Safeguarding Adults Executive Board

ANNUAL REPORT

2024–2025

Thriving Together

Collaborating for Safeguarding Excellence

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Safeguarding Adults Executive Board

City of Westminster

My Journey to Becoming a Safeguarding Ambassador

Jackie James

Caseworker at Carers Network and Safeguarding Ambassador

Hi, my name is Jackie James, I am a Caseworker at Carers Network, and I am delighted to share my journey of becoming a Safeguarding Ambassador.

It all began with my feedback on the “Say No to Abuse: “If you see something that does not feel right, tell someone” video released by the SAEB Safeguarding Ambassadors in April 2024.

As someone who is neurodivergent, I found the video challenging to watch and at times hard to follow and the activity a little overwhelming. Normally, I enjoy videos like this, so I believed others might also find it difficult. This experience led me to provide feedback on how the video and future materials could be more inclusive and accessible for everyone.

My feedback was warmly received, and the SAEB Team informed me that it sparked a meaningful conversation about the importance of neurodivergent-inclusion at the Board meeting where the survey results were presented.

The SAEB want to support inclusivity for all and so they invited me to join the Safeguarding Ambassador Group to help advocate for neurodivergent-inclusion and ensure that everyone’s voice is heard. Being part of this group has been a great experience. As Ambassadors, we work together to make our materials as inclusive as possible, ensuring that everyone can learn about safeguarding.

Did you know?

Even people with the same type of neurodivergence can have very different experiences and needs.

It’s important not to make assumptions but to allow people to advocate for what they know they need.

Some people may not know they are neurodivergent or may not want to share aspects of their identity.

Being a Safeguarding Ambassador has allowed me to make a meaningful difference in our communities by helping to create more inclusive resources for neurodivergent individuals. Our group values everyone’s input in every conversation, and I genuinely enjoy sharing my knowledge and experience to advocate for change. Being part of this group is truly rewarding, and I find the other members incredibly inspiring.

Thank you for taking the time to read my story. I hope it inspires others to speak up and advocate for neurodivergent-inclusion in their own organisations, and across community settings.

Contents

Foreword

Chairing Responsibilities

1

To Chair all meetings of the Safeguarding Adults Executive Board x 4 per year and any extraordinary meetings as required in an effective and professional manner including setting of agendas, approval of minutes and management of associated business.

2

Liaise with Key Partners: The Metropolitan Police; North West London Integrated Care Board (NWL ICB) and Adult Social Care.

3

Meet with the Executive Director of Adult Social Care Services, CEO's and liaise with the Cabinet Members for Adult Social Care, Health and Wellbeing Board and Scrutiny committee or representatives as required.

4

Ensure the Board monitors and develops a safeguarding adult's strategy and implement this in line with an agreed annual business plan which maintains a clear focus on outcomes for adults at risk and their carers.

5

Ensure that the Board works effectively, with good collaboration between its members, encouraging and supporting the development of partnership working between partner agencies, including the Chairs Group and its Subgroups.

6

Provide assurance that the Board operates independently of its member agencies and that any conflicts of interest are appropriately managed.

I am delighted to present the 8th Annual Report of the Safeguarding Adults Executive Board for 2024-25. This annual report provides the partnership an opportunity to reflect on our achievements and progress, focusing on the positive impact and improvements we have made for adults at risk in Kensington & Chelsea, and Westminster. It also allows us to reflect where improvements need to be made across the partnership to ensure our collaborative efforts are all united in commitment to safeguarding adults from harm and abuse.

Working together allows us to listen to varied viewpoints. By valuing inclusive and diverse perspectives we are better equipped to understand what safeguarding means across all our communities. The BME Safeguarding Network has played a pivotal role in deepening our awareness of how culture influences safeguarding practices. Adopting a back-to-basics approach, we are engaging more closely with our communities, supporting them to identify safety risks and collect valuable feedback to further improve safeguarding practice. We realise that there is much more we can learn from engaging with communities in this way .

By making improvements to practice and learning from when things go wrong the Safeguarding Adults Case Review Group has demonstrated a strategic and successful approach to creative commissioning of Safeguarding Adults Reviews (SARs) preventing duplication and focusing in on local improvements to practice. The Learning and Development Subgroup has been growing in strength identifying practice issues from findings of a recent partnership audit on mental capacity act practice and coming up with an improvement plan for the partnership to lead on. In addition, the Quality Assurance Subgroup has undertaken a focussed review of the steady increase in Domestic Abuse among older people, raising awareness of familial abuse and highlighting the need for training and effective signposting.

This year has been particularly busy for SARs referrals, completion and evaluation of action plans, and finalising closing recommendations from the Fatal Fires Thematic Review. A well-attended evaluation event in February 2025 explored the impact of our interventions on Fire Safety with praise for the SAEB website and suite of online videos and resources. These resources have achieved significant outreach, including to voluntary organisations. Feedback confirms that our awareness-raising efforts are having a tangible impact and embedding lasting improvements to practice.

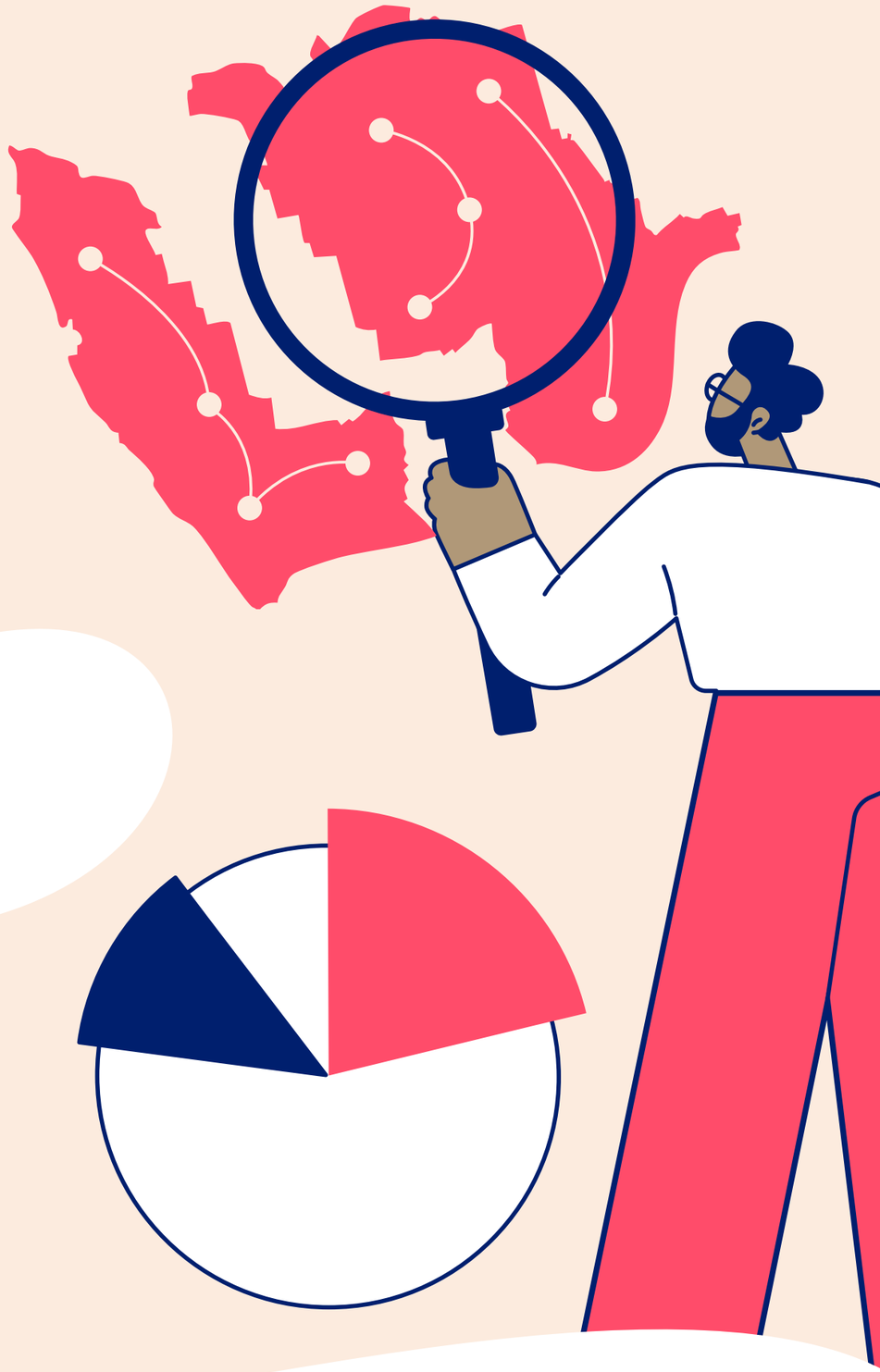
Last but by no means least, the SAEB would like to pay tribute to our Safeguarding Ambassadors, whose lived experience and willingness to share their experiences ensures the SAEB is current and relevant to local needs. Their commitment to raising awareness of emerging safeguarding themes such as digital online abuse and romance fraud demonstrate the invaluable role they play. The Ambassadors bring not only lived experience, insight, and energy but their presence ensures safeguarding remains both responsive and local.

I am grateful to our statutory partners, the chairs of our subgroups, and all Board partners for their consistent support, dedication, and meaningful contributions to keeping people safe. This is evident in the articles and case studies in this report. I hope you find this annual report engaging and that it inspires you to join us in our commitment to enabling adults at risk to live free from abuse and neglect, while promoting a personalised approach to safeguarding for everyone.

Aileen Buckton OBE

Independent Chair of the SAEB

Data insights into the population of the boroughs of Kensington & Chelsea and Westminster



How does the SAEB address the challenges to working with a diverse population in the boroughs of Kensington & Chelsea and Westminster.

No single organisation can solve these challenges in isolation. A whole systems approach is required to safeguard the population harnessing the skills and resources of key partners and local communities , and working more closely together to improve the safeguarding health and wellbeing of our residents.

The following data insights are taken from the Public Health Joint Needs Assessment updated in March 2025. We have focused on information pertinent to our understanding of our safeguarding responsibilities.

Understanding Kensington & Chelsea's diverse population

Kensington & Chelsea is home to

147,500 residents

and is the **smallest** London Borough both in terms of **size** and **population**. Despite its size there is great diversity. It is **densely populated** with a **high proportion** of single households. There are

105,300 residents

aged **16-64** (71%).

There are

8,900 residents

residents over the **age of 65**. The number of people **aged 65 or over** is expected to **increase** by almost **40%** in the next **20 years**.

COMMUNITY DATA INSIGHTS

Analysing local data in Kensington & Chelsea helps create targeted safeguarding strategies to address deprivation and community needs with a focus on safeguarding adults.

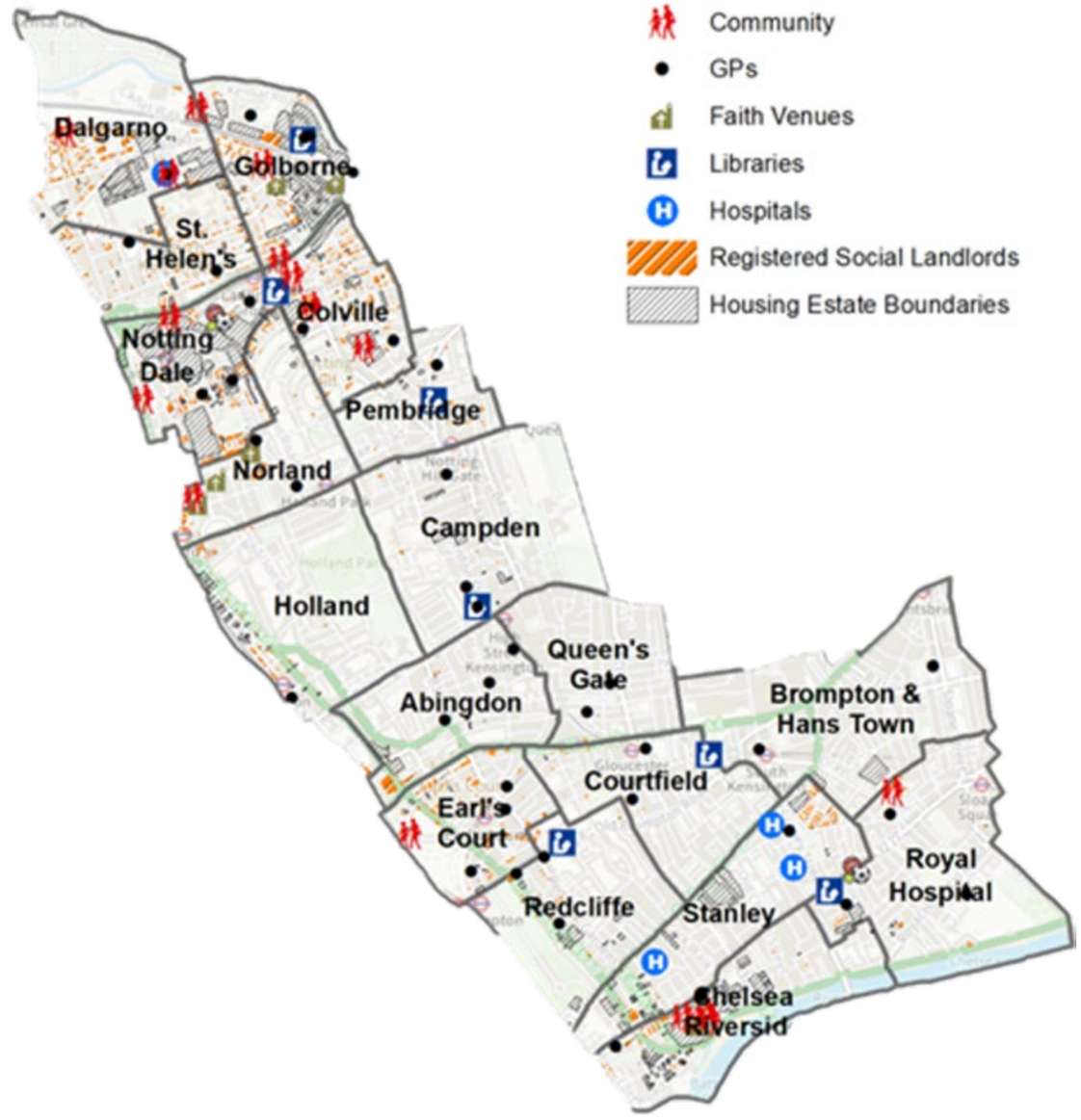
AGEING POPULATION NEEDS

Understanding the 65+ population highlights the specific needs of an ageing community for better care, support and protection.

