcome is not yet known but there is a plan for the independent scrutineer to invite the LA to reflect on this with the SAB. The scrutineer will also feed back on her part in this, reflecting learning that might support development in the Board and with its partners."

"We have offered support to the LA at strategic level to assist with safeguarding improvement plans following a requires improvement rating. The SAB has active involvement from wider local authority partners also committed to assisting with practice

improvement. This includes public health, mental health, community safety and housing. We have been able to offer training, but take up is not where we would like it to be."

Free text observations on the process of CQC assessment visits varied. Some SAB respondents were positive and reported finding the process helpful, comprehensive and/or fair. Other respondents were more critical, for example of inconsistencies, lack of understanding of SAB roles, responsibilities and governance, and delays. NSCN will be reviewing the experiences and outcomes of CQC assessment visits at its meetings in March and July 2026, and advocating for change where it is felt that this would improve both focus and approach.

"Lead in time and turnaround time for outcome report and judgement/scoring was very long. Would recommend that SAB Business Managers are involved in future inspection processes. Consistency of approach has been raised as issue."

"Took too long - virtually a year from start to receipt of report. Little engagement with the SAB."

"It was a lot of work in preparation. The number and breadth of documentation required as evidence was cumbersome. Our experience was positive; however there are lengthy delays in the publication of the result."

"Inconsistent - praised and suggested areas for development on same topic/practice."

"While the process initially felt daunting due to the length of time since the previous inspection, it provided [the] SAB with an opportunity to identify any gaps in the Board's work and review how the team operates as a whole. This led to the planning of a process-mapping exercise to ensure that work processes are as efficient as possible. However, during the interview process, there were occasions where a lack of knowledge or understanding of the Board and its role appeared evident."

"We supported ASC in submitting their self-assessment and the SAB's Annual Report was produced ahead of schedule to do this, including content which had been suggested via national guidance for this purpose. CQC obviously interviewed the SAB Chair and this seemed straight forward, but they decided not to engage with SAB Managers which is a strange decision, and a missed

opportunity as they hold the organisational memory and knowledge for the SAB and the wider safeguarding system. This has not been explained but it indicates a lack of understanding of how SABs operate."

"Independent Chair experience was positive. It was a very good interview, and the questions were very relevant. They used the Independent Chair as an assurance to check their findings."

"It was surprising that the questions asked did not relate particularly to the role of the SAB and appeared more general in relation to the Local Authority Safeguarding processes rather than a focus on people and the impact of translating strategic objectives through partners to those working directly with people."

"This was for me as a scrutineer a positive opportunity to reflect on the SAB's role, how far it achieves this (including seeking assurance) and how far the LA contributes to this. Thinking about, in what ways the LA in particular and also the SAB have contributed to having an impact on the issues reflected in data and SARs. It would make sense for this to be replicated for Health partners. In fact it is very important that it is."

"There was a surprising lack of interest in the Board and its work during CQC inspection, although information was provided for the information collection before they arrived."

"Needs to be more explicit about the separation of ASC and its safeguarding responsibilities and the role of the SAB."

"The process was thorough and involved our Chair and member agencies. However as with other LAs, there is contention that the DoLS backlog everyone has and are managing via the ADASS prioritisation tool is included in the safeguarding section and affects that section's scoring. Lots of LAs have been scored lower on this basis; this should have been included in the safe systems or overall ASC sections."

"Very variable, not consistent approach by different inspectors, somewhat superficial interviews with SAB Chair, business manager not allowed in interview by CQC."

"The assessment was very balanced and fair. The interviewer had limited knowledge of what the board was, and the role of the chair."

"I took over chairing shortly before CQC were due to visit which wasn't helpful as they judged the partnership on my direct experience and wouldn't accept my assurance that good work had preceded my appointment. It would have been much stronger had they interviewed both the SAB Chair and board manager and this should be standard practice going forward as managers do the lion's share of the work. I do not think the final report reflected the strong relational practice at the SAB, but it was a fair reflection of the improvements needed within ASC."

"My interview was a positive experience and an opportunity to share the work the SAB are undertaking."

"The SAB Chair and SAB Manager were interviewed as part of the CQC inspection and several SAB partners also contributed. The Local Authority has presented findings reports to the SAB which include plans to embed learning."

"The assessors only spoke directly to the SAB chair and no other members of the partnership. The questions were more operational than strategic and not really partnership focused."

Accountability for performance and an opportunity for review is provided by the statutory duty to publish an annual report. Amongst the "other" responses were references to ICBs, NHS and housing providers, Fire and Rescue services, public health and domestic abuse partnership boards. Some SABs noted that annual reports were published on their websites and distributed to all partners.

Who is the SAB Annual Report routinely shared with?
Number of responses to this question: 110

Number of SABs who share Annual Report routinely with	Number	Per cent
Health and Wellbeing Board	92	84%
Healthwatch	96	87%
Police Chief Inspector	90	82%

Council Chief Executive	102	93%
Council Scrutiny Committee	88	80%
Council Cabinet	53	48%
Council Full Council	20	18%
Safeguarding Children Partnership	82	75%
Community Safety Partnership	84	76%
Voluntary and independent sector representatives	81	74%
Other	63	57%

SAB Chair, Membership and Governance

The number of SABs with an independent chair has remained fairly constant (from 93% in the 2023 survey to (92% now). There has been a small reduction in the number of chairs with a social work background (down from 37%) and a small increase in those with a police background (up from 28%).

Who chairs the SAB?

	Number	Per cent
An Independent Chair	102	92%
A senior officer from one of the statutory partners	6	5%
Other (please specify)	3	3%
Total responding	**111**	

What is the professional background of the Chair?

	Number	Per cent
Social work	35	32%
Health	14	13%
Police	36	32%
Other (please specify)	26	23%
Total responding	**111**	

Is there a Safeguarding Adults Scrutineer role?

	Number	Per cent
Yes, held by the chair	24	22%
Yes, held by someone other than the chair	6	5%
No	81	73%
Total responding	**111**	

Where the professional background of independent scrutineers was identified (3 of 6), there was an even spread across social work, health and police. Free text comments on professional background mainly referred to chairs having executive/management experience across health and social care. There were occasional references to independent chairs having an academic or legal background. One SAB described having co-chairs, one independent and one statutory partner. A few SABs rotated the role of chair across the three statutory partners. One SAB commissioned independent scrutineers based on the kind of scrutiny required.

On equality and diversity, since the 2023 survey, there has been a marginal increase in the percentage of chairs who are female (up from 57%) but little change in other measures of diversity. There was very little diversity reported for independent scrutineers.

Recommendation Two: NSCN should continue efforts to improve the diversity of its membership.

Gender

	Number	Per cent
Male	41	37%
Female	66	60%
Other	0	0%
Prefer not to say	3	3%
Total responding	**110**	

Ethnicity

	Number	Per cent
Asian	2	2%
Black	1	1%
Mixed	1	0%
White	100	92%
Other	1	1%
Prefer not to say	5	5%
Total responding	**110**	

Disability status

	Number	Per cent
No known disability	91	83%
Known disability	9	8%
Prefer not to say	9	8%
Total responding	**109**	

Sexuality

	Number	Per cent
Straight or heterosexual	93	86%
Gay or lesbian	6	6%
Bisexual	0	0%
Other	0	0%
Prefer not to say	9	8%
Total responding	**108**	

The majority of SABs (75%, up from 70% in the 2023 survey) indicated that they meet on a quarterly basis, with a further 19% indicating that they meet more frequently (identical to the 2023 survey).

	Number	Per cent
Once a month or more	0	0%
Once every 2 months	20	19%
Quarterly	80	75%
Once every 6 months	0	0%
Other	7	7%
Don't know	0	0%
Total responses	**107**	**100%**

“Other” responses included additional annual or bi-annual events, such as development days, or arrangements where an executive meets quarterly in addition to quarterly or less frequent meetings of the SAB.

One choice facing SABs is how wide to extend membership of the board. Direct comparisons with the 2023 survey are difficult

because of changes in the questions that were included. However, the Department for Work and Pensions (DWP) is now represented on many SABs as a result of the memorandum of understanding with NSCN. As a result of the joint ministerial letter on homelessness, housing is now represented on most SABs. Overall, the breadth of adult safeguarding is illustrated by the wide range of agencies represented. In free text comments, SABs also referenced that membership included elected members, representatives of community safety and safeguarding children partnerships, further and higher education, drug and alcohol commissioned providers, health and social are commissioners, lay members, faith groups, diocesan representatives, and domestic abuse service providers.

Which of the following partner agencies are invited to be members of the SAB?

Number of responses to this question: 108

Partner agencies represented as members of SAB	Number	Per cent
Fire & Rescue Services	107	99%
Hospital Trusts	107	99%
Housing (Local Authority, District Councils &/or Social Housing Providers)	106	98%
Probation Services	104	96%
Representatives of the local voluntary and community sector	97	90%
Healthwatch	97	90%
Public Health	87	81%
Department for Work & Pensions	84	78%
Ambulance Service	80	74%
Other	69	64%
CQC	56	52%
Representatives of care providers	53	49%
Representatives of advocacy agency	51	47%

Advocacy	45	42%
Local Prison Service	44	41%
Representatives of carer support agency	40	37%
NHSE	26	24%

With such a wide adult safeguarding community, a challenge is to ensure that agendas are relevant for those attending, and that consideration is given to where particular services, such as prisons or DWP, can best contribute. In some regions, the ambulance trust mainly attends the SAB in whose area the service is commissioned.

"We reach care providers through attendance at provider forums as a two-way link, this is in part to ensure fairness and voice for all given the geography of the County and the size of the provider market. County Carer Support are actively engaged in the work of the partnership through its working groups and training offer. The conduit link to the ambulance service is via the local Integrated Care Board as outlined in line with our governance arrangements. Our usual review of those arrangements and endorsement will be complete by March 2026 to coincide with our new strategic plan start date of April 2026."

"Some of the above agencies sit on the Board's Sub Committees rather than the Board itself (ambulance service, local voluntary & community sector, carer support agency, advocacy)."

How often do they attend SABs?

Attendance of partner agencies at SABs	Frequently	Occasionally	Never	Don't know
CQC	7%	43%	46%	4%
NHSE	44%	24%	32%	0%
Ambulance Service	36%	39%	24%	1%
Fire & Rescue Services	83%	16%	1%	0%
Probation Services	76%	22%	2%	0%
Local Prison Service	53%	37%	9%	0%

Housing (Local Authority, District Councils &/or Social Housing Providers)	92%	7%	1%	0%
Representatives of the local voluntary and community sector	94%	5%	1%	0%
Representatives of care providers	69%	19%	12%	0%
Representatives of carer support agency	67%	17%	14%	3%
Representatives of advocacy agency	68%	23%	9%	0%
Advocacy	69%	31%	0%	0%
Department for Work & Pensions	70%	26%	4%	0%
Healthwatch	74%	22%	4%	0%
Hospital Trusts	98%	2%	0%	0%
Public Health	77%	22%	1%	0%
Other	78%	16%	4%	1%

Do you have any protocols or agreements about attendance and membership?

	Number	Per cent
Yes	73	68%
No	34	32%
Total	**107**	**100%**

“Attendance is monitored for SAB and subgroups and is flagged to SAB/Chair if non-attendance is an issue impacting on delivery of strategic plan.”