SINGLE-PERSON HOUSEHOLDS

Identifying single-person households allows tailored services to reduce isolation and improve residents' well-being.

Kensington & Chelsea Map



Data insights into our diverse communities

36% of residents identify themselves as from a **Black, Asian** or other **non-white ethnic** background.

53% of our residents are **female**.

1 in 25 residents identify as being **LGBTQ+**.

There are **80 languages** spoken in Kensington & Chelsea and **24%** of residents do not have English as their main language.

Although **French** is the most commonly spoken language after **English**, there is great variation across all wards. In the 2021 Census, only **1.3%** of residents reported that they could not speak English well.

The most common religions are **Christianity (48%)** and **Islam (12%)**. In the 2021 Census there was an increase in the proportion of residents who say they have **no religion (from 21% to 25%)**

Mental health and **wellbeing** is important across the life course **1 in 5 adults** report feeling anxious and **1 in 12** have a GP diagnosis of depression. **Depression** is more common among residents from a Caribbean, mixed White and Black Caribbean or British background and those living in more **deprived areas**.

Kensington & Chelsea insight data

Setting	18-64	65+	Total
Nursing Home	12	119	131
Residential Home	61	129	190
Community	575	787	1,362
Total	**648**	**1,035**	**1,683**

Primary Support Reason	18-64	65+	Total
Physical Support	40.7	70.8	59.2
Sensory Support	0.3	1.5	1.1
Support with Memory and Cognition	1.4	13.1	8.6
Learning Disability Support	33.2	4.0	15.2
Mental Health Support	22.7	9.7	14.7
Social Support	1.7	0.9	1.2
Total	**100**	**100**	**100**

Safeguarding and Adults receiving long term care and support

There are

296 residents

who live in a **care home** (with or without nursing).

It is estimated that

8,900 people

over 65 are **living alone** in Kensington & Chelsea. Nationally, it is estimated that around **10%** of the population aged over 65 are **lonely**. There are four life events associated with social isolation among older people: **retirement, falling ill, a spouse dying, and going into care**. Isolation remains a key vulnerability for people who experience abuse and neglect.

1 in 12 of our older population

are living with dementia. **Dementia** is probably the **biggest health care challenge** we face and is now one of the most common causes of death in London and our borough. There are an estimated **1,800** patients living with dementia in our borough, with only **1,050** with a formal diagnosis from their GP. Diagnosed prevalence is highest among Black or Black British residents.

1 in 5 older people

are digitally excluded. Around **8%** of residents are at risk of **digital exclusion**. However, older people are more likely to be digitally excluded, with **1 in 5 people aged 65 and over affected.** Digital exclusion impacts social isolation and access to services.

Understanding Westminster's diverse population

Westminster is home to

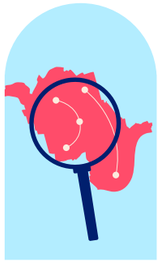
211,500 people.

The area has a large proportion of **young working age** residents, as well as high levels of **international migration** and **cultural diversity**. Westminster experiences a significant influx of **commuters** and **tourists** daily, bringing the total number of people in the area to over **one million**.

There are

158,500 residents

aged **16-64 (71%)**. The number of people in Westminster aged 65 or over is **26,200**, and this is expected to increase in the next 20 years.



COMMUNITY DATA INSIGHTS

Analysing local data in Westminster helps create targeted safeguarding strategies to address deprivation and community needs with a focus on safeguarding adults.

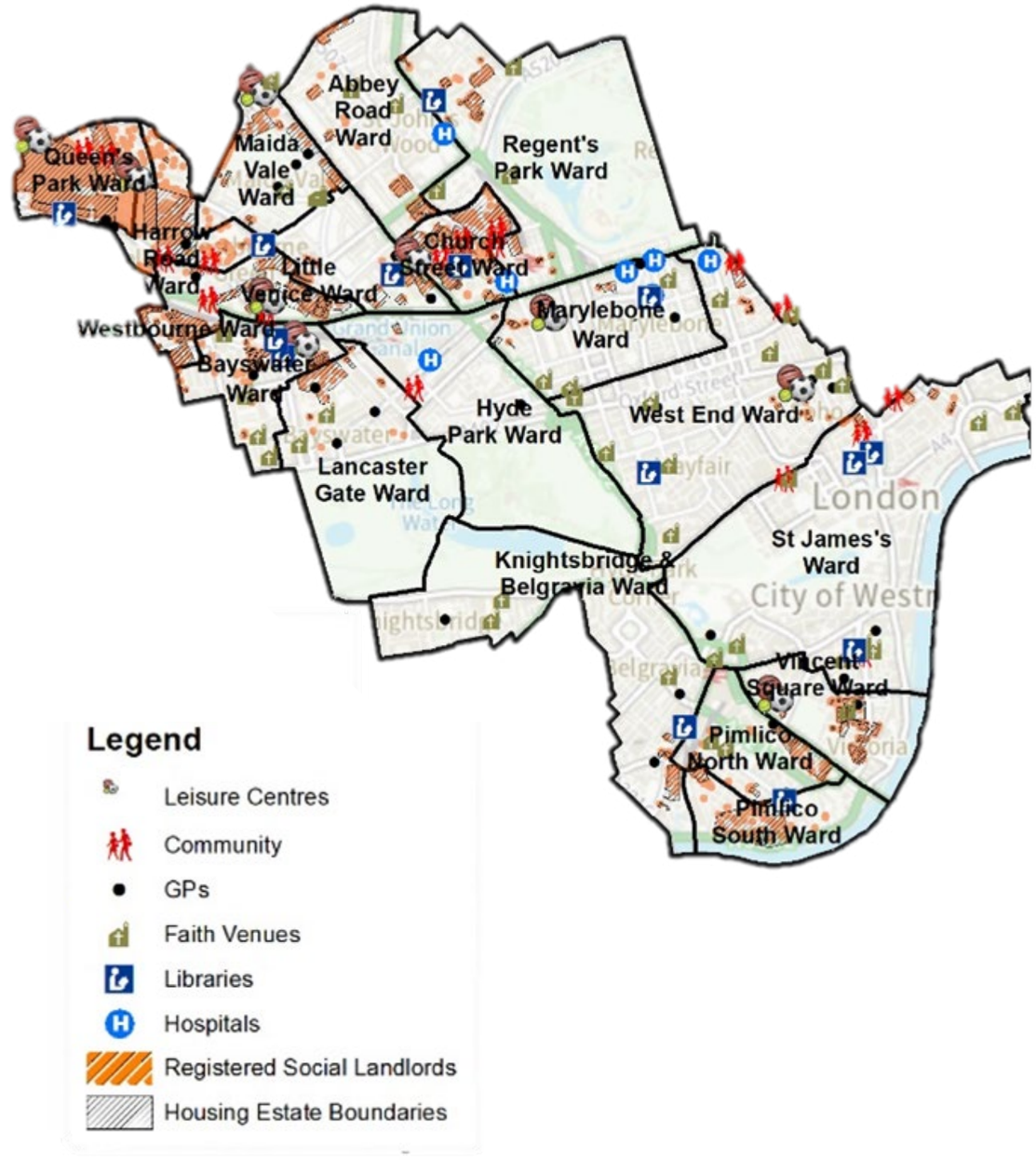
AGEING POPULATION NEEDS

Understanding the 65+ population highlights the specific needs of an ageing community for better care, support and protection.

SINGLE-PERSON HOUSEHOLDS

Identifying single-person households allows tailored services to reduce isolation and improve residents' well-being.

Westminster Map



Data insights into our diverse communities

45% of Westminster's residents identify as being from a **global majority background**.

52% of our residents are **female**.

1 in 20 residents identify as being **LGBTQ+**. a with the highest proportion (11%) in West End and Soho.

There are **85 languages** spoken in Westminster and **26%** of residents do not have English as their main language. **Arabic** is the most commonly spoken language after **English**, but there is great variation across all wards. In the 2021 Census, **4%** of residents reported that they could not speak English well.

The most common religions are **Christianity (37%)** and **Islam (20%)**. The 2021 Census showed an increase in the proportion of residents who say they have **no religion**, from **20%** to **26%**. Mental health and wellbeing is important across the life course. **Over 1 in 4 adults** report feeling anxious, and **1 in 16** have a GP diagnosis of depression. **Depression** is more common among residents from a Caribbean, mixed White and Black Caribbean, or British background, and those living in more **deprived areas**.

Westminster insight data

Setting	18-64	65+	Total
Nursing Home	20	172	192
Residential Home	135	193	328
Community	1,095	1,282	2,377
Total	**1,250**	**1,647**	**2,897**

Primary Support Reason	18-64	65+	Total
Physical Support	29.8	63.9	49.2
Sensory Support	1.2	1.3	1.2
Support with Memory and Cognition	1.5	17.6	10.7
Learning Disability Support	29.1	3.4	14.5
Mental Health Support	37.1	12.4	23.1
Social Support	1.2	1.3	1.3
Total	**100**	**100**	**100**

Safeguarding and Adults receiving long term care and support

There are

522 residents

who live in a **care home** (with or without nursing) in Westminster.

It is estimated that

11,900 people

aged 65 and over are **living alone** in Westminster. Nationally, it is estimated that around **10%** of the population aged over 65 are **lonely**. There are four life events associated with social isolation among older people: **retirement, falling ill, a spouse dying, and going into care**. Isolation remains a key vulnerability for people who experience abuse and neglect.

1 in 14 of our older population

are living with dementia. **Dementia** is probably the **biggest health care challenge** we face and is now one of the most common causes of death in London and our borough. There are an estimated **1,950** patients living with dementia in our borough, with only **1,250** with a formal diagnosis from their GP. The diagnosed prevalence of dementia is highest among Black or Black British residents.

1 in 5 older people

are digitally excluded in Westminster. Around **8%** of residents are at risk of **digital exclusion**. However, older people are more likely to be digitally excluded, with **1 in 5 people aged 65 and over affected.** Digital exclusion impacts social isolation and access to services.

Introduction to the Annual Report 2024-25

This is the 8th Annual Report for the Kensington & Chelsea and Westminster Safeguarding Adults Executive Board SAEB.

Over the past years, the Safeguarding Adults Executive Board (SAEB) has dedicated significant effort to ensuring people's safety. This section of the report offers a brief overview of the partnership's achievements from 2022 to 2025. The last year, in particular, has been very active, and we have seen considerable progress.

The SAEB's success has largely stemmed from collaboration with community organisations and local residents. This teamwork has been essential. We have prioritised understanding and respecting diverse cultures, supported by groups such as the Community Engagement Group and the Black Minority Ethnic (BME) Safeguarding Network. Additionally, we have reviewed our "Making Safeguarding Personal" approach to ensure it remains relevant to our diverse community, keeping adults at risk opinions central to our work.

Communities have played a vital role in identifying risks and providing valuable feedback, which helps us maintain effective and compassionate safeguarding practices. Strong communication within the partnership has been key to coordinating our efforts to protect adults at risk.

The report is broadly laid out into 4 sections .

1. **Quality Assurance and Performance**

   This section demonstrates a commitment to quality assure performance of safeguarding activity to continually understand and make improvements to the system

2. **Leading Listening and Learning**

   How we learn from cases when things go wrong

3. **Communities keeping themselves safe**

   Raising awareness of safeguarding and preventing harm and abuse from occurring

4. **Making Safeguarding personal**

   Safeguarding Ambassadors – Hearing the voice of our communities and service users by experience

We hope this report is informative and that you share our commitment to promoting safety for all.

EIGHTH EDITION

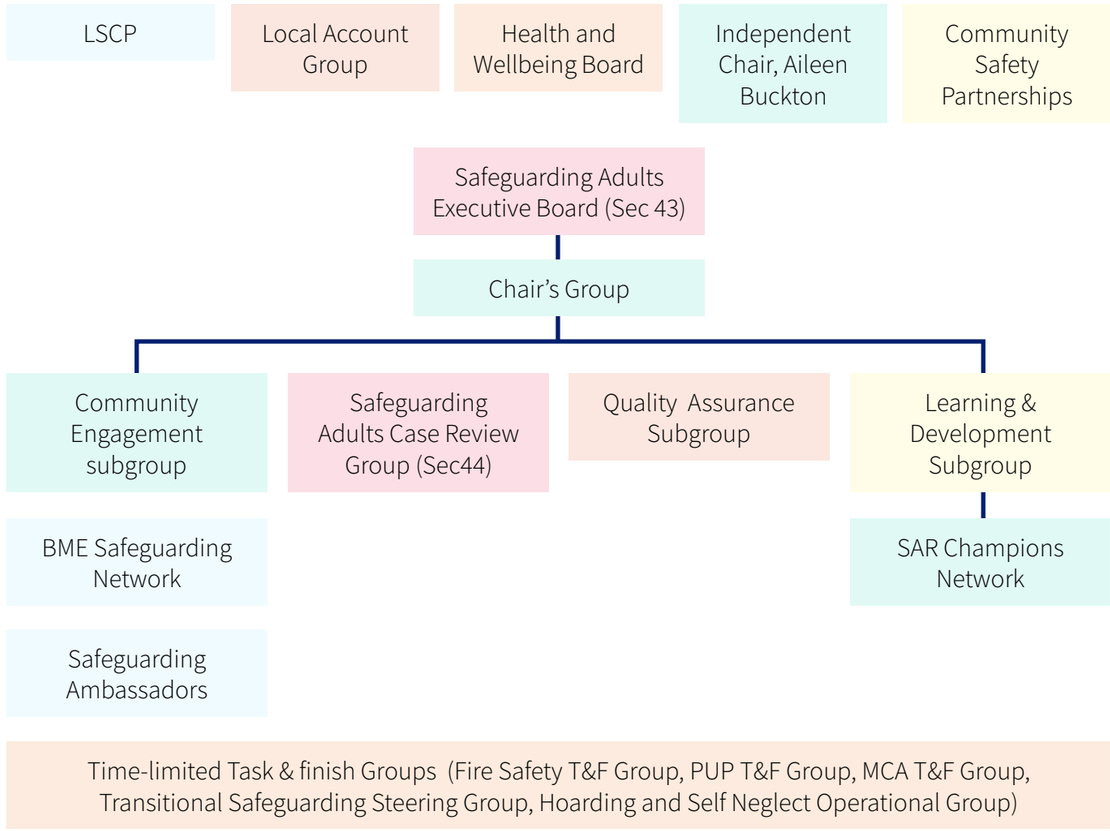
Who is this report for?

The Annual Report is intended for residents and all those who work in the boroughs of Kensington & Chelsea and Westminster City Council. It uses personal accounts and stories to demonstrate local ownership of the work it undertakes.

The SAEB is a partnership of senior representatives from statutory and various other organisations that have a duty to respond to adult safeguarding in the Bi-borough area. The Board takes pride in its accomplishments, especially its strong connections with community groups and the Safeguarding Ambassadors who are service users by experience and are dedicated in promoting awareness of abuse and neglect.

The Bi-borough Safeguarding Adults Executive Board (SAEB) is proud of its far-reaching remit and pays particular attention to its role in prevention and early intervention within the communities of Kensington & Chelsea and Westminster.

Safeguarding Adults Executive Board and workstreams 2025 - 2028



Key Roles and Responsibilities of Statutory Partners in Safeguarding Adults Boards

Safeguarding Adults Boards, SAB's are statutory bodies established under the Care Act 2014, with key statutory partners being the Local Authority (LA), Police, and Integrated Care Board (ICB) (representing local health services).

These partners hold an active strategic role within the SAEB and play a leading role in contributing to subgroup work while actively overseeing and ensuring the effectiveness of adult safeguarding arrangements within their areas.

Local Authority (LA): Bernie Flaherty

Deputy Chief Executive Officer for Westminster City Council and Bi-borough Executive Director of Adult Social Care and Health, Royal Borough of Kensington & Chelsea and Westminster City Council

The LA is responsible for establishing the SAEB and ensuring local safeguarding arrangements are in place and meet the requirements of the Care Act 2014 and statutory guidance.

Metropolitan Police: Lucy O'Connor

Detective Superintendent, Public Protection Central West Basic Command Unit, Metropolitan Police Service

The police play a crucial role in investigating abuse and neglect, providing expertise in law enforcement aspects of safeguarding, and contributing to risk assessments and responses to incidents.

Integrated Care Board (ICB): Sue Sheldon

Assistant Director for Safeguarding, Lead for NWL Child Death Review/LeDeR Service, Chief Nursing Officer Directorate NHS North West London

The ICB ensures health services contribute to safeguarding adults by providing guidance and support for health-related safeguarding issues and promoting person-centred care.

Key Partnerships Achievements in 2024-25

Individual Organisation Safeguarding Achievements 2022- 25

NHS NWL ICB:

- Completed NWL ICB Safeguarding Training Policy and Strategy.
- Rolled out Level 3 training to ICB staff and GPs.
- Delivered topical Safeguarding training sessions.
- Developed a PiPoT Policy.
- Continued to seek safeguarding assurance from commissioned NHS Providers.
- Worked on fire safety initiatives and domestic abuse training.
- Supported the government VAWG initiative.

METROPOLITAN POLICE:

- Delivered Fire Awareness training to all inspectors across the BCU.
- Launched a new decision-making tool for vulnerable adults for MASH practitioners.

COMMUNITY SAFETY PARTNERSHIP

- Raised the profile of domestic abuse (DA) in adults.

CNWL NHS FOUNDATION TRUST:

- Developed learning resources around older abuse and familial abuse.
- Delivered Domestic Abuse in Older People training across the boroughs.
- Conducted an audit on MARAC referrals from Adult Safeguarding to MARAC
- Continued positive relationship with Bi-borough colleagues.
- Addressed the impact of self-neglect and hoarding.
- Conducted fire safety audits and practitioner questionnaires.
- Developed a 7-Minute Briefing on cuckooing.
- Raised awareness and supported survivors of domestic abuse.

IMPERIAL COLLEGE HEALTHCARE NHS TRUST:

- Key training is above compliance rates.
- Increased referrals to Adult Social Care due to heightened awareness of adult abuse.
- More awareness around MCA and DoLS.
- Ongoing work on discriminatory abuse.

CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST (CLCH):

- Fire safety awareness with frontline staff and managers.
- Implementation of the Pressure Ulcer Incident Response Framework (PSIRF).
- Weekly pressure ulcer meetings.
- Hosted the CLCH Safeguarding Conference.

THE ROYAL MARSDEN:

- Improved awareness of domestic abuse across the Trust.
- Completed Domestic Abuse and MCA audits and started MCA Improvement work.
- Enhanced compliance with Safeguarding Level 3 Training and PREVENT Training.

ADULT SOCIAL CARE:

- CQC Westminster Report: Good Rating.
- Good performance indicators and settled staffing.
- Joint Hoarding and Self Neglect Training across ASC and Housing.
- Self-neglect and hoarding toolkit and hoarding pathway for homelessness.

Achievements for the SAEB 2024/2025

April 2024

"If you see something that does not feel right, tell someone" video campaign.

SAEB Fire Safety Framework.

Serious Youth Violence

Review Achievements and Challenges.

Bariatric Care T&F Goup

Analysis of SAPAT returns.

Develop our Business Plan 2024 – 2025

June 2024

Brew with the Crew Fire Safety Community Event

Transitional Safeguarding

Thematic Review: Learning from rough sleeping pathway deaths

Community Voices in safeguarding Event

PUP Pilot process

August 2024

BME Safeguarding Network Champion Discriminatory Abuse and Hate Crime in collaboration with Adult Social Care the Police and Community Safety

September 2024

Safeguarding Ambassadors

SAR Family and Friends leaflet

SAY No to Abuse' EASY READ leaflet

November 2024

Prevent & Safeguarding Training

SAEB Fire Safety Competency Webinar,

National Safeguarding Adults Week 'I am someone please see me' video

December 2024

Electrical Fire Safety Webinar

SAEB MCA Multiagency Audit

SAEB Fire Safety Framework

Rough Sleeping and Mortality Reviews: Ministerial Letter Action Plan

DWP Joint Working Protocol

Quality Assurance: Safeguarding Health Outcomes Framework, NWL ICB

CQC Westminster Report

February 2025

Romance Fraud and online digital safety and scams Webinar

Thematic Review Fire Safety Learning Event

March 2025

Safeguarding Adults Reviews:

Professor Shannon Hospital Discharge Audit Report

Malcolm's Legacy – Improvement Briefing Report

Quality Assurance subgroup Data and Information Insights Report on Domestic and Elder Abuse

Putting Policy into Practice and Discriminatory Abuse (BME Safeguarding Network)

SAEB Strategy 2025 – 2028

Healthwatch - The mental health needs and experiences of young people (18-25) in Westminster and K&C

Funding arrangements

The Board is funded by Westminster City Council, The Royal Borough of Kensington & Chelsea, The North West London Integrated Care Board (ICB) and The Mayor's Office for Policing and Crime (MOPAC).

Members of Safeguarding Adults Boards (SABs) are expected to support the board's work, but there is no set formula for the total budget or contributions from each member.

Representation and financial contributions from all organisations is essential. In the Bi-borough we greatly benefit from representation from key organisations who Chair and attend our subgroups

Thanks goes to the North West London Integrated Care system contribution of £21.5k per borough, per year.

The Mayor's Office for Policing and Crime who provide an annual contribution of £5,000 to each Borough for local Safeguarding Adult Board's.

The funds received help cover the expenses of commissioning Safeguarding Adult Reviews and promoting adult safeguarding awareness in our communities.

Section 1. Quality Assurance and Performance

Quality assurance (QA) is the backbone of effective safeguarding practices for Safeguarding Adults Boards (SABs).

It plays a pivotal role in ensuring that vulnerable adults are protected, promoting a culture of continuous improvement, and holding organisations accountable for their safeguarding responsibilities. Quality Assurance helps the SAEB collaboratively identify areas for enhancement and ensure compliance with legal obligations.

This section is split into 2 parts

Part A: We explore safeguarding activity through use of data to inform our knowledge of what is working well and were we need to focus our attention for the coming year .

- Safeguarding data and analysis 2024-25
- Outcomes
- Spot light on Domestic Abuse and Mental Health and Safeguarding

Part B: This section will highlight various pieces of project work to include

- “Learning about Older People and Domestic Abuse“
- Domestic homicides of older victims
- Department of Work and Pensions and role in Safeguarding adults
- Multi-agency audit on the Mental Capacity Act.
- Integrated Care Board and safeguarding activity across the local health sector

PART A: Safeguarding Adults Performance

In this section we use data:

- to understand trends in volumes of safeguarding concerns raised and enquiries conducted.
- to analyse the profile of people involved in safeguarding enquiries, and the nature of the risk of abuse or neglect involved.
- alongside other local data on safeguarding practice and outcomes we review: Domestic Abuse and Safeguarding data; Mental Health Safeguarding Data and Ethnicity Data.

Safeguarding and the Equality Act 2010

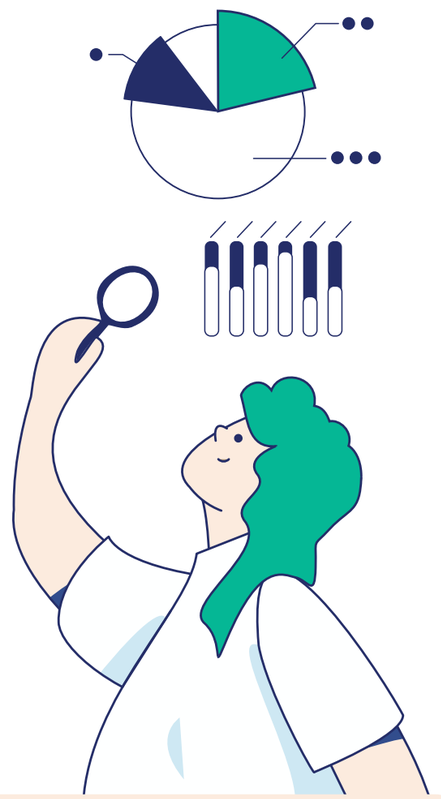
Under the Equality Act 2010 public authorities have a duty to consider how their policies and decisions may affect people who are protected under the Act.

In particular they are required to think about the need to remove or reduce disadvantages experienced by people because of protected characteristic or meet the needs of people with protected characteristics.

If our policies and practices to do with safeguarding are complying with this duty, we would expect the characteristics of those who experience harm and abuse to be largely reflective of all those who receive care and support arranged through the council, so that, for example particular groups are not under-represented or over-represented. We would expect this to be the case especially where a concern has been assessed as requiring an enquiry under the safeguarding pathway, as opposed to referral-on for other types of support such as a care management assessment. But we would not expect the match to be exact as safeguarding duties apply to all adults with care and support needs, not just those who receive care and support from the council.

We are dedicated to upholding the principles of the Equality Act 2010 by ensuring our safeguarding policies and practices actively consider the needs and experiences of those with protected characteristics. Through continual review of our data and practice, we strive to ensure that no particular group is disproportionately affected by harm or abuse, and our safeguarding pathway remains accessible and responsive to all adults with care and support needs.

Our approach centres on removing barriers and disadvantages, promoting fair outcomes, and regularly assessing whether those who experience safeguarding interventions reflect the diversity of those receiving care and support within our community.



Kensington & chelsea safeguarding adults data insights 2024-25

In 2024-25 RBKC received **1,165 safeguarding concerns**, **345 more** than were received in 2023-24, nearly one more concern per day in the year on average. This is equivalent to **9 concerns** for every **1,000 adults** in the general population, or **692 concerns** for every **1,000 adults** receiving on-going care and support at any one time.

The concerns were made up of those which were recorded on a S42(1) form as part of the formal safeguarding pathway and those which were captured on a case note but were not progressed as they were assessed as requiring follow-up under another pathway. Of the **1,165 concerns** received, **384 were progressed** to a safeguarding enquiry, a conversion rate of **33%**, a little above the national conversion rate in 2023-24 (31%). These **384 enquiries** involved **358 individuals**, an average of just over one enquiry per individual.

NATIONAL AVERAGE:

The national average conversion rate for safeguarding concerns to enquiries in 2023-24 was 31%, the conversion rate provides a useful benchmark.

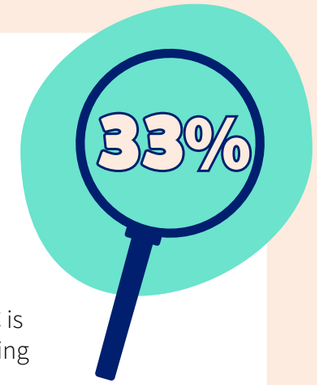
31% conversion rate

ANALYSIS:

Volume of Concerns:
RBKC's rate of **9 concerns** per 1,000 adults in the **general population** and **692 concerns** per 1,000 adults receiving **ongoing care and support** indicates a high level of vigilance and reporting within the borough.