“Ambulance are represented via the ICB and CQC attend when requested.”

“Informally we agree with some members that they can receive papers and only attend if required i.e. CQC and NHS England.”

“Each member has a detailed Safeguarding Adults Board Handbook and is asked to sign an MOU.”

“CQC receive the agenda and minutes, however would only attend for relevant items, however they do attend the Regional SAB Chairs Network and receive relevant updates within this forum.”

“We have Terms of Reference/Governance Arrangements and compliance reporting in place. The compliance report includes attendance levels and contributions from partners to the work of the board and is reported on a six-monthly basis. We do have opt in arrangements across all our working groups Terms of Reference and should a group feel a member needs to be included.”

“We have a Board Constitution which all members sign.”

“Probation is super busy but do try to attend the more important face-to-face meetings, people are supposed to send reps and often do, but resources have gone ever more stretched and this is not always possible.”

“The ICB represent the local Ambulance service. CQC have indicated recently that they intend to attend the SAB and link with sub groups. CQC do attend one of our groups that feeds into the Quality and Performance sub group (The Quality Intelligence Group). we have Prisons and probation sub group which is attended by Prison representatives.”

Another choice for SABs is how to manage the business arising from their three statutory duties and the roles and responsibilities as identified in the Care Act 2014 and the care and support statutory guidance.

Does your SAB have an Executive Group?

	Number	Per cent
Yes	84	79%
No	23	21%

Total	107	100%

What is the membership of the Executive Group?

	Number	Per cent
NHS Integrated Care Board	84	100%
Police	84	100%
Adult Social Care (Local Authority)	82	98%
NHS Provider Trusts	30	36%
Other	21	25%
Children's Services (Local Authority)	20	24%
Local Councillor/ Cabinet Member/ Portfolio Holder	17	20%
Public Health	16	19%
Strategic Housing (Local Authority)	14	17%
Voluntary sector providers	14	17%
Fire & Rescue Services	13	15%
Local Probation Service	8	10%
Local Prison Service	4	5%
Trading Standards (Local Authority)	2	2%
Local Account Group (Healthwatch)	1	1%
Department for Work and Pensions	0	0%

"Other" responses referenced chairs of sub-groups, local authority chief executives, mental health service providers and district council representatives. Especially where an executive has a broad membership across statutory and other partners, a question arises about the relationship between the SAB and the executive, about the roles and responsibilities of each.

On sub-groups, all 107 SAB that answered this question indicated that they had one or more.

Number of sub groups listed	Number	Per cent
One	1	1%
Two	3	3%
Three	15	14%
Four	36	34%
Five	52	49%
Total	**107**	**100%**

SABs were asked to name up to five sub-groups. Nomenclature of sub-groups makes analysis of the picture difficult. For example, some SABs had different sub-groups for decision-making about SAR referrals and implementation of review recommendations. Some SABs combined a focus on quality assurance and learning and development, whilst others differentiated between audit and assurance. Nonetheless, unsurprisingly given the statutory duty to commission SARs and the mandate to seek assurance about, and to promote the effectiveness of adult safeguarding, the most frequently mentioned sub-groups focused on performance and quality, SARs (89%) and learning and development. There followed in descending order references to sub-groups on communication and engagement, policy and procedural review and development, exploitation, prevention and engaging with lived experience and experts by experience.

The breadth of SAB responsibilities and activity is demonstrated by multiple references to other sub-groups, the convening of which originating in agreed priorities arising from SARs and assurance/audit activity. For example, sub-groups were mentioned on mental capacity, self-neglect and hoarding, prisons and probation, transitional safeguarding, housing/homelessness , learning disability and autism, and engagement with community groups and third sector organisations. Some SABs reported that some sub-groups were shared jointly with either community safety or safeguarding children partnerships; others that sub-groups were shared with neighbouring SABs.

As reported in the 2023 survey, sub-group leadership was spread across statutory and other partners.

Percentage of groups chaired by	Per cent
SAB Chair	5%
Deputy SAB Chair	1%
Other Executive or work member of SAB	82%
Other	12%

The survey explored further the degree to which SABs engage with third sector and other organisations through sub-groups and/or board or executive membership. Once again, survey results indicate the breadth of adult safeguarding and how SABs are increasingly adopting an inclusive approach to membership, although this is not without its challenges.

How are the voluntary and community sector, educational establishments and faith organisations involved in the work of the SAB?

SABs (or sub groups) where there is representation from	Number	Per cent
Voluntary sector providers	92	87%
Voluntary and community organisation representing service user groups (e.g. MIND, Sense)	90	85%
Housing providers	77	73%
Private providers (e.g. Home Care and Care Home representatives)	52	49%
Educational establishments	33	31%
Faith organisations	25	24%
Other (please specify)	24	23%
Chamber of Commerce	0	0%

Total responding	106	

“Other” included references to fire and rescue services, immigration and removal centres, advocacy providers, probation and lay members.

“We have some gaps being addressed.”

“Healthwatch, City, District & Borough Councils - Housing and educational providers will be invited to any relevant meeting e.g. SAR group.”

“The Practitioners Alliance subgroup focuses on the community and voluntary sector and has a wide range of members. Those from faith groups and private providers are also invited to join but we do not currently have any members from these groups.”

The breadth of adult safeguarding and of SAB activity is also illustrated by survey responses to the question about meetings. Of the 107 SABs that responded to this question, 55% reported that meetings regularly take place outside formal SAB meetings and are regularly reported to board partners. These are wide-ranging, which demonstrates the breadth of topic areas being covered by SABs, and included the following:

- *Suicide and drug and alcohol deaths*
- *Community Meetings with BME Network organisations, Residents and Service User Group*
- *Safeguarding in Sports meeting. Voice and Influence Meeting.*
- *Care home forum and Domiciliary Care Forum*
- *Domestic Abuse Group, Honour Based Abuse, Social Care Forums*
- *Provider forums coordinated by the local authority and registered manager networks that the partnership links in with for key messaging. There is also a Supporting the Provider Market mechanism that the partnership links in with for learning and development opportunities.*
- *Channel and Prevent Duty annually and on an exception basis where risk dictates partnership consideration is needed.*

- *Homelessness and Rough Sleeping Delivery Group, Carers Delivery Group, PREVENT, Domestic Abuse Steering Group*
- *Diocese Safeguarding Board*
- *Sexual Safety Partnership Board / Domestic Abuse Partnership*
- *District Councils Safeguarding Leads subgroup.*

Involving people with lived experience

SABs described different ways in which they are involving people with lived experience of adult safeguarding and their carers in the work of the SAB. These included the following:

- Service users, carers and lay persons as SAB members
- Use of sub-groups and service user groups
- Involvement in SARs
- SAB meetings opening with case studies and lived experience human stories
- Links with learning disability forums and mental health networks, and making contact with community groups
- Obtaining feedback on the experience of Section 42 enquiries
- Engaging in research projects
- Newsletters
- Linking with Healthwatch and VCS partners
- Attending local network events and citizen assemblies
- Co-producing key documents and learning events, organising themed development days and focus group discussions
- Employing a project officer
- Using safeguarding champions and quality checkers

Involving people with lived experience of adult safeguarding was often referenced as a key component of a SAB's strategic plan, having recognised that this was "*an area for development*" that "*requires strengthening*." Although survey responses often described innovative approaches to hearing and learning from people with lived experience, this core component of a SAB's role

clearly remains an ongoing challenge.

“Comms and Engagement sub-group tasked with expanding and improving service user involvement.”

“The SAB has been working towards more integration with people with lived experience for the last 2 years, with minimal success. Links with voluntary sector, Healthwatch and user groups via the Local Authority. This work is continuing through the next year and any guidance and support or examples from other areas would be appreciated as we consider this is a critical component that is currently lacking within our SAB.”

“Very limited at this point. Some attendance at meetings, but not strong.”

“The SAB does not have any lived experience membership and this is acknowledged as a weakness that needs to be remedied.”

“Through attendance at SAB and subgroups, supported through the Community Engagement Group. In past have had a case study presentation with people with lived experience at the board. Has waned and considering bringing this back.”

“People with lived experience have been involved in our annual joint safeguarding conference. SAB Chair has visited community groups to make connections.”

“This unique group [of safeguarding ambassadors] comprises individuals (both users and carers) from prominent service user groups who are deeply committed to preventing abuse and neglect. They play a crucial role in raising awareness of safeguarding issues that impact the wellbeing of local residents, empowering the communities within [the locality] to confidently respond to abuse and neglect. All SAB awareness-raising resources are co-produced with the Safeguarding Ambassadors and include a variety of video materials designed to help everyone understand a range of safeguarding topics, as well as detailed information on what happens after a safeguarding concern is reported.”

The priority given to this component of a SAB's work can be seen in data reporting increased activity. Compared with the 2023 survey there has been a slight increase in the number of SABs reporting an increase in activity, and a corresponding decrease in those reporting no change.

How has the SAB's involvement of people with lived experience of adult safeguarding and their carers developed since the last survey in Autumn 2023?

Change since 2023	Number	Per cent
It has increased greatly	29	27%
It has increased somewhat	55	51%
There has been no change	20	19%
It has decreased somewhat	3	3%
It has decreased greatly	0	0%
Total responding	**107**	

Among the reasons for increased activity surrounding the involvement of people with lived experience, SABs commented on greater use of in-person meetings following the Covid-19 pandemic, the outcomes of gap analysis that revealed "*still some work to do*" and inclusion in strategic plans, and the impact of appointments of new independent chairs, business managers and/or engagement officer or participation leads.

Free text comments referred to:

- Use of surveys and commissioning of projects, for example through Healthwatch
- Use of assurance reports from advocacy providers to develop stronger links with people with lived experience
- The work of engagement sub-groups
- Leadership from people with lived experience in co-producing resources, such as easy read documents and videos, and contributing to campaigns and webinars, for example on mate crime, fire safety, falls prevention and domestic abuse
- Establishing relationships with faith groups

- Engaging people with lived experience as quality checkers and in training sessions following publication of SARs

"The SAB identified that we had undertaken very little outreach with people with lived experience and to fulfil our statutory responsibilities needed to do so."

"We now link in better with user groups due to the local authorities having set them up. It means we can coproduce materials."

"Lived experience and learning disability work presented to the SAB in July 2025. This has had a significant impact on board members and has helped shaped this work going forward."

However, staffing and resource pressures were occasionally reported as constraining this activity. Some SABs had concluded that they needed to find ways to engage beyond inviting people to meetings and workshops. Also recognised was that "*impact has yet to be evaluated*."

"A greater understanding of the broader aspects of safeguarding has led to this work being identified. The impact is yet to be determined as we are awaiting survey responses. However, the working relationship with Healthwatch has significantly strengthened, enabling closer collaboration and the identification of additional areas where the Board and Healthwatch can work together. This partnership has resulted in the joint identification of emerging safeguarding themes, which in turn supports the delivery of better services for people."

"The SAB strategic priorities are developed by members at an away day event and this was identified by the partnership as a priority. The impact cannot be measured yet but the aim is for this work to be undertaken over the cycle of the three-year strategic plan with a report being presented to the board."

"We have tried numerous methodologies and trialled different processes based on good practice from other SABs. However has been a challenge to identify individuals who want to share their experiences of safeguarding directly. We do have good involvement from family members in SARs. We have tried to mitigate the impact of this by working with agencies that represent the voice of people with lived experience."