Conversion Rate: The conversion rate of **33% in RBKC** is slightly higher than the **national average of 31%**, suggesting that a higher proportion of concerns in RBKC are deemed serious enough to warrant further investigation.

This comparison highlights that RBKC is **performing slightly above** the national average in terms of converting safeguarding concerns into enquiries, which could indicate effective safeguarding practices and thorough assessments.



SAFEGUARDING AND PROTECTED CHARACTERISTICS

Tables 1.1 To 1.5 compare the characteristics of those adults for whom concerns were received in 2024-25 with the characteristics of all adults who were receiving on-going care and support, with regard to five factors: age, gender, ethnicity, primary support reason (the main reason why an individual is receiving on-going care and support) and deprivation.

Charts 1.1. and 1.2 show that the gender and age profile of those for whom concerns had been received largely reflected the corresponding profiles of those who were receiving on-going care and support. The correspondence was closest for those concerns which progressed to a S42 enquiry. This would be expected as in almost all of these cases the adult involved had care and support needs, whereas this was not the case for those concerns which were assessed as not requiring an enquiry.

CHART 1.1 GENDER: Individuals aged 18+ involved in safeguarding concerns, S42 enquiries and in receipt of on-going adult social care at 31 March 2025 by gender.

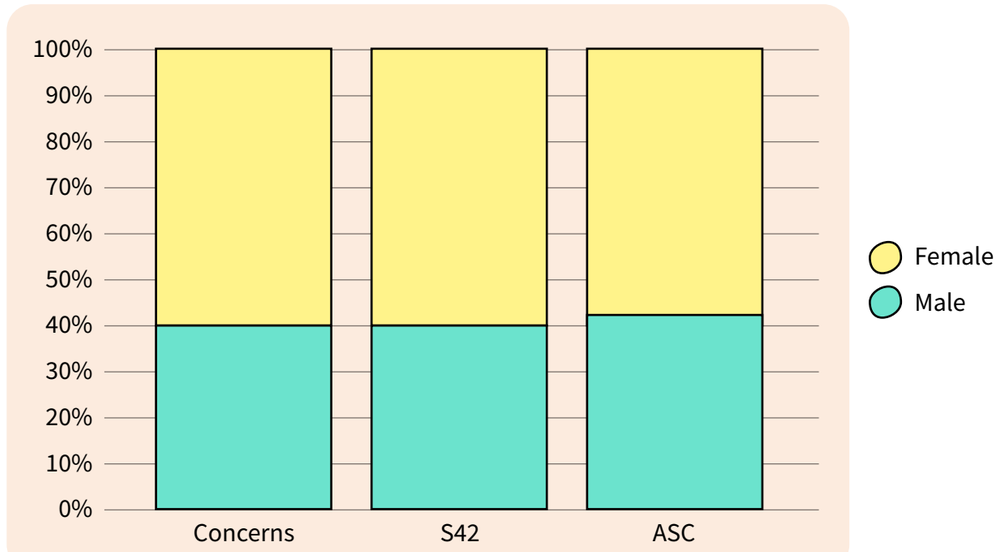


CHART 1.2 AGE: Individuals involved in safeguarding concerns, S42 enquiries and in receipt of on-going adult social care at 31 March 2025 by age band.

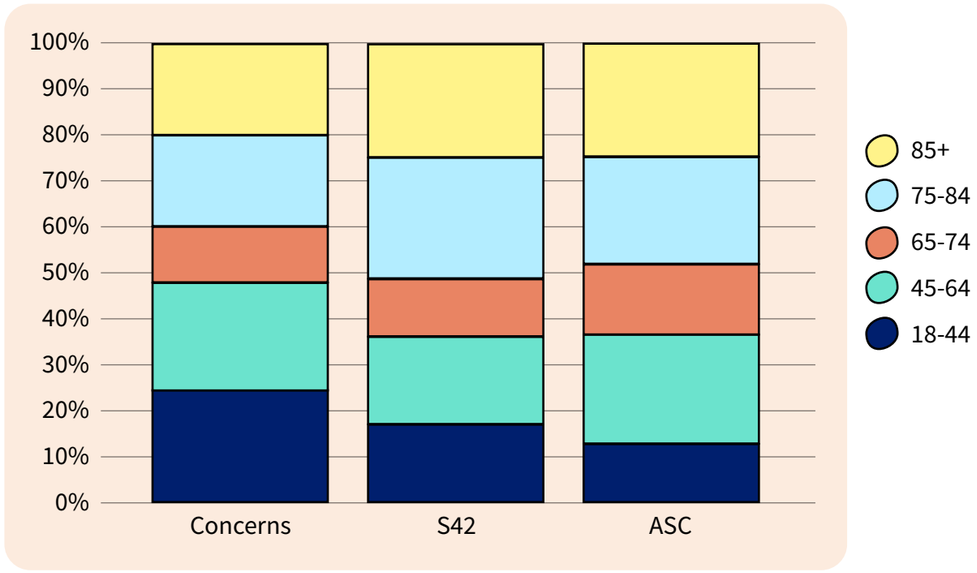


CHART 1.3 ETHNICITY: Individuals aged 18+ involved in safeguarding concerns, S42 enquiries and in receipt of on-going adult social care at 31 March 2025 by ethnic group.

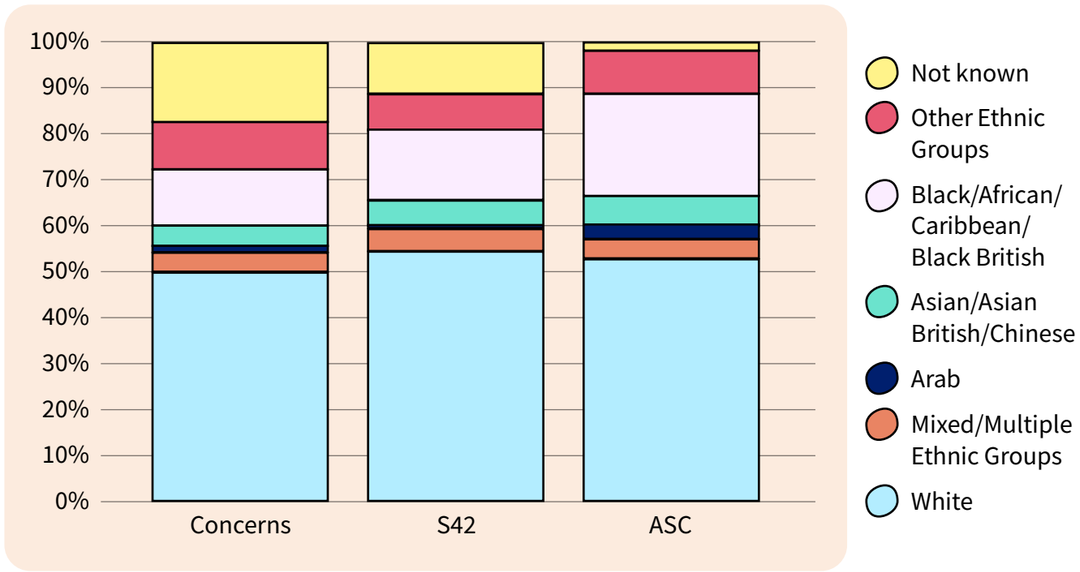
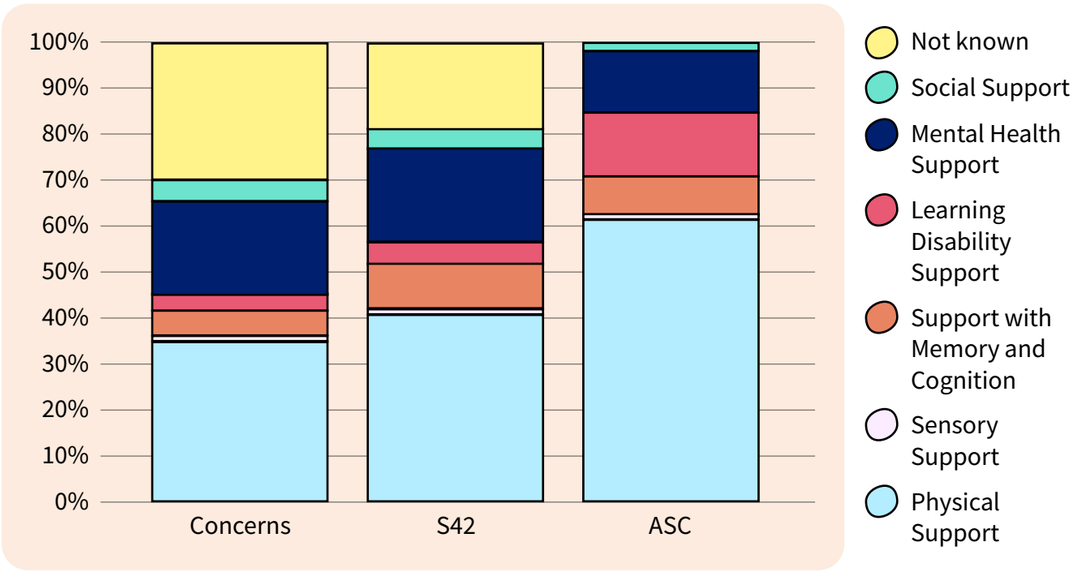


CHART 1.4 PRIMARY SUPPORT REASON: Individuals aged 18+ involved in safeguarding concerns, S42 enquiries and in receipt of on-going adult social care at 31 March 2025 by primary support reason.



There was less correspondence in the case of ethnicity and primary support reason, but this is due in part to a lack of information on both factors among the adults at risk. As mentioned, this would be expected to some extent as in many cases the adult at risk was not previously known to the council and therefore did not have a record of ethnicity on the council case management system and had not been assigned a primary support reason.

CHART 1.5A CONCERNS: Safeguarding concerns received in 2024-25

Golborne	69	Redcliffe	29
Earl's Court	61	Holland	28
Colville	60	Norland	28
Notting Dale	56	Pembridge	28
Chelsea Riverside	52	Courtfield	24
Dalgarno	50	Brompton and Hans Town	13
Stanley	44	Campden	12
St Helen's	41	Queen's Gate	0
Royal Hospital	38		
Abingdon	34		

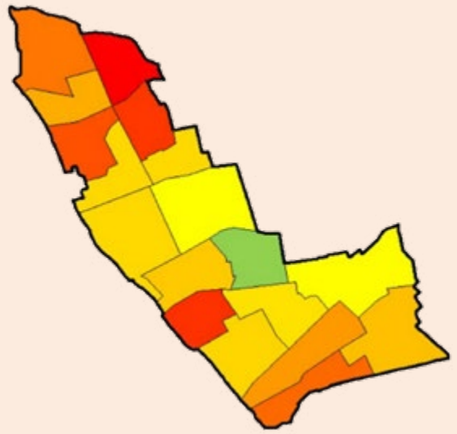


CHART 1.5B INDEX OF MULTIPLE DEPRIVATION: Kensington & Chelsea

Legend

Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10% of LSOAs)

1		6	
2		7	
3		8	
4		9	
5		10	

Chart 1.5a shows the geographical distribution of the concerns according to the electoral ward in which the adult at risk lived (which may not necessarily have been the location where the incident occurred) – for those adults who lived in the Borough. A comparison with Chart 5.1b, which shows the location of the most deprived areas within each ward, shows that the geographical distribution of concerns tended to reflect the geographical distribution of deprivation. This provides evidence that our safeguarding policies and practices are reaching all those in the Borough with care and support needs, not just those who live in the less deprived areas, for example.

RISK TYPES: Type of risk alleged by age band, S42 enquiries, 2024-25

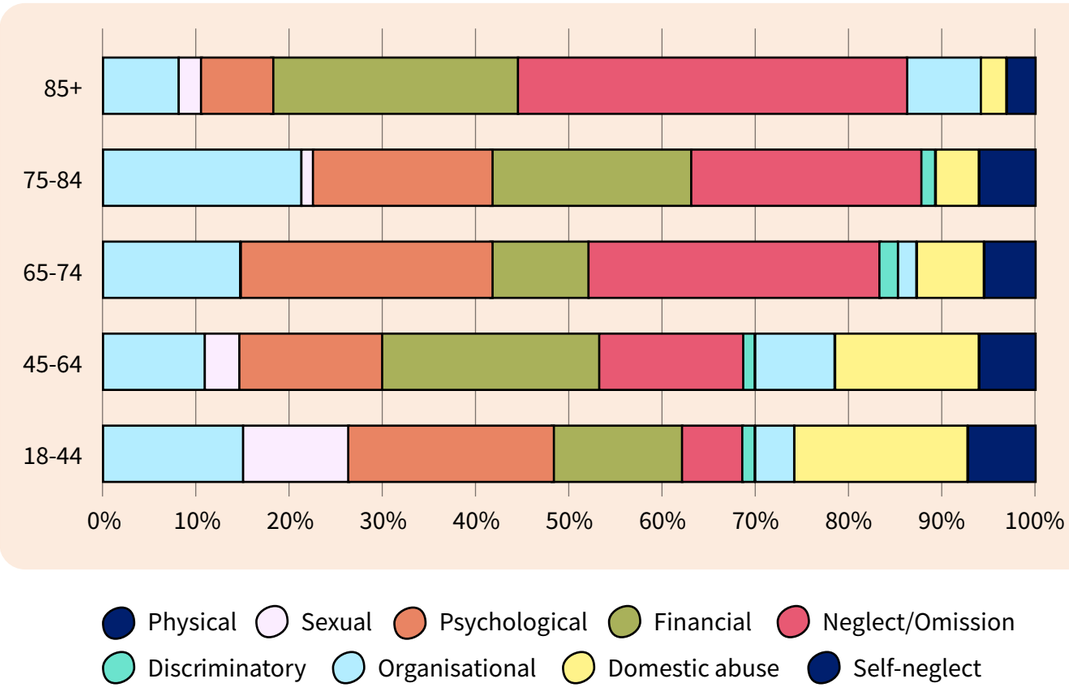
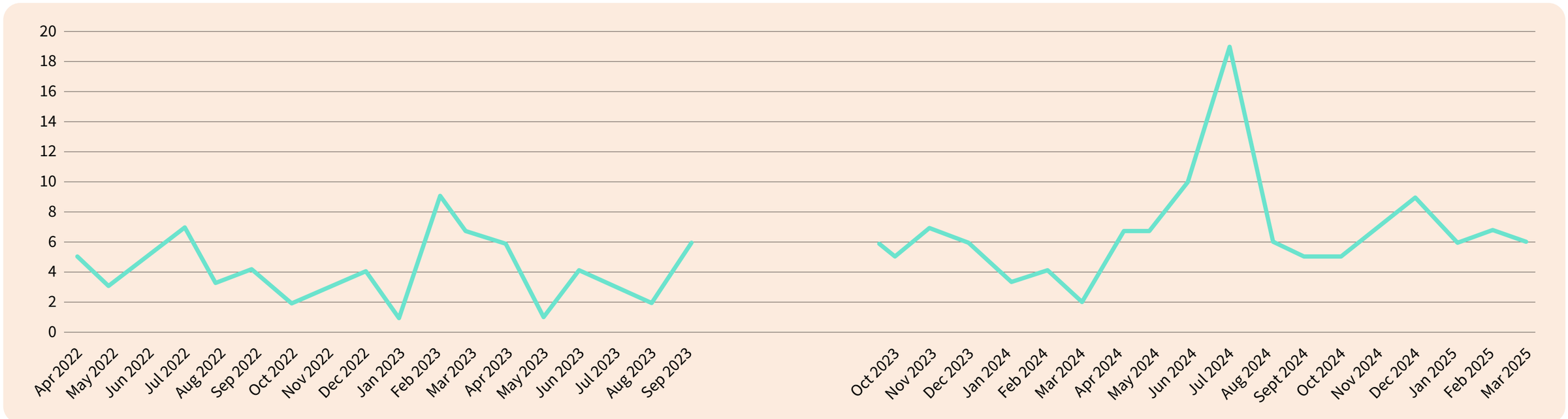


Chart 2 shows the main types of harm or abuse that were alleged for those concerns that progressed to a S42 enquiry and how the frequency of each type varied by age. For example, whereas acts of neglect or omission tended to account for an increasing proportion of concerns with increasing age, domestic abuse and sexual abuse tended to account for a decreasing proportion of concerns with increasing age.

CHART 3: Domestic abuse. Number of concerns received, as recorded on S42(1) forms, where the type of harm or abuse alleged included domestic abuse.



In our Annual Report last year we noted that the total number of concerns involving domestic abuse or violence had changed only slightly in the previous two years, despite an uneven trend line (53 in 2022-23 and 49 in 2023-24). In 2024-25, however, the number of corresponding concerns received increased to 94, an increase of 92% (Chart 3). This is equivalent to 7.8 concerns per month on average, compared with 4.1 per month in 2023-24.

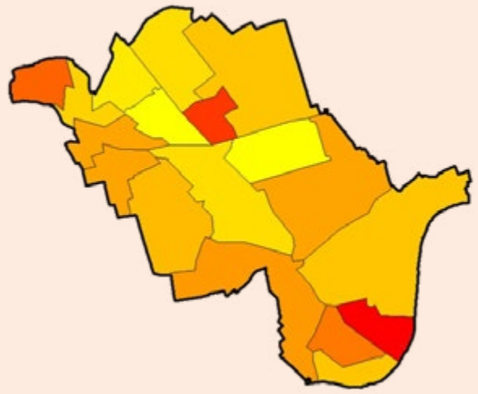
This increase was due entirely to an increase in the number of concerns received for younger adults, both in the 18-44 and 45-64 age groups. There was only a slight change in the number for the 65+ age group. This in turn was associated with two other trends: (a) an increase in the number of people with a primary support reason of mental health support (from 4 to 28) and the number with no recorded primary support reason (from 18 to 33); and (b) an increase in the number of referrals to Multi-Agency Risk Assessment Conference (MARAC) (from 16 to 39) and to Independent Domestic Violence Advisors (IDVAs) from (11 to 30).

This increase can be attributed to a number of factors, notably an increase in the number of referrals received from partner agencies, especially the police, community health staff, hospitals and housing; and the ending of a S75 agreement between the local authority and the mental health trust which resulted in the transfer of mental health staff back to the local authority.

Chart 4 shows the geographical distribution of the concerns received over the last three years involving domestic abuse according to the electoral ward in which the adult at risk lived (for those adults who lived within the borough). As with the distribution for all concerns received, this distribution tends to reflect the geographical distribution of deprivation within the borough, with more concerns being received from those areas in the borough with higher levels of deprivation.

CHART 4: Number of concerns received involving domestic abuse, 2022-25

Golborne	23	Pembridge	8
Dalgarno	20	Stanley	7
Notting Dale	15	Royal Hospital	7
Abingdon	15	Norland	7
Chelsea Riverside	12	Courtfield	4
St Helen's	11	Brompton and Hans Town	4
Earl's Court	11		
Redcliffe	10	Campden	3
Colville	9		
Holland	8		



In the great majority (80.0%) of cases the incidents of domestic abuse occurred in the adult at risk's own home, but some incidents occurred in another person's home and some also in the community.

Although in the majority of cases the adult at risk was under 65 years old, incidents of domestic abuse occurred among a significant number of people aged 65 and over. In this age group the person alleged to have caused harm was more likely to live with the adult at risk and to be the adult at risk's primary carer.

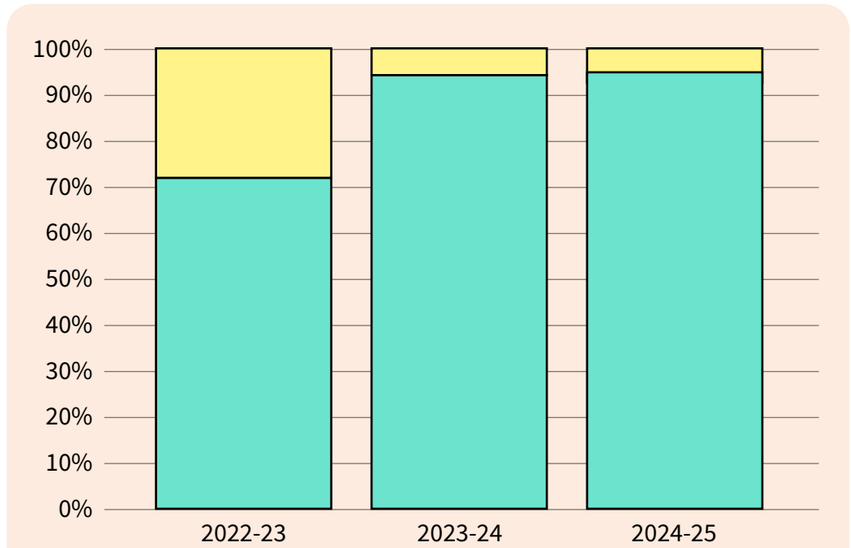
In 2024-25 the Quality and Assurance sub-group of the SAEB presented to the Board the findings of a review of partnership-wide data specifically on domestic and elder abuse. A deep dive report into Domestic Abuse and older people can be found in Part B of this section.

OUTCOMES OF COMPLETED S42 ENQUIRIES

The Outcomes Framework for Adult Social Care for 2023-24 included for the first time as a mandatory indicator relating to safeguarding. This indicator measures the impact that S42 enquiries have on the risk identified, specifically, where a risk was identified, whether the reported outcome was that the risk was reduced or removed.

In our annual report last year we reported that between 2022-23 and 2023-24 there was a marked increase in the proportion of completed S42 enquiries where the risk identified was assessed as having been removed or reduced (from 72% to 94%). In 2024-25 this level of impact was maintained with the risk identified being removed or reduced in 95% of the S42 enquiries completed in the year.

Outcome of S42 enquiry, where a risk was identified



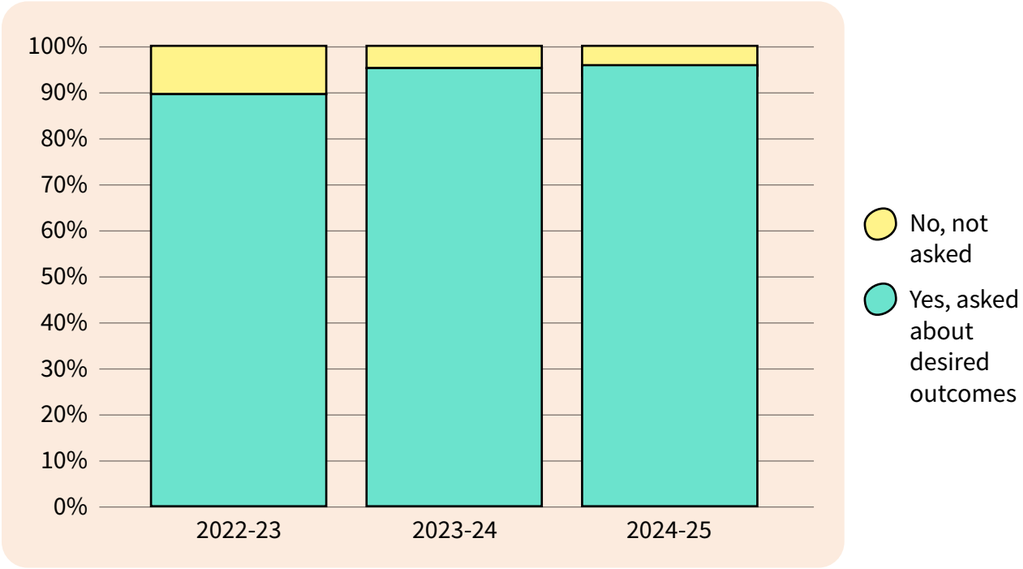
ANALYSIS:

RBKC's performance in removing or reducing the risk in **95% of completed S42 enquiries** indicates effective safeguarding practices and represents a key measure of success in safeguarding practices across the country. RBKC is performing well in terms of outcomes of completed S42 enquiries maintaining a **high level of impact** in reducing or removing identified risks.

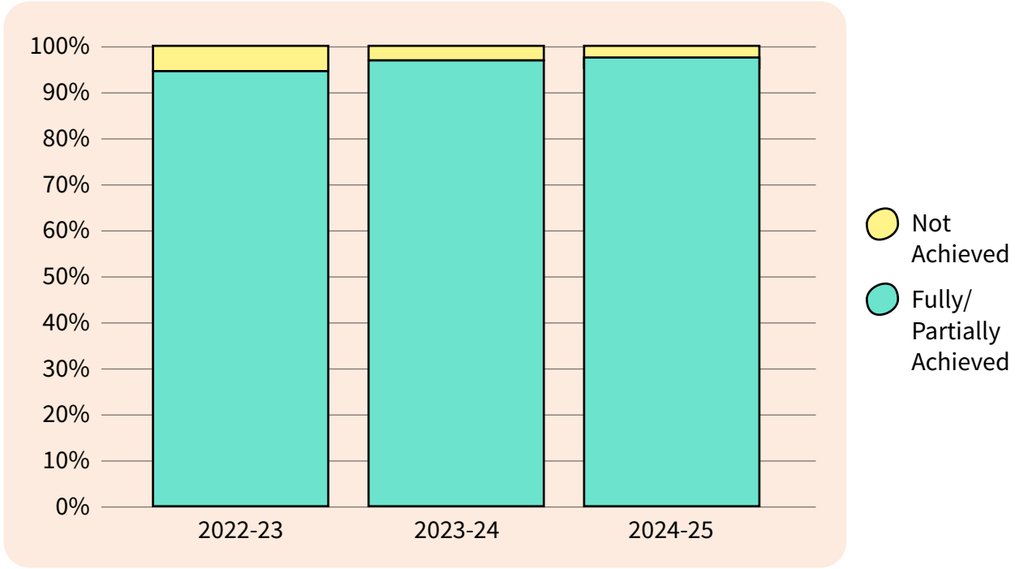
MAKING SAFEGUARDING PERSONAL

In 2024-25 positive outcomes were also maintained in relation to two indicators which look at the extent to which the adult at risk, or their representative, are placed at the centre of the safeguarding enquiry. In over 95% of S42 enquiries completed in the year the adult at risk (or their representative) was asked about the outcomes they wanted to achieve. And where a desired outcome was expressed in over 95% of cases these desired outcomes were assessed as having been fully or partially achieved.

Whether the adult at risk, or their representative, was asked what their desired outcomes were



Whether the desired outcomes were achieved



Westminster safeguarding adults data insights 2024-25

In 2024-25 WCC received 1,363 safeguarding concerns, 391 more than were received in 2023-24, a little over one more concern per day in the year on average. This is equivalent to 9 concerns for every 1,000 adults in the general population, or 692 concerns for every 1,000 adults receiving on-going care and support at any one time.

The concerns were made up of those which were recorded on a S42(1) form as part of the formal safeguarding pathway and those which were captured on a case note but were not progressed as they were assessed as requiring follow-up under another pathway. Of the 1,363 concerns received, 449 were progressed to a safeguarding enquiry, a conversion rate of 33%, a little above the national conversion rate in 2023-24 (31%). These 449 enquiries involved 421 individuals, an average of just over one enquiry per individual.

NATIONAL AVERAGE:

The national average conversion rate for safeguarding concerns to enquiries in 2023-24 was 31% ,the conversion rate provides a useful benchmark.

31% conversion rate

ANALYSIS:

The national data for safeguarding adults in 2024-25 indicates that the conversion rate for safeguarding concerns to enquiries was **31%**, which serves as a useful benchmark. This means that **WCC's conversion rate of 33%** is slightly higher than the **national average**, suggesting that a higher proportion of concerns in WCC are deemed serious enough to warrant further investigation.