"Limited increase in this area of activity is due to restricted capacity within the board business team to carry this work forward."

Recommendation Three: The work of the NSCN task and finish group should continue to disseminate examples of how SABs have effectively engaged with people with lived experience of adult safeguarding.

Seeking Assurance

The care and support statutory guidance mandates SABs to seek assurance about the effectiveness of adult safeguarding. Survey data offers a window into how SABs implement that mandate and the challenges they experience when doing so.

Does your SAB have a multi-agency dashboard which is routinely discussed?

	Number	Per cent
Yes	80	73%
No	29	27%
Total	**109**	**100%**

There were frequent free text comments that dashboards were under development. Data was often provided via a performance and quality sub-group, with an emphasis on local authority safeguarding data (Section 42 referrals, outcomes of enquiries, and types of abuse/neglect). Free text comments also indicate the breadth of safeguarding data that was either sought and/or obtained, and the challenges involved in data collection.

"Currently in development as view that it doesn't provide the level of oversight we require."

"80% ASC Safeguarding activity data, plus fire safety checks from LFB, advocacy, limited health data."

"Quarterly Performance Data Dashboard which is scrutinised and challenged quarterly at a multi-agency Performance and Quality Assurance Subgroup which reports to the Board."

"Safeguarding referrals, PIPOT activity, training, internal QA activity, Best practice examples, homeless data."

"The dashboard is reviewed quarterly at the Quality Group meeting and is currently maintained by ASC. Additional discussions are underway to ensure that more meaningful data from the Police and Health sectors is fully incorporated. This will enable comprehensive triangulation of data metrics to support more informed decision-making."

"This is a work in progress and has taken significant time to develop and start to receive data from multi- agency partners. It has currently reached a point where it contains data from Adult Social Care (statutory safeguarding data), local authority housing (including homelessness), Integrated Care Board (safeguarding activity across provider organisations and DoLS data) and the Police (exploitation data and cuckooing/modern slavery in particular)."

"We receive data via the Quality Assurance subgroup; this is not via a dashboard."

"This is a work in progress - we try to get RCRP data, we do get homelessness information and we do get reports on care homes of concern."

"Local Authority Safeguarding Adults data, Local Authority Housing data, Fire Service data, Police data, NHS data from acute hospital trust and mental health trust. Other agencies also contribute their top safeguarding themes/trends for the quarter, and this is discussed in the Quality Assurance Sub Committee."

How often do the following agencies provide data on adult safeguarding performance for SAB scrutiny and assurance?

Provision of data for SAB scrutiny and assurance	Sum of responses	Regularly	Sometimes	Rarely	Never	Total

Social care and health provider	108	86%	8%	3%	3%	100%
Specialist safeguarding staff	96	70%	13%	9%	8%	100%
Service and professional regulators	88	22%	20%	24%	34%	100%
Police and criminal justice system	108	51%	31%	11%	6%	100%
Professionals, i.e. clinicians and social workers	95	36%	37%	13%	15%	100%
Advocacy Provider	97	23%	33%	15%	29%	100%
Care providers	92	26%	29%	22%	23%	100%
Healthwatch	94	23%	31%	22%	23%	100%
Fire and ambulance service	103	34%	40%	15%	12%	100%
Housing	105	43%	37%	9%	11%	100%
Other (please specify)	14	71%	21%	0%	7%	100%

"Other" responses included references to data from community safety and/or safeguarding children partnerships, drug and alcohol services, DWP, prisons and probation, and education. One SAB included data on suicide here. Once again, free text comments referred to this activity being a work in progress. They also referenced the challenges in seeking assurance data. SAB effectiveness relies heavily on the relationships built and maintained with partner agencies. Even when information is requested under Section 45 Care Act 2014, SABs are limited in what they can do, short of seeking judicial review, if an agency does not comply.

"Data provided and requested is still hard to gain useful data on a regular basis from some agencies."

"The SAB data set has been a priority and a risk for the SAB for the last 12 months. there has been a lot of progression in developing an initial multi-agency dataset which we now have but there is work to do to develop this further."

"Data dashboard in development to work through wider areas to assure SAB on key areas of risks on safeguarding."

“The partnership has a dashboard which includes CQC ratings across the health and social care provider market as well as data relating to the top emerging themes and features and actions relating to providers. That dashboard also includes data relating to any embargos and decommissioned services as well as providers sitting within organisational concerns processes. The local authority regularly report data on caseloads for safeguarding and enquiry completion timescales. Other agencies such as Health Trusts share updates relating to regulatory inspection and/or progress updates. There is a wide range of assurance activity linked to performance across the partners reported at regular intervals.”

“The need for multi-agency data and an analyst has been identified as a KEY priority for the SAB from April 2026 to 2029 and will be supported by a new subgroup to deliver this.”

“At present, Adult Social Care is the only partner consistently providing safeguarding performance data for SAB scrutiny. Despite repeated requests over the past 12 months, no other statutory or relevant agencies have submitted routine data returns, which significantly limits the Board’s ability to undertake full multi-agency assurance or triangulate risk. To address this, the SAB has set a new deadline of 1 December for all statutory partners to provide the required data ahead of the next SAB meeting. Strengthening this area remains a key priority within our Quality Assurance and Performance work.”

“At every quarterly SAB meeting we have 2 specialist 'assurance' presentations - the topics are linked to our strategic work e.g. recent meeting covered DWP and Safeguarding and LA CQC Theme 3 - outcomes and improvement work.

“Obtaining partnership data in a coherent way to add value to the board is challenging due to the way organisations record their data and system integration. It would useful if there was a combined nation steer around what data each board should monitor as a minimum, with other data monitored relative to board priorities.”

"It is becoming harder to secure reliable data from partners as resource is taken out of adult safeguarding. Where possible we have used s45 powers to request data for thematic assurance pieces (e.g. homelessness provision). Partners also sometimes complement data with qualitative reports, case studies etc."

How often does your SAB receive the following information regarding carers?

Information about carers	Sum of responses	Regularly	Sometimes	Rarely	Never	Total
Information about carers who may experience intentional or unintentional harm	106	9%	35%	28%	27%	100%
Information about carers who may unintentionally or intentionally harm or neglect the adult they are supporting on their own or with others	106	16%	30%	27%	26%	100%
Information on carers who may witness or speak up about abuse or neglect	105	7%	34%	25%	34%	100%

Some SABs acknowledged that this was a gap; others that data regarding carers was an area under development or review. Also referenced were engagement with carer groups/organisations, specific assurance work such as surveys, and carer representation on sub-groups or SABs.

"This is acknowledged as an area that needs development and we have a Carers Contingency Planning task and finish group but the wider piece likely to be a strategic objective in the forthcoming biennial plan."

"Carers Groups sometimes attend SAB; we rely on Local Authority commissioning and oversight- there is a joint integrated Carers' Board and group."

“This isn't fed into the SAB directly however it is received via SARs and monitoring of carer assessment and review data plus the data breakdowns on the concerns that are received that may involve a carer.”

“Identified as a strategic priority for 2026-29.”

“We work fairly closely with the commissioned care support agency and ASC who are the commissioning authority for this. This has included audits and reviews and data collection, attendance at engagement workshops to listen to those with lived experience, and invites to speak at SAB meetings.”

“The Carers Centre, a local organisation for Carers, is a member of the community and voluntary sector subgroup and the SAB has delivered presentations to the Carers Centre on adult safeguarding. We have a range of protocols and guidance, such as guidance on safeguarding thresholds, to support carers in relation to safeguarding.”

“We have a Carers reference group who feed in trends and data. Concerns are then raised at Board meetings. These are then monitored via our risk register.”

“This is a priority on the newly established SAB business plan. This will formalise less focused /regular feedback which comes via the lead of the stakeholder subgroup. This is an area that has been actively pursued following relevant issues surfacing in SARs, which is why it is now firmly in the business plan to address those issues. The focus group discussions in early 2024 included one with carers. This has informed the business plan actions.”

“Plans are underway as a regular part of the reporting framework. The partnership has undertaken two audit activities following the 'safe care at home review' to explore the nature of safeguarding enquiries linked to carers and cared for persons. The partnership is exploring new indicators and revisions to current dashboards ahead of its new strategic plan start date of April 2026.”

"Our local Carers Support Centre and the carers support team within the local authority are represented on our subgroups and any emerging themes and trends are reported through. Bespoke actions of a safeguarding nature are woven into our delivery plan to ensure that carers voice and experiences are heard and responded to."

Is your SAB receiving information on the target homelessness group – the people who need additional help in line with the Ministerial Letter?

	Number	Per cent
Yes	94	88%
No	13	12%
Total	**107**	**100%**

An NSCN survey conducted in late 2024 and early 2025 identified that SABs had responded positively to the guidance in the joint ministerial letter with respect to ensuring a sustained focus on homelessness, including senior leader membership of SABs, identification and safeguarding responses in respect of people at particular risk of homelessness, and the commissioning of SARs. This survey confirms SAB engagement with homelessness as an adult safeguarding concern.

To what extent do the following present challenges in data collection and analysis on performance needed by the SAB?

Present challenges in data collection and analysis on performance	Sum of responses	To a great extent	To some extent	Not at all	Total
Technical systems do not enable collection of the data in the required format	106	32%	50%	18%	100%

There are not enough staff / staff do not have time to complete the data collection	105	25%	53%	22%	100%
Staff are not trained on data collection and analysis	105	18%	43%	39%	100%
Data collection and analysis is not seen as a priority	105	6%	36%	58%	100%
Agencies do not provide relevant data	106	10%	62%	27%	100%
Other	10	60%	30%	10%	100%

Challenges in data collection and analysis have already been referenced above. Compared with the 2023 survey results, there has been a marked increase in concerns about the adequacy of technical systems (82% from 43%) and staff resource (78% from 47%). A shortfall in available data analysis expertise remains an ongoing concern. Also worrying, mindful of the SABs mandate and responsibility to seek assurance about the effectiveness of adult safeguarding, are the figures for agencies failing to provide relevant data, and data collection and analysis not being prioritised.

"Other" comments continued to refer to the lack of analytic capability and both time and funding for development. In summary, the challenges focused on the lack of agreement on what data is required (absence of a minimum data set), then obtaining the data, managing the volume and variability of data, followed by capacity for analysis and identifying the human stories behind the data.

"It isn't always understood that the SAB has an assurance role and that information/data internal to organisations must come to SAB where agreed as necessary."

"Difficult to get SAB specific data from agencies who are more inclined to be open with the data they already collect. The capability to layer this data to make it more relevant to the SAB is difficult due to a technology

and business unit skills/capacity gap."

"There has not been a multi-agency approach in place for data collection, which is now being addressed."

"Funding challenges, disproportionate contributions from police to SAB verses SCP. Therefore reduces the resource for data collection and analysis."

"Very difficult getting data out of the NHS. Told we have to go via the ICB which is not in a good place right now."

"Agencies provide limited data, the business unit do not have an analytical function and are reliant on ASC performance team - this is a priority for the SAB."

"There is a lot of data available from different sources and most agencies will share this, but it can be a slow process, and we do not have dedicated staff hours or roles to do this. That is a business continuity risk."

"We have had rapid development of our data dashboard and we are still refining the data, the challenges are less about the provision and more about the timeframes and analysis of the data."