The national data for safeguarding adults in 2024-25 indicates a **significant increase** in safeguarding referrals. There was a **45.6% increase** in safeguarding-related advice provision compared to the previous year, and a **28.2% rise** compared to the baseline year of 2019-20. Additionally, there was a **274% increase** in the number of referrals from 2021-22 to 2024-25.

WCC saw an increase in safeguarding concerns which indicates a broader trend of **heightened awareness** and reporting across the council which demonstrates that key messages around **raising awareness** is reaching into **communities.**

This comparison highlights that **WCC** is performing **slightly above** the national average in terms of converting safeguarding concerns into enquiries, which could indicate **effective safeguarding practices** and **thorough assessments.**

33%

SAFEGUARDING AND PROTECTED CHARACTERISTICS

Tables 1.1 To 1.5 compare the compare the characteristics of those adults for whom concerns were received in 2024-25 with the characteristics of all adults who were receiving on-going care and support with regard to five factors: age, gender, ethnicity, primary support reason (the main reason why an individual is receiving on-going care and support) and deprivation.

Charts 1.1. and 1.2 show that the gender and age profile of those for whom concerns had been received largely reflected the corresponding profiles of those who were receiving on-going care and support, although there was a slight over-representation among the former of those aged 18-44. The correspondence was closest for those concerns which progressed to a S42 enquiry. This would be expected as in almost all of these cases the adult involved had care and support needs, whereas this was not the case for those concerns which were assessed as not requiring an enquiry.

CHART 1.1 GENDER: Individuals aged 18+ involved in safeguarding concerns, S42 enquiries and in receipt of on-going adult social care at 31 March 2025 by gender.

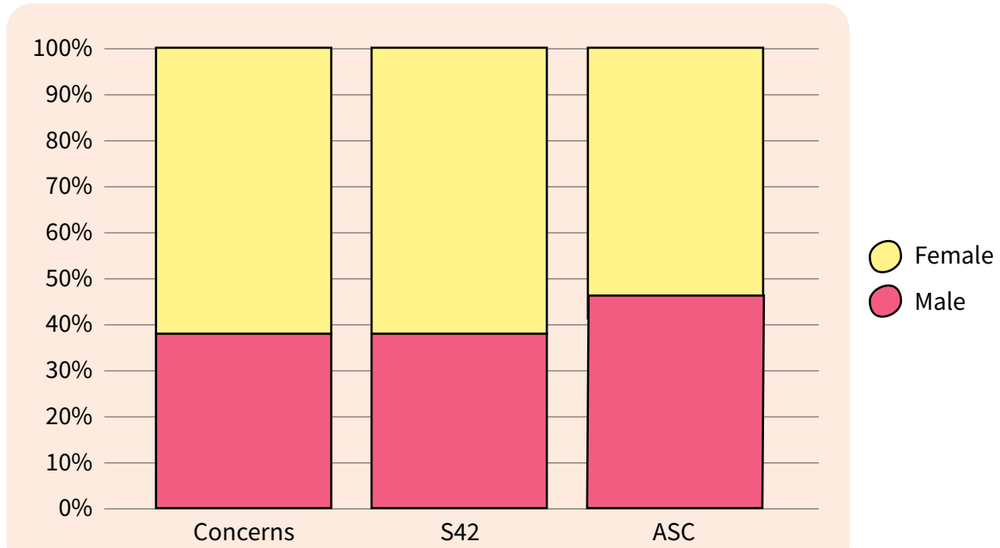


CHART 1.2 AGE: Individuals involved in safeguarding concerns, S42 enquiries and in receipt of on-going adult social care at 31 March 2025 by age band.

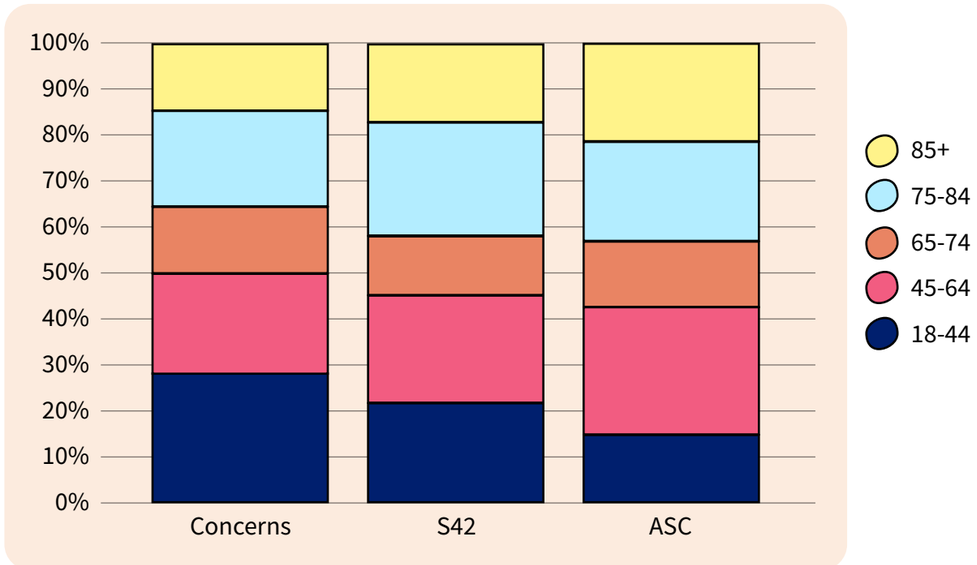


CHART 1.3 ETHNICITY: Individuals aged 18+ involved in safeguarding concerns, S42 enquiries and in receipt of on-going adult social care at 31 March 2025 by ethnic group.

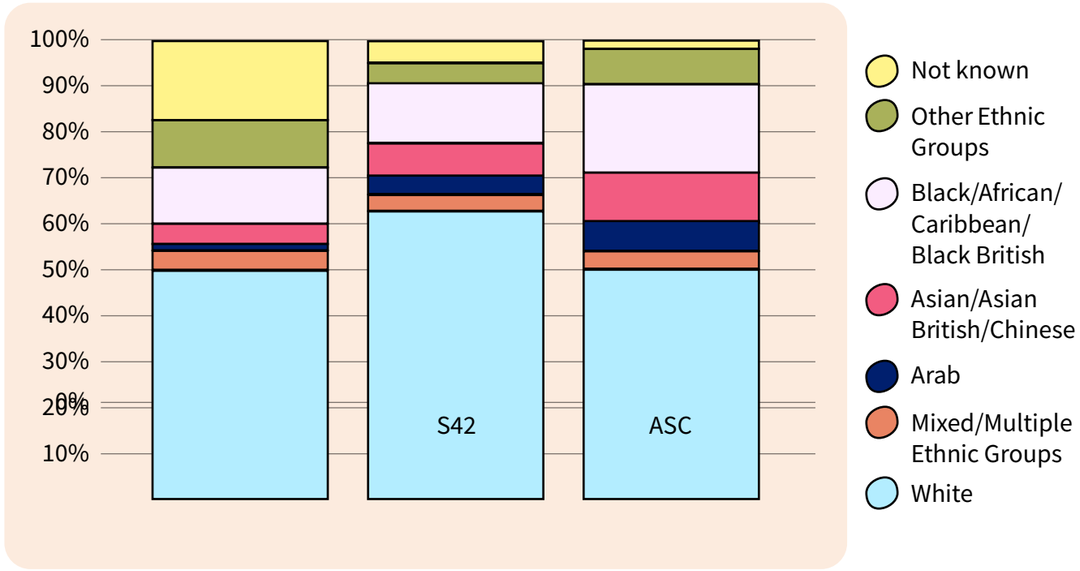
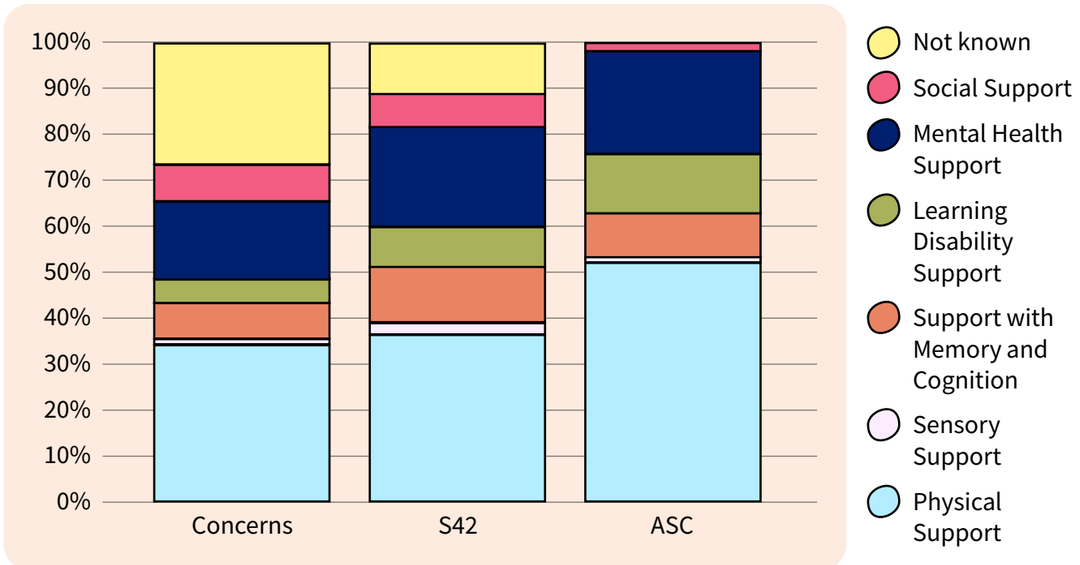


CHART 1.4 PRIMARY SUPPORT REASON: Individuals aged 18+ involved in safeguarding concerns, S42 enquiries and in receipt of on-going adult social care at 31 March 2025 by primary support reason.



There was less correspondence in the case of ethnicity and primary support reason, but this is due in part to a lack of information on both factors among the adults at risk. As mentioned, this would be expected to some extent as in many cases the adult at risk was not previously known to the council and therefore did not have a record of ethnicity on the council case management system and had not been assigned a primary support reason.

CHART 1.5A CONCERNS: Safeguarding concerns received in 2024-25

Queen's Park	79	Little Venice	40
Church Street	78	Harrow Road	39
St James's	73	West End	39
Westbourne	73	Knightbridge and Belgravia	35
Vincent Square	66	Regent's Park	35
Pimlico South	65	Bayswater	28
Pimlico North	55	Marylebone	26
Maida Vale	51	Hyde Park	24
Abbey Road	42		
Lancaster Gate	40		

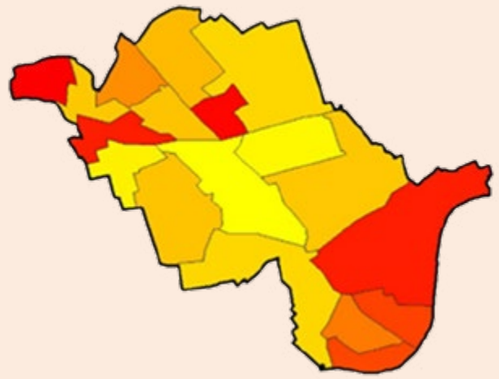


CHART 1.5B INDEX OF MULTIPLE DEPRIVATION: Westminster

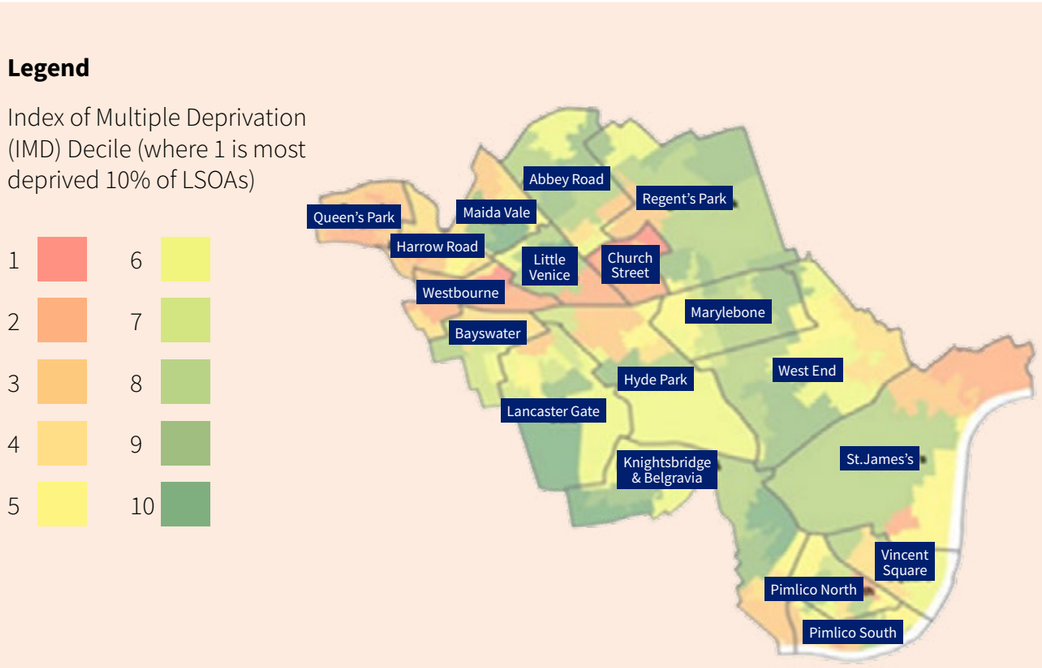


Chart 1.5a shows the geographical distribution of the concerns according to the electoral ward in which the adult at risk lived (which may not necessarily have been the location where the incident occurred) – for those adults who lived in the borough. A comparison with Chart 5.1b, which shows the location of the most deprived areas within each ward, shows that the geographical distribution of concerns tended to reflect the geographical distribution of deprivation. This provides evidence that our safeguarding policies and practices are reaching all those in the borough with care and support needs, not just those who live in the less deprived areas, for example.