"Agencies are keen to provide meaningful data and prevent duplication but there has not been unified agreement as to what is required. Re homelessness, there is work in progress to establish a reporting pathway into the SABs."

"There are so many safeguarding priorities and agendas that would benefit from a complete analysis of data held by partners that any attempt to identify the most important is difficult and that list changes. We collect data on specific areas of work relevant at the time."

"We have a strong data dashboard in place which is shared quarterly with the subgroups for oversight of our

local themes and trends. The SAB data dashboard allows partners to have oversight on key safeguarding categories and demographics and includes real-time data in relation to timescales and ongoing enquiries. The dashboard includes key areas such as concerns, enquiries, geographical location, timescales and outcomes. In addition to the dashboard, a quarterly story board is also shared which gives context and triangulates the data. In addition, a bespoke provider data dashboard (care homes and home care) is shared to identify themes and trends in the data received from providers. We are continuing to see improvements in our ability to capture data and share this information with both the Board and wider partners."

To what extent does your SAB use the Safeguarding Adults Collection (SAC) data published by NHS England?

	To a great extent	To a moderate extent	To some extent	Not at all	Total
Use of the Safeguarding Adults Collection (SAC)	44%	29%	22%	5%	100%

Overall, compared to the 2023 survey results, there has been a marginal increase in SAB use of SAC data, with a marked rise in those SABs using it to a great extent (44% from 28%). Whilst some SABs reported that they were planning to increase their use of this data, others noted delays in obtaining it and questioned its usefulness.

Two reports produced by Partners in Care and Health provide analysis and benchmarking by council area using the Safeguarding Adults Collection (SAC).
Adult Safeguarding Narrative Report
An Overview of Adult Safeguarding
(You will need to register and sign in to LG Inform to access the reports. All council staff and members can register here: sign in - Register (https://signin.esd.org.uk/register.html?app=inform).

"The SAC data is used to measure performance against regional and national trends an determine if we are an outlier."

“We very carefully analyse and compare our borough to neighbouring areas, regional and national trends. This is the only way to provide context to the local safeguarding data, otherwise they are just a series of numbers. We tracked these trends both year on year and over an extended period and this allows us to establish disproportionality and therefore local priorities.”

“We tend to receive the data that goes to NHS England prior to it being submitted to them, rather than using the published NHS England data per se.”

“As the data dashboard continues to develop this is an area we intend to explore further, considering comparable areas to better understand our performance and specific areas of focus.”

“SAB members felt the SAC data did not provide a multi-agency picture of safeguarding and have been working towards gathering data from a wider group of partners beyond the Local Authorities.”

“The SAC is used for comparison but it doesn't cover all the data sets that the board is interested in.”

“It is difficult to use due to way individual areas collect their data. because of inconstancies it’s difficult to know whether data is comparable.”

Once again, the survey asked for recommendations on how the SAC data might be improved, mindful that this was also a service improvement priority identified for DHSC in the second national analysis of SARs. Free text contributions referenced:

- Enhanced focus on specific issues, such as prevention, domestic abuse, out of area placements, homelessness, exploitation, poverty, PIPOT, falls and risk.
- Expanding focus so that data being captured is multi-agency rather than just local authority.
- Expanding focus to include provider concerns and care home performance.
- Greater detail on Section 42, to include source of referrals, repeat referrals and enquiries, the types of enquiries and interventions that reduce or remove risk.

- Making reporting on Making Safeguarding Personal mandatory.
- Distinguishing the data between operational safeguarding and SAB roles and responsibilities.
- Standardisation of a data set to reduce variation in how safeguarding concerns are defined and recorded, and how types of abuse/neglect are understood.
- Reporting of protected characteristics in adult safeguarding data (Equality Act 2010).
- Improved SAR data, including the types of abuse/neglect reviewed, differentiation between mandatory and discretionary reviews (Section 44(1-3) and Section 44(4).
- Timeliness, for example advocating quarterly rather than annual returns to facilitate proactive risk management and prevention work.
- Embed qualitative feedback alongside quantitative data to capture people's lived experience of adult safeguarding.

Recommendation Four: NSCN should consider the development of a minimum data set for SABs when seeking assurance about the effectiveness of adult safeguarding.

Recommendation Five: NSCN should use this survey to continue the discussion with DHSC about improving the data collected through the SAC return.

Commented [PL1]: You may want to reference seeking opportunities for extending the Client Level Dataset to include safeguarding events.

Mechanisms for referring in safeguarding concerns (S42(1))

The SAB mandate to seek assurance about the effectiveness of adult safeguarding clearly covers duties surrounding the referral of adult safeguarding concerns and decision-making about adult safeguarding enquiries. This focus begins with how decisions are made when local authorities receive referrals of adult safeguarding concerns.

Is there a Multi-Agency Safeguarding Hub (MASH) in your SAB area?

	Number	Per cent
Yes - separate children and adults MASH	32	30%
Yes - a joint children and adults MASH	20	19%

No	55	51%
Total	**107**	**100%**

Where a MASH had not been established, SAB respondents described other systems for decision-making.

“Referred in through front door for ASC, triaged and allocated for appropriate team to carry out enquiry.”

“An Adult MASH is being developed locally. Currently there is a specialist Safeguarding Adult Social Care Front Door receiving and triaging safeguarding concerns. The SAB audits and seeks assurance about the work of this unit, with specific reference to how effective multi-agency working arrangements are. Work is currently ongoing to bring Police and Health into this team.”

“Adult Safeguarding referrals are made thorough an online form available to both professionals and public. Police and Ambulance colleagues send in Adult Protection and Vulnerable Person Alerts to the Children and Adult Business Support Team. Referrals through either of these routes are received into our dedicated Safeguarding Team where they are screened on the day by the Safeguarding Concerns strand of the service, to ascertain whether they meet the criteria for s.42 Enquiries to be undertaken and determine any immediate safety measures that are required. As part of the screening, fact finding is undertaken and the Terms of Reference for fact finding are set by DSOs who are senior social workers or above.”

“We have created a task and finish group which is now focussed on creating an adult MASH, it is expected to be aligned with the children's MASH.”

“Safeguarding concerns under s42(1) are received and triaged by Adult Social Care (ASC) through their established front-door and safeguarding pathways. ASC provides bi-monthly data and narrative reporting to the SAB on volumes, trends, thresholds, and triage outcomes. At present, no other agency provides routine data on safeguarding concern activity, referrals made, or internal triage processes. This is recognised as a gap, and work is underway with statutory partners—including Police, ICB and providers—to develop a consistent, multi-agency reporting framework that can be aligned to the SAB’s Quality Assurance and Performance arrangements.”

Whatever arrangements are in place for decision-making on referrals of safeguarding concerns, a key question to be answered is whether such decision-making is lawful, rational and timely. The SAB mandate to seek assurance about the effectiveness of adult safeguarding therefore extends to scrutiny of these decision-making systems. Survey respondents were asked to describe how this was undertaken. Commonly described were use of audits, independent scrutiny, surveys and performance reporting. Also described were reviews of SAR findings, monitoring of complaints and compliments, and feedback from people with lived experience and families, carers and communities.

"Assurance is sought and provided via the quality sub group with a report being provide with full oversight, this report is then shared with the independent chair."

"We have conducted external audits which have been comprehensive and revealing. We have also conducted/overseen internal self-assessment and audit."

"We have instigated peer audits and SARs themselves provide a significant opportunity to seek assurance, as well as the action plans that follow, which can often continue on for some time."

"This is recognised as a gap in the SAB function and has been set as a priority for 2026 onwards (data)."

"We hold a challenge event where each partner submits a self-assessment and then each Board member and deputy meet with independent chair, business manager and representative from Healthwatch to discuss in depth outcomes of self-assessment."

Both the first and second national analyses of SARs have reported shortcomings in the referral of adult safeguarding concerns and subsequent decision-making. The outcome of CQC assessment visits has also cast light on the degree of compliance with the care and support statutory guidance on Section 42. The survey therefore asked SAB respondents to comment on their confidence with respect to use of Section 42.

How confident are you that the SAB agencies understand the scope of section 42(i) and section 42 (ii) and are following the LGA guidance?

	Number	Per cent
Confident	43	41%
Somewhat confident	56	54%
Not at all confident	5	5%
Total	**104**	**100%**

Free text comments sometimes identified concerns about the interpretation of the criteria in Section 42(1) and decision-making about when to conduct safeguarding enquiries. Sometimes the focus was on how SABs were seeking assurance about, and were endeavouring to improve operational practice. Approaches that had been found to be helpful included joint training, for example on legal literacy and information-sharing, development of policies, briefings, animations and newsletters, use of case studies and audits, and annual development events. Noteworthy amongst the free text comments were references to thresholds when, in fact, the components of Section 42(1) are criteria.

"Some partners don't understand the section 42 threshold ... In the mean time we do awareness sessions with care homes for example to help push to only submit appropriate concerns. The SAB is aware that overloading the concern review process is expensive and could increase risk."

"Partners who are frequent attenders at SAB demonstrate a good understanding and many have been in attendance for some years now."

"Multi-agency training offered through board. Multi-agency impact audits following SAR publication."

"Continually raising awareness, providing MASH training and guidance, website information for partners, looking at quality of referrals and developing standards, continually emphasising the escalation process and this has been subject to a number of reviews."

“Safeguarding training is in place for partners. Conversation at Board level around appropriateness of concerns raised and including the right information in concerns to ensure that can be dealt with appropriately.”

“We will review post CQC report.”

“We raise awareness and challenge agencies. A specific input is given to care homes and their submissions are monitored. I do think this process is out of date and has been argued over for many years. I am keen to suggest we move to more of an intelligence submission with those that specifically highlight a need for section 42 or if not are so serious that an assessment is needed receiving consideration for a section 42. Only these would be reported on for a section 42 conversion. This approach would allow better low level information share, less frustration across the process and increased prevention opportunity.”

“Our data shows that 70-80% of concerns raised do not meet the criteria for a statutory safeguarding response and we continue to address this via targeting of referrer groups and local fora. However from feedback we also know that referrers will send in a safeguarding concern when they cannot get a satisfactory response from another service eg: ASC or MH services - this is more challenging to address and resource heavy in the triaging process.”

“The SAB recognises the concerns raised in several CQC assessments about partners’ variable understanding of safeguarding guidance. In response, we have taken a number of steps and are planning further activity to strengthen multi-agency confidence, clarity and consistency:
• Awareness raised at Board level: The issue has been explicitly highlighted with statutory partners, with a renewed emphasis on consistent application of the Care Act, Making Safeguarding Personal, and local threshold guidance.
• Sharing of best practice examples: We are using real cases—such as safeguarding responses relating to homelessness, self-neglect and complex needs—to demonstrate what “good” looks like and to prompt discussion and reflective challenge.
• Development of a multi-agency summit in early 2026: This event will bring together leaders and practitioners from all partner agencies to explore safeguarding thresholds, roles, responsibilities and pathways, and to build shared understanding across the system.

• Strengthening of training and communication: Partners are being encouraged to review internal training content and supervision arrangements to ensure alignment with statutory guidance. The SAB learning subgroup will support this through shared resources and learning from SARs.
• Improvement of multi-agency data and intelligence: Work is underway to broaden performance reporting beyond ASC, enabling clearer visibility of how partners are interpreting and responding to safeguarding concerns.
Collectively, these actions aim to build a more consistent, confident and evidence-informed safeguarding culture across the partnership."

Specifically, since NSCN is a partner alongside PCH and CQC in taking forward service improvement priorities identified in the second national analysis of SARs on organisational abuse, especially the clarity of definition in the care and support statutory guidance when compared with that for neglect and acts of omission, a question was asked about SAB oversight of organisational abuse. As SARs have also raised concerns about the interface between Section 42 and provider concerns processes, a question was also included on this facet of operational practice.

What oversight does the SAB have regarding organisational / large scale enquiries relating to providers of concern in your area?

	Number	Per cent
Reported at each SAB Meeting	23	21%
Reported once or twice per year	10	9%
Reported as they arise	68	62%
Not reported and no oversight	9	8%
Total	**110**	**100%**

Does your local authority accept referrals under section 42(1) when the concern is about organisational or institutional abuse affecting groups of adults rather than single named individuals?

	Number	Per cent

Yes	82	76%
No	4	4%
Not sure	22	20%
Total	**108**	**100%**

Safeguarding Adult Reviews

The second national analysis of SARs covered the period April 2019 to March 2023. As the safeguarding adult annual returns by local authorities contain very limited data on SARs, this survey provides the best available information about the level of activity and the types of abuse/neglect featuring in SARs since the second national analysis.

Compared with the 2023 survey, SABs have been dealing with increasing numbers of referrals. The mean average (average value of all responses) has risen from 17 to 20; the median average (middle number when all numbers are lined up in ascending order) has risen from 14 to 16. The number of referrals accepted as meeting either the mandatory or discretionary criteria has stayed relatively constant (median average (5 and 5) and mean average up (from 6 to 7).

How many SARs have been referred to your SAB since April 2023?

	Total number	Average per SAB
Number of SARs	2075	20
Number of responses	104	

Of those referrals, how many were accepted as meeting the mandatory or discretionary criteria for SARs to be commissioned?

	Total number	Average per SAB
Number of SARs	680	7

Number of responses	102	
Average proportion per SAB	36%	

A variety of responses were given to the question of how SABs promoted learning from referrals that did not result in the commissioning of a SAR. These included single agency reviews and requests for assurance reports, use of referrals as case studies within learning events or roundtables, and publication of seven-minute briefings. Referrals were also used to inform training needs analysis, reviews of policies and procedures, and key lines of enquiry for audits. Task and finish groups might be convened to identify and disseminate learning, or to conduct a thematic review of themes from referrals.

Types of Abuse/Neglect

As found in both the first and second national analyses of SARs, self-neglect continues to be the most frequently reviewed type of abuse/neglect, followed by neglect and acts of omission.

Of the SARs that you have commissioned since April 2023, please could you count how many have included each of the ten types of abuse/neglect referenced in the statutory guidance?
Number of responses: 93

	Number of SARs	Number of SABs reporting a number >=1	% of SABs who responded to this question who reported a number >=1
Self-neglect	382	86	92%
Neglect or acts of omission	296	77	83%
Domestic or violent abuse	137	61	66%
Psychological or emotional abuse	132	50	54%
Physical abuse	110	43	47%
Financial or material abuse	63	37	40%

Sexual abuse	41	23	25%
Organisational or institutional abuse	45	23	25%
Discriminatory abuse	19	13	14%
Modern slavery	17	10	11%

SABs were asked to identify themes within completed SARs. Using the domains of analysis adopted in both the first and second national analyses of SARs, most reported themes fell within the domain of direct practice. These included shortcomings in assessments, an absence of professional curiosity and trauma-informed practice, and concerns about hospital discharge. Also referenced were poor recording, shortcomings in legal literacy, and insufficient support for carers. Other themes included mental health, suicide, transitional safeguarding, fire safety, substance misuse, exploitation and cuckooing, neurodiversity, responses to co-occurring conditions and lack of engagement, especially with seldom-heard groups.

In the domain of the team around the person, mentioned themes involved concern about communication and information-sharing between agencies and shortcomings in coordination and collaboration, for example missed opportunities to convene multi-agency risk management meetings. Other themes included lack of knowledge of safeguarding processes, a failure to escalate concerns, and poor oversight of out of area placements.

Only one theme could be characterised under organisational support for practice, with one SAB identifying an ineffective learning culture in the organisations involved in a review.

These themes have been identified also in both the first and second national analyses of SARs. They are repetitive and once again highlight the importance of reviews answering the question “why?” and building on prior learning. NSCN will shortly publish guidance to support analysis across all five domains used in the national analyses. In addition, consideration could be given to thematic reviews of and development work designed to strengthen practice on particular repetitive concerns.

Management of ongoing learning

NSCN will shortly publish a briefing on best practice for capturing the impact and outcomes of SAR learning. Meanwhile, SABs were asked to comment on how they ensure learning. Their free text comments have been summarised in this table.

Assurance reports to a SAB	Tracking learning through action plans and audits	Webinars, podcasts, workshops and videos
Briefings and newsletters	Learning and development events	Reviews of policies and procedures
Task and finish groups, and sub-groups, working on themes	Partner self-assessments and independent scrutiny	Inviting SAR authors to return to review what has (not) changed
Using safeguarding champions to promote learning	Triangulating data with enquiries with people with lived experience	Ensuring new SARs build on and enquire into the outcome of prior learning

Prior learning is available from both the first and second national analyses of SARs. SABs were asked to comment on how they have responded to the findings and recommendations in these analyses. In terms of SAR processes, several SABs commented that they were now distinguishing between mandatory and discretionary reviews (the criteria in Section 44 Care Act 2014), had provided training for reviewers and IMR writers, and/or were making greater use of the SCIE quality markers. Some had quality assured their commissioning of reviews and, where found necessary, had revised their procedures. There were references to having escalated SAR recommendations nationally through NSCN to DHSC, and also to making use of the SAR library.

Other SABs had used the findings to inform their audit priorities and to focus on specific practice areas, such as homelessness or self-neglect. The findings had also been used to review safeguarding practice and to enhance their learning and development provision. There were also references to working with colleagues in ADASS and/or CQC on specific issues, for example out of area placements and models of care.

Some SABs had used the findings to review and enhance their policies and procedures, for example on when and how to convene multi-agency risk management meetings, or to ensure recognition and responses to protected characteristics, or to establish a process for investigating alleged abuse by people in positions of trust.

Finally, there were occasional references to working regionally to collate and disseminate learning, or to engaging with universities on research projects, or to working with third sector organisations.

Nonetheless, one SAB was sufficiently candid to acknowledge that “this is an area for development.”

Use of SCIE Quality Markers

90 respondents commented on using the quality markers, with references to inclusion in commissioning practice, SAR panel meetings, quality assurance of reports and learning events. There were references to their inclusion in policy and in guidance when setting up a review, then managing it, and when considering review impact and outcomes. Some respondents described at length their SAR procedures and how these aligned with the quality markers.

“As a checklist when setting up the review to ensure all key elements (referral, decision-making, clarity of purpose, etc.) are addressed from the start. Guide decision-making – Apply when deciding whether a review is needed, its scope, and how it will be commissioned.”

“Monitor progress during the review to check that the process remains timely, respectful, and focused on learning. Quality assurance at the end of the review, revisit the markers to confirm that standards were met and identify any improvements for future reviews. Promote learning culture – Share with partners and practitioners.”

“To ensure clear, meaningful improvements, including checking that findings and recommendations are written clearly, evidence-based, and focused on learning rather than blame, ensuring reports are accessible and transparent. To guide the development of action plans so that actions are specific, achievable, and directly linked to the learning identified in the review. And applied to implementation to confirm that actions have been completed and have made a real difference to safeguarding practice and outcomes.”

“We have a checklist we use at each stage to ensure we have met the expectations in the quality markers.”

Governance process and models for SARs

98 respondent offered free text comments under this heading. There were quite detailed descriptions of the systems in use. From their descriptions it was not always clear where the locus of decision-making lay when considering whether to commission a mandatory or discretionary review. Some SABs reported that they generally used one specific methodology, such as reviews in rapid time or the Welsh model.

"Referral to SAR panel, Scoping of relevant information, reviewed at panel and decision made based on Care Act 2014 section 44 thresholds, outcome shared with SAB chair, quality process undertaken, uphold decision or discuss at executive."

"The referral comes to the business unit and is sent for scoping; there is then a multi-agency panel meeting to review the referral and multi-agency chronologies against the criteria and a multi-agency decision made on next steps. This is sent to the statutory partners for ratification and final decision and this decision is then reviewed by the independent chair for final sign off."

"The referral is presented to the SAR Subgroup for consideration and agreement. If approved, an author is identified and a panel is established. The Terms of Reference and Key Lines of Enquiry are discussed at the SAR Subgroup before being agreed by the Independent Chair. The panel then completes the report. The final draft report is presented to the SAR Subgroup for agreement, after which the Independent Chair undertakes a final quality assurance review prior to ratification by the SAB main board. (Please note: this process may vary depending on the methodology used.)"

"The adult and/or their family/representative should be consulted when deciding how to complete the review, so that they can be as involved as they wish to be and to ensure that their views are considered and recorded in the Terms of Reference."

"A practitioners workshop event will take place with frontline professionals directly involved in the case."

"In terms of sign off, the report is signed of in this order: panel, subgroup (and independent chair comments), senior officers, and the main Board. Families see the learning and panel stage and again at final stage."

"SAR author invited to present to the full SAB and to produce a 7 minute briefing."

"The partnership has a Safeguarding Adults Review protocol in place as well as a Coroners Annexe which was agreed with local HM Coroner several years prior to the National Business Managers Coroner Guidance issued. The partnership has SARs as a standing agenda item for board meetings and updates are provided of progress along with a SAR dashboard. The recent development session ensured oversight from the partners on the dashboard which suggested activity to take forward for 2026-2027. The panel arrangements act as a sense check for submitted reports and the partnership unit take a role of ensuring the quality of reports are appropriate along with any potential legal elements are addressed. The partnership will receive the final drafts with opportunity for all board members to raise queries and/or concerns, as part of the accepting/endorsing of reports. The partnership continually reviews ways of working and changes to its practice as part of its improvement journey each year. Resource need for SARs and current activity is significant."

Review challenges

Understanding the areas that are presenting difficulties with delivering SARs to publication is important for providing support and driving improvement. The 2023 survey did not report on the challenge of finding and commissioning reviewers but clearly this represents a significant challenge. Compared with the 2023 survey, there has been an increase in moderate challenges with respect to consultation with families, disagreements on recommendations and author disagreements. An increase has been reported in challenges to a great extent with respect to interfaces with other processes. However, a reduction has been reported in challenges involving the quality of report writing.

Challenges in delivering SARs to publication	Sum of responses	To a great extent	To a moderate extent	To some extent	Not at all
Finding and commissioning reviewers	106	15%	29%	32%	24%
Lack of cooperation from voluntary/third sector agencies	104	0%	8%	14%	78%

Lack of cooperation from statutory agencies	103	1%	4%	19%	76%
Disagreements on recommendations	104	1%	13%	49%	38%
Quality of report writing	105	3%	17%	57%	23%
Consultation with families	104	2%	12%	41%	45%
Author disagreements	104	1%	8%	36%	56%
The interface with other processes e.g. the Coroner and Independent Office of Police Complaints	104	8%	9%	22%	62%
Other	20	30%	40%	20%	10%

Free text observations give further insight into the challenges that SABs face, especially with reference to funding and agency co-operation.