RISK TYPES: Type of risk alleged by age band, S42 enquiries, 2024-25

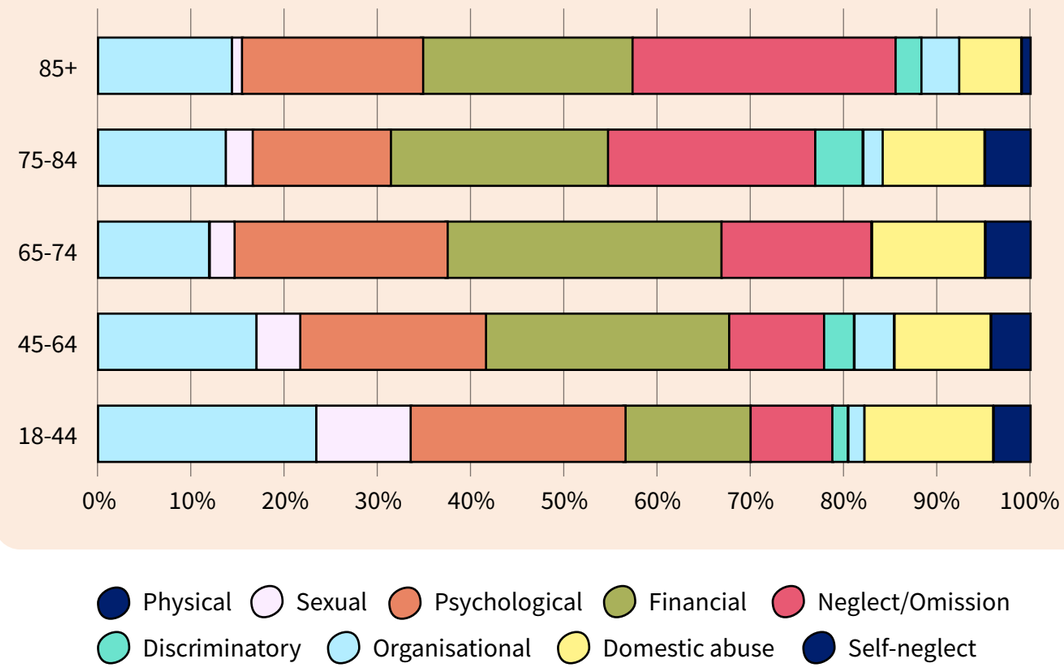
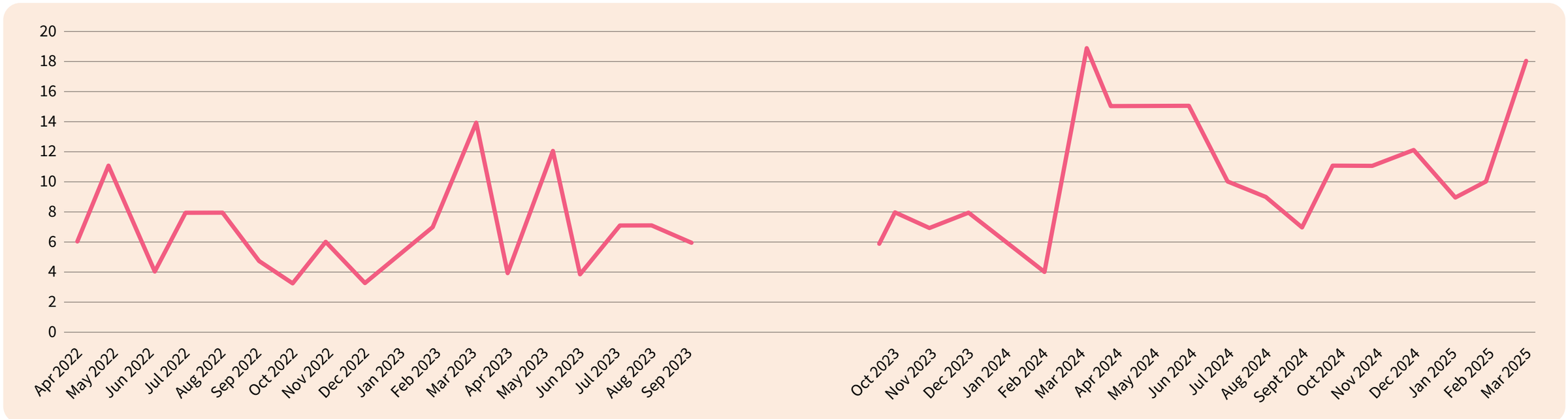


Chart 2 shows the main types of harm or abuse that were alleged for those concerns that progressed to a S42 enquiry and how the frequency of each type varied by age. For example, whereas acts of neglect or omission tended to account for an increasing proportion of concerns with increasing age, domestic abuse and sexual abuse tended to account for a decreasing proportion of concerns with increasing age.

CHART 3: Domestic abuse. Number of concerns received, as recorded on S42(1) forms, where the type of harm or abuse alleged included domestic abuse.



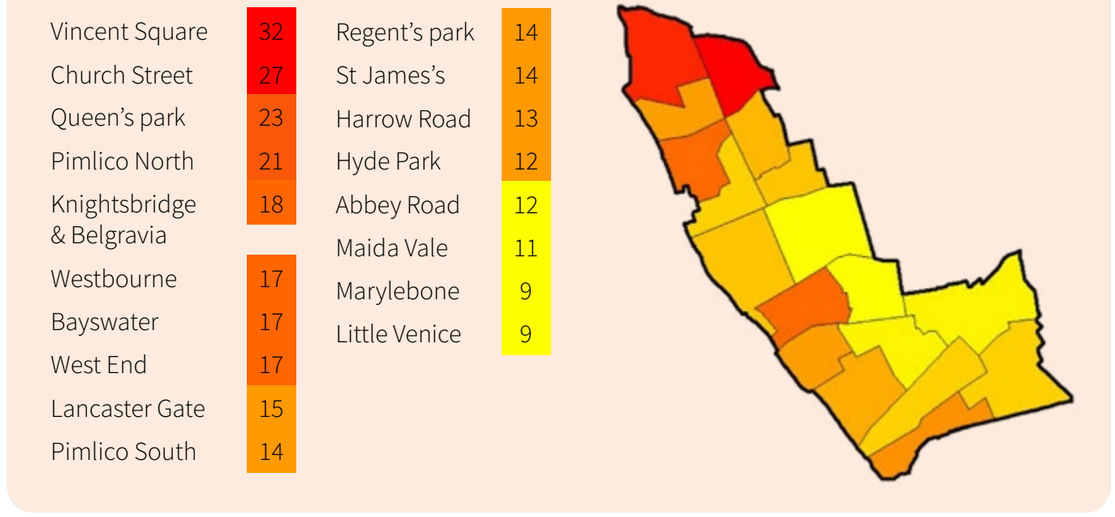
In our Annual Report last year we noted that there had been an increase in the number of concerns received involving domestic abuse or violence, from 80 in 2002-23 to 95 in 2023-24. In 2024-25 the number of concerns received increased further to 148, an increase of 56% (Chart 3). This is equivalent to average of 12.3 concerns per month, compared with 7.9 per month in 2023-24.

This increase was due in large part to an increase in the number of concerns received for younger adults, both in the 18-44 (from 45 to 71) and 45-64 (from 18 to 34) age groups. But it was also evident in the 65+ age group (from 32 to 43). This overall increase was associated in turn with three other trends: (a) an increase in the number of concerns where there was no recorded primary support reason (from 34 to 74) indicating that the adult had not previously been known to Adult Social Care; (b) an increase in the number of concerns for people from Asian/Asian British/ Chinese communities (from 10 to 28); and (c) an increase in the number of referrals to Multi-Agency Risk Assessment Conference (MARAC) (from 29 to 54) and to Independent Domestic Violence Advisors (IDVAs) from (20 to 29).

This increase can be attributed to a number of factors, notably an increase in the number of referrals received from partner agencies, especially the police, community health staff, hospitals and housing; and the ending of a S75 agreement between the local authority and the mental health trust which resulted in the transfer of mental health staff back to the local authority.

Chart 4 shows the geographical distribution of the concerns received over the last three years involving domestic abuse according to the electoral ward in which the adult at risk lived (for those adults who lived within the borough). A comparison with the distribution of deprivation across the borough (Chart 1.5b) shows that there is not a clear relationship between the two factors, with those wards with the highest number of concerns not necessarily being those with the higher levels of deprivation.

CHART 4: Number of concerns received involving domestic abuse, 2022-25



In the majority (73%) of cases the incidents of domestic abuse occurred in the adult at risk's own home, but some incidents occurred in another person's home and some also in the community.

Although the increase in concerns involving domestic abuse was most evident in the younger age groups there was also, as noted, an increase in the 65 years and over age group. And in this age group the person alleged to have caused harm was more likely to live with the adult at risk and to be the adult at risk's primary carer.

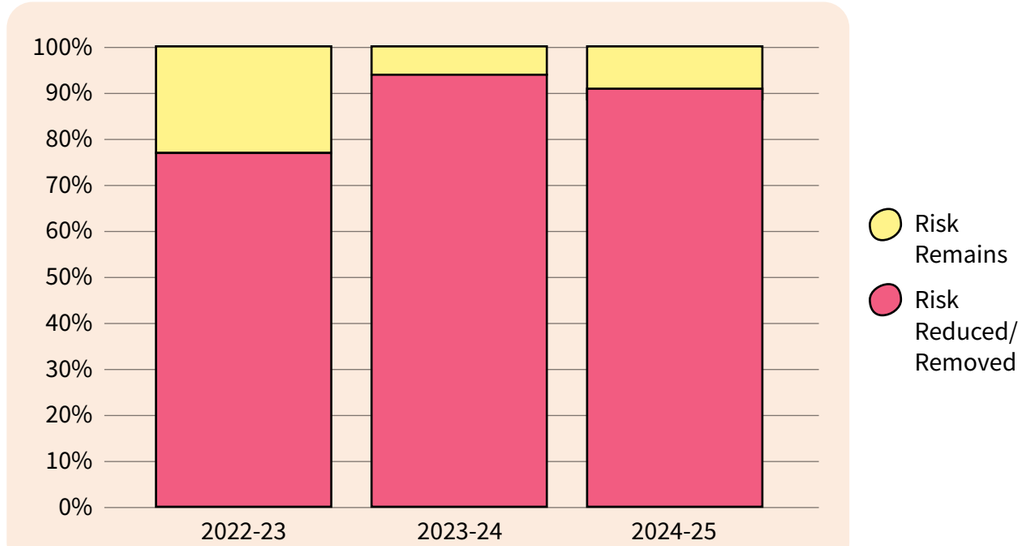
In 2024-25 the Quality and Assurance sub-group of the SAEB presented to the Board the findings of a review of partnership-wide data specifically on domestic and elder abuse. A deep dive report into domestic abuse and older people can be found in Part B of this section.

OUTCOMES OF COMPLETED S42 ENQUIRIES

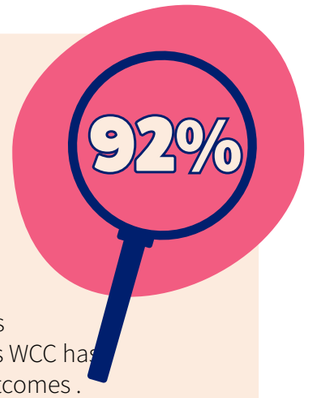
The Outcomes Framework for Adult Social Care for 2023-24 included for the first time an indicator relating to safeguarding. This indicator measures the impact that S42 enquiries have on the risk identified, specifically, where a risk was identified, whether the reported outcome was that the risk was reduced or removed.

In our annual report last year we reported that between 2022-23 and 2023-24 there was a marked increase in the proportion of completed S42 enquiries where the risk identified was assessed as having been removed or reduced (from 78% to 95%). In 2024-25 a high level of impact was maintained with the risk identified being removed or reduced in 92% of the S42 enquiries completed in the year.

Outcome of S42 enquiry, where a risk was identified



ANALYSIS:

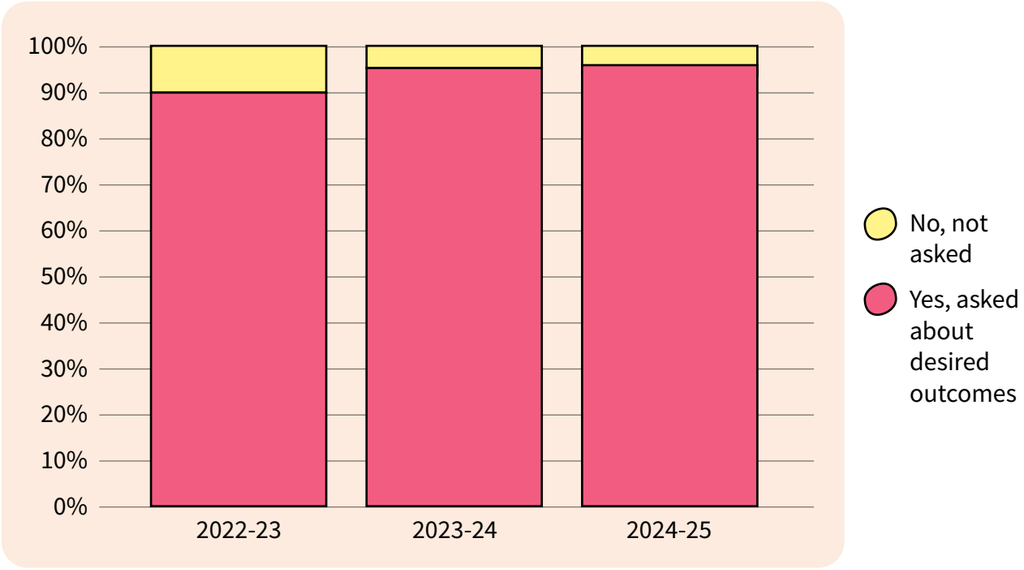


WCC's performance in removing or reducing the risk in **92% of completed S42 enquiries** indicates effective safeguarding practices and represents a key measure of success in safeguarding practices across the country. WCC is performing well in terms of outcomes of completed S42 enquiries maintaining a **high level of impact** in reducing or removing identified risks with effective practices in place and high levels of satisfaction among services users WCC has demonstrated exceptional performance in safeguarding outcomes .