“We try to share funding but agencies don't comply with this and the Local Authority bears the majority of costs.”

“Refused to engage in SAR screening - nothing we can do - needs national consideration.”

"We have started recording in a focused way timeframe for each stage of the process, so we can evidence where delays are creating an issue.”

“Lack of funding is impacting greatly.”

“Quality of independent authors.”

“Determining SMART actions.”

Mindful of resources (see the subsequent section on funding in this report), SABs were asked to quantify the amount of time (person hours) spent on SARs in the last year. 97 responses were received. Some SABs were unable to quantify the time spent and clearly some refinement of the question will be necessary if included in the next survey..

“This is un-measurable - the people involved in SARs include all panel members, front line practitioners, managers and strategic leads.”

“This is very difficult to estimate. Each SAR goes through a comprehensive triage process with a summary produced for the SAR subgroup and the referrer(s) also attend these meetings, further information is often requested from agencies involved before a final recommendation is made to the Independent Chair and a further summary written up for the Chair. Each SAR involves a great deal of work by the SAB including arranging learning events, working with the reviewer on the final review report, developing learning briefings and any resources identified in the recommendations, and progressing the action plan until it is complete.”

"It's not clear what elements are to be included in this question - is this partner times, IMRs, panel meetings, subgroups, learning events, SAR action plan?”

“Unable to quantify - each member would have different times scales of involvement dependent on how involved their agency was - each organisation contributes to the panels, and 3 people from the Board business unit progress the SARs, setting up panels, practitioner events, seeking information, and planning – it is extremely time consuming.”

“The how much time question is difficult to answer as we don't know how much time individual Board members will have spent. The SAB Chair will routinely spend one day per SAR and the ICB rep who Chairs the SAR Subgroup may spend as much as 15/20 days per year. The SAR Subgroup meets a minimum of quarterly and members attend this meeting as well as contributing to SAR responses if needed which is a significant amount of additional days. Each commissioned review will have a minimum of two additional extraordinary meetings as well as regular panels and practitioner events which all agencies are required to support. If we were to include all the time taken to embed learning and develop materials, this is a significant amount of additional days for all agencies.”

Considerable caution should, therefore, be attached to the estimates that were given but what is clear is the amount of resource taken up in delivering this statutory duty. Estimates of days spent included 377, whilst estimates of hours ranged up to 3000.

"SARs seem to predominate the work of the SAB."

Not every SAB reported experiencing challenges but those that did were invited to describe how they had tried to overcome them. The SAR reviewer community of practice had been helpful in finding potential reviewers and some SABs had also "*grown their own*." Nonetheless, challenges remained, especially in commissioning reviewers with specialist expertise.

Section 45 Care Act 2014 had been used in an effort to ensure agency co-operation but the number of reviews was acknowledged as placing a high demand on the capacity of services to respond. Training and mentoring had also been offered to support agencies to provide chronologies and management reports.

Negotiations with reviewers could prove challenging when discussing the quality of their reports or their framing of recommendations. There were occasional references to ending contracts with a reviewer when agreement could not be reached, as well as strengthening the commissioning process by evaluating the quality of their prior work. Disagreements between partners were acknowledged as sometimes generating "*healthy challenge*" and occasionally inclusion in final reports of references to where there were divergent views.

Some SABs reported difficulty in engaging Coroners whilst others had agreements in place. Negotiations could be complicated when determining how to proceed, for example whether to wait for the outcome of the inquest and how to manage a process focused on learning when a Coroner was delaying an inquest until the SAR was available.

Finally, there were references to the importance of time and relationship-building with families, for example when their expectations might differ from the SAR focus on learning.

Does your SAB routinely share SARs with the SAR library and complete the SAR form?

	Number	Per cent
Yes	96	90%
No	11	10%
Total	**107**	**100%**

One SAB commented that ensuring submissions to the SAR library was “*an area for development*.” Another described the process of submission as “*onerous*” and “*not easy to complete*.” It is worth noting that SABs can either send the SAR publication itself for inclusion and/or can complete a template that identifies three main themes from the review and provides a weblink.

Funding

The care and support statutory guidance, at section 14.105, advises that: “*Members of a SAB should consider what assistance they can provide in supporting the SAB in its work. This might be through payment to the local authority or to a joint fund established by the local authority. Members might also support the work of the SAB by providing administrative help, premises to meet or hold training sessions*.” In a current context of financial austerity across statutory services, with the addition of significant reductions in operating costs being required of ICBs, this statutory guidance is arguably relatively weak.

Just over half of the SABs that responded to the survey said that they were funded by contributions of different amounts from a range of members. This represents a marginal reduction from the 2023 survey where the figure was 60%. Additionally, 29% recorded that they were funded by the statutory partners in a three-way split of equal amounts.

How is your SAB funded?

	Number	Per cent
A three-way split between the statutory partners	31	28%
Contributions of different amounts are received from a range of members	59	54%

There is no budget as such	2	2%
Other (please specify)	17	16%
Total	**109**	**100%**

“Other” responses mainly recorded that the split between the statutory partners was unequal, with local authorities contributing the majority of funds and resources such as equipment and office space. Occasionally there were references to other partners making smaller contributions. There was one reference to a combined partnership that did not separate contributions for the SAB, community safety partnership and safeguarding children partnership.

	Average % contribution	Maximum % contribution
NHS ICBs	21.34	47.00
Police	8.86	35.00
Local authorities	47.76	90.00
Other partners	1.59	50.00

Given the reference to financial austerity and known current or forthcoming budget reductions faced by statutory and other partners, SABs were asked to indicate changes in funding since April 2023. 103 SABs responded to the question with respect to statutory partners, whilst 22 answered the question with respect to other partners.

Partners	Funding has increased greatly	Funding has increased somewhat	No change	Funding has decreased somewhat	Funding has decreased greatly
NHS ICBs	5%	19%	67%	7%	0%
Police	2%	17%	77%	2%	0%

Local authorities	11%	32%	53%	1%	1%
Other partners	0%	5%	50%	5%	23%

As in the 2023 survey, the majority of SABs indicated that there had been no change in the levels of funding from the three statutory partners. Some SABs had seen increased funding from these partners, at slightly higher levels since the 2023 survey reported. 43% of SABs reported increased funding from local authorities, an increase from 29% reported in the 2023 survey, and 24% from ICBs, and increase from 15% reported in the 2023 survey. There has been a decrease in the percentage of SABs reporting reduced funding from local authorities (7% in 2023 to 2%). The figure for ICBs remains the same as reported in 2023. Probation and fire and rescue services were mentioned as “other partners” where funding had been withdrawn.

The following observations from SAB chairs and business managers illustrate that local authorities are the principal funders, and that future funding levels feel uncertain.

“Police funding is extremely low considering they are a statutory partners. With changes to ICBs we are unsure what funding will be in the future.”

“No additional funds for inflation.”

“We are largely funded by the 3 statutory partners. We seek small contributions from all our other members which are ringfenced for training. We receive variable amounts each year (3% last year).”

“As Independent Chair a regular ask is shared with partners to consider uplift and increased contributions. The local authority has continued to uplift its contributions, in addition they have further support the resource needs of the partnership with additional significant investment in further staff resource. The police have uplifted by 1 per cent several years ago. There is no government funding stream available to boards and we are reliant and grateful to our partners for their continued commitment; however funding is not equitable.”

"Annual expenditure totalled £118,050, with the shortfall of £39,250 covered by the Local Authority. So therefore the local authority covers 65% of the total funding required."

"The ICB funds pay for the administrator. Police funds cover cost of website and some materials. LA pick up remaining costs."

"Not had any information from ICB about how the NHS reforms will impact, but have received an indication it is likely to decrease."

"The LA has provided additional funding to support additional capacity in the provision of multi-agency learning and development and in the management of SARs and the monitoring or recommendations, learning and outcomes."

What does the funding pay for?
Number of responses to this question: 106

	Number	Per cent
The salary of the Chair	101	95%
The salary of the Business Manager	95	90%
Other staff resource	92	87%
Other initiatives	81	76%
Other	63	59%

Besides salaries, SABs mainly referred to funding paying for SARs. There were occasional references to multi-agency training, learning and development, development events and away days, costs for updating procedural manuals and the purchase of promotional materials, and the maintenance of websites. Local authorities were often providing the budget for initiatives such as audits and specialist posts.

"In addition to the baseline budget Adults Social Care are currently funding a Complex Adult Risk Management lead for one year. This was previously funded equally by the three statutory partners."

Please describe how SARs are funded.
Please select the option that most closely fits.

	Number	Per cent
The SAB budget has funding set aside for SARs	85	78%
Funding is sought from partners each time there is a new SAR	5	5%
Funding is sought from key statutory partners and the expectation is this is split equally three ways	5	5%
None of the above	14	13%
Total	**109**	**100%**

SARs were observed to be "an increasing cost pressure" and, as the following quotations illustrate, there are challenges in ensuring compliance with this statutory duty.

"The Business Unit is too small and there is a significant need for increased funding to increase unit capacity to support our statutory functions. SARs have increased massively for a variety of reasons. A significant contingency fund has cushioned this; however this is also unsustainable."

"We do not have enough resource to cover the number of SARs and then other desirable activity."

"Ongoing uncertainty year on year of funding level and of whether SAR activity will be supported."

"SARs are forecast and funding included in initial budget split between the statutory partners as per unequal percentage split. Overspend on SARs requires ad-hoc requests with a similar structured split."

"We try to seek funding from partners but they rarely provide anything or anything in kind."

“SARs are funded through the SAB budget which is made up of contributions from partners, however given there has been no increase in contribution and more SAR activity the budget is now stretched and the SAB will need to think more creatively about how SARs are commissioned or look at further funding agreements.”

“Having to find innovative, less costly ways to run SARs.”

In conclusion, not all SABs reported concerns about current funding levels and arrangements. However, numerous concerns were expressed about inequity funding when compared with investment in safeguarding children partnerships, and about a SABs ability to meet its statutory duties and sustain its broader mandate to seek assurance about and enhance the effectiveness of adult safeguarding.

“Underfunded when compared with SCP.”

“LAs are generally under huge financial pressure, and are curtailing the multiagency training programme that the SAB used to run and looking to partners to contribute (no additional funding offered so far) or seeking offers "in kind" to share training.”

“Limited opportunities to develop work to deliver strategic ambitions as a very small team.”

“Given the number of SARs currently in progress the small reserve budget that was held will be depleted by 2027; face to face events cannot be considered due to cost impact.”

“The budget has not changed in 10 years. If this doesn't change in the next 1-2 years the current level of staffing, including for the Independent Chair, will be unsustainable. The SAB is already overspending and the local authority is absorbing this because it is relatively small (under £10k), but when this increases it will not be acceptable. We cannot progress discussions on this at present because of the uncertainty with ICB's.”

“Funding has remained the same, but has not increased with inflation therefore overall the SABs have less in real terms.”

“The lack of funding increases from the ICB and Police have meant that our previous budget surplus is reducing. We are very careful in terms of what we fund, such as learning resources, etc and look to develop these internally wherever possible.”

Recommendation Six: NSCN should continue to identify specifically the impact on SABs of policy decisions relating to ICBs and generally the weak clause in the care and support statutory guidance on ensuring that SABs have sufficient resource to comply with their statutory duties and mandates.

Multi-agency Policies and Procedures

Adult safeguarding is commonly stated to be “everyone’s business, hence the importance of all the agencies involved operating within standard policies and procedures. Some regions or sub-regions have developed policies and procedures in common, either spanning adult safeguarding in its entirety or focusing down on specific types of abuse/neglect, such as self-neglect or investigations of organisational abuse. The breadth of adult safeguarding is illustrated once again in survey responses to the question on multi-agency policies and procedures. Quite striking, however, is the number of SABs reporting that there is no multi-agency policy or procedure in place, for example for supporting people to engage, addressing exploitation, or responding to concerns about organisational abuse.

Partners	SAB has its own policy/procedure	SAB has adopted a regionally agreed policy/procedure	There is no multi-agency policy/procedure in place
Multi-Agency Safeguarding Adults (MASA) policy and procedures (n=107)	51%	45%	4%
Information Sharing Protocol (n=108)	64%	31%	5%
Resolving professional disagreements / escalation procedure (n=107)	81%	16%	3%

Person in Position of Trust (PIPOT) (n=104)	69%	24%	7%
Multi-Agency Risk Management (MARM) or equivalent (n=98)	70%	12%	17%
Cuckooing (n=99)	39%	21%	39%
Supporting people to engage (or equivalent) (n=94)	44%	14%	43%
Organisational abuse or equivalent (n=101)	48%	31%	22%
Exploitation (all-age) (n=89)	29%	22%	48%
Exploitation (children) (n=75)	27%	31%	43%
Exploitation (adults) (n=84)	36%	26%	38%
Decision support tool or equivalent (n=94)	63%	16%	21%
Other (n=42)	74%	24%	2%

The breadth of adult safeguarding is further illustrated by the "other" comments provided by survey respondents. There were references to multi-agency policies and procedures on self-neglect and hoarding, transitional safeguarding, medication incidents, allegations against people in positions of trust, risk assessment and management, "*was not brought*" or non-engagement, professional curiosity, thinking family and domestic abuse.

Learning and development within SABs

SAB chairs have an obligation under the care and support statutory guidance to remain up-to-date with and to promote good practice. Survey respondents were asked to describe how chairs identify and access support to meet this requirement.

In the last two years, have you used any Partners in Care and Health resources and tools or attended any webinars?
Number of responses to this question: **98**

	Number	Per cent (of those responding to the question)
Attended a webinar	88	90%
Used our website for information	76	78%
Downloaded / used a tool developed by PCH	46	47%
Other (please specify)	11	11%

"Other" contributions referenced webinars organised by PCH (for example, on exploitation, preparation for CQC assessment, homelessness and missing adults) and/or ADASS regionally, and research reports and briefings published by the Local Government Association (making safeguarding personal toolkit, and second national analysis of SARs, for example) or Research in Practice. Also referenced were NSCN meetings.

"Through Chairs Network. Chair is a registered social worker and receives updates from regulator."

"Information sent through the National and Local SAB chairs networks, personal reading and research."

"The Chair meets Care Act statutory guidance requirements by routinely reviewing national guidance and SCIE resources to remain up to date with developments in case law, research, and good practice. She actively engages with national and regional networks and subscribes to specialist updates from SCIE, RiPfA, and legal briefings to ensure timely and relevant information. By prioritising ongoing professional development through training, webinars, and conferences, she maintains a high level of knowledge and expertise. Working closely with the Board Manager and subgroups, she helps collate, interpret, and disseminate learning across the partnership. Additionally, she seeks peer support through reciprocal reviews and mentoring with other SAB Chairs to share insights, strengthen governance, and embed a culture of continuous improvement."

"Subscriptions to journals, including those covering case law. Weekly notifications of LGSCO decisions."

“These have supported horizon scanning and strengthened understanding of national practice expectations.”

One respondent commented as follows: “*Need to consider use in future.”*

A follow-up question asked respondents to describe how the SAB itself engages in learning and development across the local system. Here respondents referred to participation in adult safeguarding week, organising multi-agency learning events and targeted development sessions, and monitoring training data. There were references to disseminating learning, for example from SARs, via e-learning packages, podcasts, videos and seven-minute briefings. Some of this work was undertaken jointly with safeguarding children partnerships and with third sector organisations.

“The partnership hosts a trainer network attended by the statutory and relevant partners and officers with a role in learning and development. That network consults upon key partnership training core offers and a range of resources published on the board website, for example, MCA resources. There are also links with wider agencies such as providers through a non-confidential trainer network where key information is shared and communicated with partnership contribution to a range of provider forums and registered manager networks which act as a two way communicative link. As Independent Chair I have an active role in the development and delivery of key training initiatives for example, toxic cultures.”

“Multi-agency practitioner forums - learning from good practice examples.”

“Produce a quarterly national policy developments document which includes policy updates locally and nationally and includes its impact on SAB- further explored where required.”

“Have a learning and development part time officer recently appointed in place and they are developing our programme and coordinating learning sessions / mechanisms; SAB partners are sharing their learning and training sessions as much as possible.”

SABs were also asked to describe how learning from SARs is promoted. Once again, webinars, lunch and learn sessions, seven-minute briefings and conferences were prominent amongst the answers. SABs also reported using audits and assurance reporting, progress summits and scanning SARs published by other boards.

“Revisit learning 6 monthly and Actions.”

“We undertake thematic SARS that look back at previous learning, We undertake bespoke activity re learning from SARS.”

“Development of tool to track actions and outcomes.”

“Standing agenda item on SAR Subgroup to look at national SARs and what we might need to consider locally.”

“Use of case studies and building a thematic picture by reflecting back on SARs within each actual review.”.

“We complete an assurance template at the end of the process to measure impact and see what has worked and what has not. This is reported into the SABs.”

“A piece of work is being undertaken to identify common themes from SARs, DARDRs/DHRs, CPSRs and LeDeRs locally to consider joint learning activities and opportunities.”

“Messages are shared via the North East Safeguarding Adults Review Champions Network and updates are provided at each North East ADASS safeguarding leads network. Individual boards also have opportunity to share key messages from local and regional reviews ... Locally we have started to explore impact monitoring and linked the domains emerged from the second SAR analysis. Our self-assessment exercises which are completed on a biennial basis also include key questions for partners on how they have embedded learning with their own organisations. Our self-assessment activity will inform the priority setting discussions at the January development session and the future strategic plan revision.”

SABs were asked to indicate what PCH resources had been accessed, including attendance at webinars. 90% of respondents reported attendance at webinars, 78% had used the PCH website for resources, and 47% had downloaded tools. There were occasional references to the need to consider using these resources in future.

“Amongst other resources, we have used: i) The two national analyses of SARs. ii)The collated set of resources on organisational abuse iii)The paper on carers and safeguarding iv)Making Safeguarding Personal in self-neglect tools v) work on making safeguarding personal for commissioners and providers vi) Work on website on building confidence on what is a safeguarding concern vii) MSP myths. Use this website regularly. It is a very much valued resource.”

“Peer review”

“The PCH website is used regularly as a source of updated guidance, sector-led improvement materials, SAR resources, and practice tools. This supports continuous professional development and ensures alignment with national best practice.”

Questions from the Home Office

What challenges do local authority safeguarding adults leads face contacting the Home Office when a Safeguarding Adult Review (SAR) is required due to a serious safeguarding incident?

There were few detailed answers to this question, most respondents either responding that they had no experience here or entering not applicable. Detailed answers referred to a lack of response to the issues highlighted, length of time responding, lack of clear governance for escalation and lack of clarity as to the named accountable person.

“Lack of clarity of who deals with what in the Home Office in relation to SG and the exploitation of overseas workers.”

“Having the right point of contact can be challenge.”

“There are no challenges currently that we can reflect. The current SAR referral form has been updated to reflect when a case falls within for example migration or border force involvement that the partnership should liaise with the home via their dedicated safeguarding mailbox.”

“Relationships require further development.”

There were few detailed answers to the Home Office's second question.

How would you describe the quality of adult safeguarding referrals made to you by the Home Office?
Number of responses to this question: 98

	Number	Per cent
Excellent	1	5%
Good	0	0%
Acceptable	13	62%
Poor	7	33%
Very poor	0	0%
Total	**21**	**100%**

"There does appear to be a lack of understanding about the SG criteria in relation to care and support needs or the appearance of these, and about what the LA Safeguarding Team's remit is in relation to case management.."

"Referrals could be improved by providing clear context, focusing only on cases that meet safeguarding criteria, including relevant details and current risks, and ensuring Home Office staff have sufficient safeguarding awareness and guidance on when and how to refer. This would make referrals more actionable, targeted, and effective in protecting individuals at risk."

"We usually only get operational referrals for safeguarding for suicidal failed asylum seekers, who are usually not know to services and for whom we have no contact."

"Improved understanding of the Care Act and localised relationships between partners."

"We are in the process of commissioning a rapid review that will require HO input but it is too early to say. However, this wasn't referred as a s44 by the HO when perhaps it should have been."

Question from the Independent Safeguarding Chairs' and Scrutineers' National Forum

In order to better understand any difficulty in accessing views from the voluntary sector, are there any recognised representative groups of voluntary or independent providers in your area?

	Number	Per cent
Yes	91	92%
No	8	8%
Total	**99**	**100%**

NSCN has established a relationship with the national forum of independent safeguarding chairs who represent third sector organisations. A few respondents recognised that this was an area for improvement. In the main, however, answers detailed the relationships that had been established either directly with third sector organisations or indirectly through commissioning and/or Healthwatch.

"Healthwatch part of the SAB."

"Voluntary groups have been engaged with the Board for some time. Recently they have been constituted into a scrutiny group looking at the work of the SAB."
"Age UK and disability positive are members of the board and sub groups. They chair our Community Engagement subgroup - regarded as a real strength of the Board."

"Membership and attendance at SAB Board, Executive and in subgroup. Involvement in development of new policy, procedure or tool (e.g. current development of Safeguarding in Faith Toolkit and website). Involved in audit activity and challenge events. Collaboration in engaging with voluntary sector and adults / carers supported by voluntary sector organisations."

“Voluntary partners are members of subgroups and there is a specific community and voluntary sector-focused subgroup.”

“Not routinely except MIND. Invitations to conferences. Newsletters circulated.”

Questions requested by the Department of Health and Social Care

Has the announcement of ICB reform had any impact on current or future planning? If so, in what way?

NSCN has raised concerns about the proposed changes with DHSC and with HNS England. There were 104 responses to this question. Some respondents recognised the continued engagement of ICB colleagues in order to maintain stability during this transition period. However, every respondent reported either immediate concerns and impact, or anticipated concerns and impact. They cited concerns about funding and statutory compliance, uncertainty about future capacity and strategic support, and inequity in the priority within ICB reform given to adult safeguarding as opposed to the safeguarding of children.

“Uncertainty of future of safeguarding partnership working and structure of the health sector in terms of who it is reporting to. This could have a major impact on the ability of the SAB to be able to work in partnership with the health sector.”

“Yes, reduction in resources in the ICB will impact their ability to contribute to the partnership. Loss of [sub-group] chair, loss of knowledge and expertise.”

“Yes it has had an impact on future planning as there is a complete lack of clarity on how SG will be managed in the future.”

“Yes, regular updates provided by ICB colleagues. ICB colleagues no longer able to lead partnership work. Further impacts not yet understood.”

“The prolonged lead in time for yet another structural change in the NHS has created some inertia within the system. There is a sense amongst partners that the regularity of personnel changes from the time that Clinical Commissioning Groups ceased to exist has caused some fragmentation in working arrangements. Service quality must be considered in conjunction with safeguarding

responsibilities and the ICB should be resourced adequately to monitor key contracts where care is being delivered by the NHS as well as independent health providers so ensuring that quality concerns can be acted upon before developing into something much more serious. Furthermore, safeguarding is not limited to the operational functions of Trusts and the input of the local ICB is crucial to the work of the Safeguarding Adults Boards to support some of the challenges that exist within a multi-agency arrangement across all forms of abuse and commissioning and provider functions."

"Created uncertainty about future arrangements for statutory safeguarding duties from the NHS. There has been staff sickness, and a much depleted resource locally. Arrangements remain unclear. National NHS guidance has focussed largely on child safeguarding and neglected to comprehensively make recommendations for adults."

"The situation has caused unrest within the ICB, which is affecting the efficiency of engagement. There is widespread concern among staff about potential job losses, contributing to uncertainty and reduced capacity for collaboration."

What recommendations for improvements do SABs want to see the CQC LA assessment framework process, and what can be improved?

NSCH has been collating and will continue to gather recommendations from SAB chairs based on their experiences of CQC assessment. This evidence will be discussed at future NSCN meetings and with both CQC and DHSC civil servants.

Fifty seven SABs responded to this question, with several providing more than one recommendation. There was some acknowledgement of improvement as assessments have progressed, with more recent visits appearing more informed and focused. However, there was considerable overlap in the recommendations:

- Improved timescales (7)
- Greater consistency (14)
- Reduction in the amount of required documentation and improved transparency about what information is being requested and why particular questions are being asked (4)
- Involvement of SAB business managers and SAB partners (8)

- Standardised questions and assurance measures used by inspectors for SABs, and greater clarity of evidence used for assessment and judgement (8)
- Improved understanding of SABs and their functions, and recognition of the multi-agency nature of adult safeguarding, both operational and governance (24)
- More detailed inspections to consider to consider thematic issues (3)
- Greater triangulation of evidence, of what individuals tell inspectors with case file audits and direct observation, to understand practice (8)
- Removal of points based system and single word judgements, and greater reliance on triangulation (7)

“We appreciate the importance of speaking with front line staff and understand why their contributions are valued. However, in addition to those discussions we feel there was a missed opportunity to have gained valuable information from conversations with operational and middle managers from the local authority. If the purpose of the local authority assessment process is to look at the LA’s effectiveness in commissioning and providing adult social care services with everything that entails, then it would appear somewhat limited simply to interview the Chair of the Safeguarding Adults Board in relation to the interface with the Council’s statutory adult safeguarding/social care responsibilities. I would suggest therefore that along with operational adult protection staff discussions take place with key personnel from the business unit including Business Managers, Partnership Review and Learning and Development Officers.”

“Clarity about what is LA and what is SAB responsibility as part of inspection.”

“Any authority identified as Inadequate should be informed immediately as soon as the assessment has been completed. This will allow for immediate improvements and safeguarding where appropriate.”

“Appears to have less focus on the partnership (holistically) and more so just on the LA itself, which does not lend itself to capturing the nature of safeguarding in partnership.”

“Understanding or the independent role of the SAB and how this differs from the LA responsibilities in safeguarding practice.”

"Clearer guidance on what constitutes “strong evidence” for each domain and reduce subjectivity by using more standardised indicators and templates across local authorities.”

“The removal of single word outcomes and the ranking of local authorities raises concerns about fairness. These assessments often rely on professional judgment, which can introduce subjectivity. I believe the inspection process would benefit from a review to ensure greater consistency and transparency across local authorities.”

“Less reliance on stories of single agencies or individuals.”

What are your views about an independent scrutineer role in addition to or instead of an independent chair position?

Some respondents expressed support for the role of independent scrutineer, either instead of an independent chair or, less often, in addition. However, the majority of contributions favoured retention of the role of independent chair, especially when this role incorporate the challenge arising from scrutiny. There was a recognition of the need to research outcomes of the role of an independent scrutineer in both safeguarding children partnerships and in those SABs that have a model of a statutory partner chair with an independent scrutineer.

“We have an independent scrutineer instead of a chair and would recommend this for other SABs.”

“I think this where the direction of travel is heading to and figureheads are not really needed anymore as Boards are now more mature and there is a lot of experience with SAB managers. We have asked the new chair to be more of a scrutineer, so I think they can be combined.”

“SAB have an Independent Scrutineer and this provides challenge outside of the three statutory partners. As a member of the Chairs Network they also bring a national perspective and support looking at things independently and asking questions. There is an additional cost to the board on top of the board team so this is factored into the HSAB budget each year. The role of Independent Scrutineer is different from that of a Chair and this could be further explored to create consistency on this role.”

“Yet to fully understand the implications of this in the children's world.”

“I don't think that both roles are required. My experience of the Children's' Partnership scrutineer is positive but she undertakes specific pieces of identified work only, meaning that the statutory agencies chair the Partnership on a rotational basis. This is not independent in the way the SAB chair is.”

“I work in both adult and child boards. I think that the replacement of the chair for a scrutineer would be a significant backward step and should not happen. I definitely feel it would lessen the significance of the board and limit the appreciation of the public as to its independence. What would be great is for funding to be increased slightly so that scrutineers could be hired to undertake specific pieces of scrutiny.”

“Resource implications. Varying degrees of success in children's arena in relation to Scrutineers.”

“Duplication as the chair fulfils that role anyway.”

“Still monitoring the role as set out in Working Together, however whilst we retain an independent chair, the role of scrutiny seems to fit with that independent oversight. If you had independent scrutiny as well it would increase the cost at a time of limited funding.”

“The IC is critical to leading the partnership while remaining independent of the agencies involved.”

“The IC have a clear core function to ensure priorities and statutory duties and improvement plans are delivered. We do not feel that a Scrutineer role in addition would be necessary as the partnership is effective in evaluating and being accountable for achieving impact. If IC role were to be removed then the scrutineer role would need to be put in place to provide independence and transparency. Not necessary as independence is provided by the chair.”

“The Independence of the chair is important to ensure that partners are working effectively together but a Chair that will undertake scrutiny as part of that role brings a greater level of independent assurance. Both roles can be done together.”

“Currently the legislation does not require an independent chair; however we have one because it is important for the independence. We feel it is important that this continues so that challenge can take place and independent decisions are made. As it is now, SABs can commission additional scrutiny as they see fit and the requirement for a particular role for this is not needed. Things work well as they are. Partners views are that the Independent Chair role is working well so there is no need for change.”

“The independent chair role is preferrable and offers a lot more for adult safeguarding. It would be good to see funds available for the commissioning of small pieces of scrutiny and for the commissioning of scrutiny to be more common place. The independent chair role is also a great source of support for the SAB Business Unit.”

“As Board Manager, I support the Independent Chair position and would not wish to have an independent scrutineer instead. The Chair provides the required level of accountability and independence. Provides greater confidence to the public and agencies. They are also a key point for escalations to be considered and resolved. I feel this role would be diluted with a scrutineer.”

“Have worked in systems with both for the adults arrangements but where it’s a scrutineer ASC decisions tend to dominate the partnership decisions without an independent Chair to provide balance.”

“A dual model (i.e. a joint role of Independent Chair + Scrutineer) provides the greatest value. It combines strong system leadership with independent, objective oversight. This creates a healthier safeguarding culture.”

Recommendation Seven: NSCN should undertake a research project on the different leadership and scrutiny approaches adopted by SABs to ensure compliance with statutory duties and mandates.

Looking Back and Focusing Forward

The outcomes of the recommendations from the previous survey have been reported at the beginning of this report. Reviewing the data from this survey, the work of NSCN’s task and finish group on involvement with people with lived experience remains a key priority. The qualitative data from this survey will be shared with that task and finish group in order to facilitate its further work.

This survey has reported on SAR activity since April 2023, thereby offering the only update currently available on the types of abuse/neglect being reviewed, themes emerging from SAR findings, and the volume of activity. The survey has reported on how SABs are endeavouring to ensure quality reports and to embed learning into practice and service development. Among the priorities that survey respondents wished to draw attention to for the Network focused on SARs, for example how to manage referrals from individuals and/or their families, how to select methodologies that enable a SAB to build on prior learning and to manage the volume of activity, and how to capture the outcomes of learning. NSCN, along with NBMN, has supported two task and finish groups, whose work on best practice across the SAR domains of direct practice, team around the person, organisational support for practice and governance, and on approaches to demonstrating SAR impact and outcomes will be completed by the end of March 2026 and formally launched at a conference in May. An Essential SAR Guide will also be formally launched at this conference. NSCN continues to engage with DHSC on implementation of the service improvement priorities from the second national analysis of SARs and on escalation to the department of specific recommendations from individual reviews.

An improvement priority from earlier surveys was to develop tools for data collection and analysis. The network's website contains some tools that have been developed and this survey has enabled the collation of examples of how SABs are responding to the challenge of analysing performance and the effectiveness of adult safeguarding. However, there is more to do to complete recommendation four from the last survey, not least to enable SABs to demonstrate the added value of their work, and this will need to be factored into NSCN task and finish group activity for 2026/7.

A joint NSCN/NBMN tsk and finish group has produced an analysis of the Care Act 2014. This report will be formally launched at the in-person conference in May 2026. It will provide a basis for ongoing discussions with civil servants in DHSC. It will also infirm our discussion with, and submissions to the Casey Commission about adult social care and adult safeguarding, and with CQC and DHSC about the future shape and scope of local authority assessment.

NSCN works closely with PCH, especially through several expert reference groups that also include other partners. Those on transitional safeguarding, organisational abuse and homelessness clearly align with priorities that survey respondents wanted to draw attention to nationally. NSCN has established a project on engagement and continues to support a task and finish group on engagement with prisons. Survey respondents also identified these as priorities for national work.

The breadth of adult safeguarding has been observed throughout this survey report and is illustrated again by comments on SAB priorities for NSCN's attention. These include out of area placements, all age partnership working (for example around exploitation), cultural competence, professional curiosity, self-neglect, mental capacity assessment, discriminatory abuse, and domestic abuse. NSCN will need to identify where it can signpost SABs to existing resources and where additional task and finish group activity might be indicated.

Conclusion

The network remains in a strong and stable position, with its legal status confirmed and with subscription income enabling it to invest in supporting its members and in sector-led improvement priorities. The outcomes of this survey will enable the Network to redefine its strategic priorities for the coming two years and continue to support the membership in specific areas with issuing briefings for SAB Chairs, as well as to lobby nationally with government and other agencies for changes and updates to policy and regulation. However, as survey data indicates, these are challenging times for the governance of adult safeguarding, with ICB reforms, local government reorganisation, and funding all contributing to uncertainty and complexity. Importantly, therefore, NSCN is initiating discussion with members on how best to support SAB chairs going forward.

The length of this survey meant that it took quite some time to complete. NSCN will need to review the clarity of some of the questions that have been asked and to determine what the Network really needs to know from the next survey.

Appendix

TO INSERT APPENDIX WITH THE SURVEY QUESTIONS