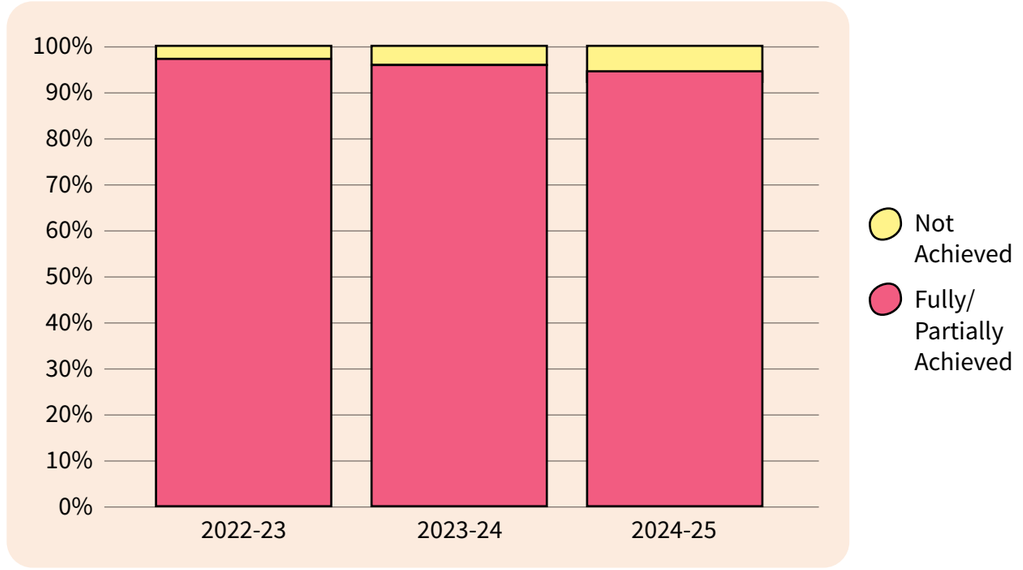
MAKING SAFEGUARDING PERSONAL

In 2024-25 positive outcomes were also maintained in relation to two indicators which look at the extent to which the adult at risk, or their representative, are placed at the centre of the safeguarding enquiry. In over 95% of S42 enquiries completed in the year the adult at risk (or their representative) was asked about the outcomes they wanted to achieve. And where a desired outcome was expressed in over 95% of cases these desired outcomes were assessed as having been fully or partially achieved.

Whether the adult at risk, or their representative, was asked what their desired outcomes were



Whether the desired outcomes were achieved



PART B: The Quality Assurance subgroup is co-chaired by the Metropolitan Police and Adult Social Care

In this section:

- Domestic Abuse and Older People
- Domestic Abuse Related Death Reviews (DARDR) and Learning for Safeguarding Adults
- Department of Work and Pensions commitment to Safeguarding Adults
- A Collaborative Effort: Reviewing and Enhancing Mental Capacity Act Compliance through use of Multi-Agency Audit

The Quality & Assurance subgroup has completed an enhanced review of the data and shared insights on Domestic and Elder Abuse.

There is a strong partnership in place in the Bi-borough, and over the past year, the group's efforts have focused on reviewing and discussing Domestic Abuse information and data insights from and with:

- Adult Social Care
- Chelsea and Westminster and West Middlesex Hospitals
- Serious Violence Duty Strategic RBKC Needs Assessment
- Bi-borough MARAC
- Central and North West London NHS Foundation Trust
- Carers Network
- Bi-borough Housing Departments
- Standing Together: Macmillan Domestic Abuse Toolkit
- Imperial College NHS Trust
- Metropolitan Police Service

> Protecting Adults at Risk and enhancing their lives is something very important to me.

Lucy O'Connor

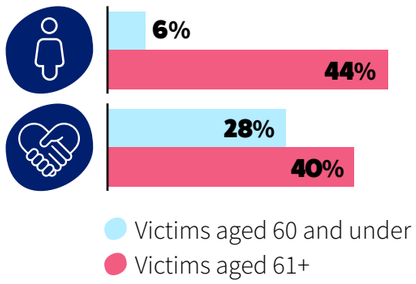
Detective Superintendent, Public Protection Central West Basic Command Unit, Metropolitan Police Service

Louise Butler

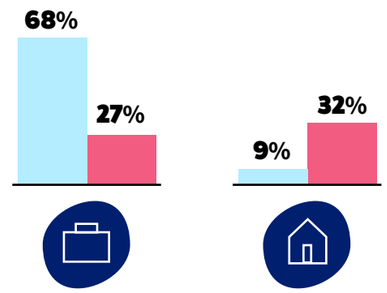
Head of Safeguarding, Quality Assurance and Engagement, Royal Borough of Kensington & Chelsea and Westminster City Council

What's different: Domestic Abuse and Older People

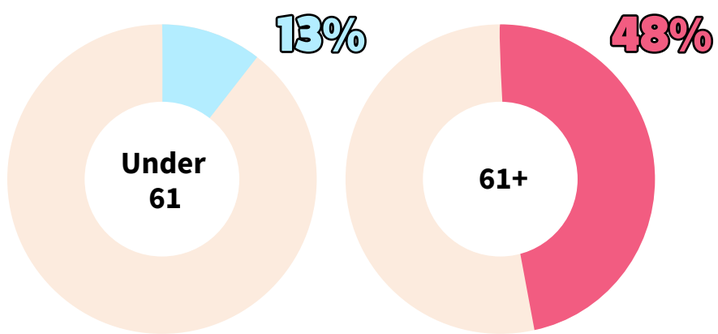
Victims aged 61+ are much more likely to experience abuse from an **adult family member** or **current intimate partner** than those 60 and under.



Older victims are **less likely to attempt to leave** in the year before accessing help, and **more likely to be living with the perpetrator** after getting support.



Older victims are significantly **more likely to have a disability** – for a third, this is physical (34%).



In partnership with

Data Insights into Domestic Abuse

1

Adult Social Care (Increase in Domestic Abuse concerns over the last 3 years):

The progression to a full safeguarding enquiry has increased, indicating greater awareness in this area and the need for more intensive interventions. In addition, the number of referrals to MARAC has increased in the last 3 years from 16 in 2022/23 to 34 in 24/5 in RBKC a 112% increase. In WCC from 32 in 22/23 to 47 in 24/25 which demonstrates a 47% increase.

2

Demographic Data:

There has been an increase in concerns among younger age groups, particularly those under 65. The rise in concerns is notable among the Asian/Asian British/ Chinese community and the 'unknown ethnic group' category.

3

Primary Support Reason:

There has been an increase in concerns among people without a recorded primary support reason, suggesting they were not previously known to ASC, and among people with a primary support reason of mental health, especially in RBKC.

4

Source of Referral:

The number of referrals over the last 2 years has significantly increased by 74% RBKC and 37% WCC from Police, Community Health Staff Hospitals Housing and 'other' in this area. Indicating greater awareness of how to refer.

5

Chelsea and Westminster and West Middlesex Hospitals:

A significant proportion of domestic abuse safeguarding referrals involve older individuals, particularly those aged 55 and above. Most referrals come through the Accident & Emergency department where there is a specalist worker.

6

Serious Violence Duty Strategic RBKC Needs Assessment:

MARAC data showed a high percentage of female victims and a low sanction detection rate for domestic abuse. There is also a high number of victims with disabilities.

What is an IDVA Independent Domestic Violence Advisers (IDVAs)

IDVAs will help victim/survivors to:

- Consider their options.
- Decide their next steps.
- Link in with the services of their choice.

Offer to ALL victim/survivors, regardless of risk.

Examples of support:

- In-depth risk assessment
- Tailored safety planning
- Support accessing specialist services – for example: counselling, housing, legal and refuge services
- Advice and advocacy on criminal and civil remedies.

1

Domestic Abuse and Mental Health (CNWL):

Insights include a lack of confidence in recognising and addressing domestic abuse among older adults, the importance of training and awareness, and the need to understand and identify subtle forms of control e.g coersion.

2

Carers and Domestic Abuse:

Challenges include complexity, isolation, and relationship deterioration. There can be a change in roles from romantic to careing which can cause confusion in terms of knowing what pathways to address the abuse.

3

Domestic Abuse Housing Alliance (DAHA) Accreditation:

Both Housing departments have developed new policies, procedures, training and data collection for domestic abuse cases and have launched a **Network of Domestic Abuse awareness champions.**

4

Cancer & Domestic Abuse Macmillan Toolkit

highlighted importance of being aware of domestic abuse signs within a health setting, ensuring safe disclosure settings at appointments, asking the right questions, providing specialist support, helping survivors make sense of their experiences and recognising health consequences - the need for in-depth training, practical information about helplines and a cultural shift where domestic abuse indicated

Domestic Abuse Related Death Reviews (DARDR) and Learning for Safeguarding Adults

Manju Lukhman

Violence against Women and Girls Strategic Lead Bi-borough

The SAEB has a close working relationship with Violence Against Girls Partnership.

The article below describes the governance arrangements for Domestic Homicide Reviews, DARDR and the interface with the SAEB and the SAEB Quality Assurance group and subsequent learning programme.

Purpose

The purpose of a Domestic Homicide Review, is to prevent domestic abuse homicides and suicides by improving service responses for all domestic abuse victims, including children, through enhanced intra and inter-agency working.

The process and objectives of Domestic Homicide Reviews DARDR sits under the Domestic Violence and Crime Act 2004, updated in 2021. The process involves establishing lessons from homicide to include suicide cases, identifying clear lessons within and between agencies, and applying these lessons to change policies and procedures. The inclusion of suicides as a result of domestic abuse and the voices of family and friends are emphasised to update the definition of domestic abuse.

Process

The process for conducting domestic homicide reviews starts with the appointment of an independent chair, the involvement of the victim's and the alleged perpetrator's families using the guidance provided by the Home Office. Currently it is the Safer Kensington & Chelsea and Safer Westminster Partnership who hold the statutory responsibility for co-ordinating the under taking of DHR/DARDR.

One key priority includes identifying all other parallel reviews such as safeguarding adults reviews for adults and child death reviews, drugs and alcohol, and suicide. The process aims to align any joint learning going forward.

The governance process includes obtaining approval from Community Safety Partnership Boards, formal notification to the Home Office, involvement of the VAWG Strategic Board, the VAWG Risk and Review Operational Group, and the completion of actions by working groups. Additionally the Safeguarding Case Review Group requests presentations on published cases review and align any current learning and training opportunities. The key learning for the purposes of this report is the increase in Domestic Abuse and older people and the key learning opportunities coming out of 2 recent DARDR's.

1

The purpose of a DARDR, which was established under the DV, Crime and Victims Act 2004 came into force in 2011. This process was formerly called 'Domestic Homicide Reviews' and the recent name change was due to;

The inclusion of suicides as a result of domestic abuse.

To include the voice of family and friends.

To include the updated definition of domestic abuse since the DA Act 2021.

2

Establish what lessons can be learned from the homicide/suicide in regarding the way in which local professionals and organisation's work individually and together to safeguard victims.

3

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

4

Apply those lessons to service responses including changes to policies and procedures as appropriate.

The newly named DARDR process has replaced the previous 'Domestic Homicide Review' process (DHRS). This name change, from the Home Office, who provide the guidance has been taken primarily, for these three key reasons:

1. To incorporate the full definition of Domestic Abuse from the DA Act 2021
2. To incorporate the full understanding of the volume of suicides nationally that have increased due to domestic abuse
3. To also ensure that friends and family members are invited to engage as much as possible, in the review process.

The new updated guidance has yet to be issued.

Each case establishes its own review panel process, with invited partner representatives. This is a confidential process. Once completed, the various CSPs sign it off and it goes to the Home Office for the final approval. The reports are published on the council websites and all of them will include a series of recommendations and actions that should be completed by the assigned partner agency.

Currently, several cases are in progress or have been completed across Westminster City Council and Kensington & Chelsea. The DARDR panel process provides a vital opportunity for learning, enabling all partners to come together to reflect on, share and analyse the lessons emerging from recent reviews. However it is important that this collaborative approach is also discussed within the safeguarding adults framework especially crucial when considering the complex needs and vulnerabilities of older people and challenges to identifying domestic or familial abuse from other types of abuse such as physical or psychological abuse. In many respects the abuse types are a product of how safeguarding adults came about and have not adapted as yet to new themes coming to light.

But despite this by engaging in open dialogue and collective evaluation, the safeguarding partnership is better equipped to identify patterns, address systemic issues, and develop coherent responses that transcend organisational boundaries. The benefits of such joint learning are substantial—pooling expertise and perspectives leads to more robust safeguarding strategies, ensures consistency in practice, and fosters an environment where early intervention and support can be prioritised for those most at risk.

Recommendations from the two recent reviews, which the SAEB has acknowledged, included several key actions and considerations for future partnership efforts, underlining the transformative potential of shared learning within the safeguarding community.

1. Piloting and embedding routine enquiry in all agencies,
2. Improving practitioners' knowledge and understanding of domestic abuse and support pathways,
3. Developing learning resources for professionals, and understanding different terminologies for identifying domestic abuse,
4. Emphasises raising public awareness of DA for older people,
5. Support for victims of long-term and sustained abuse who don't always want to leave the person who is causing the harm,
6. It highlights the importance of linking suicidal ideation to Violence Against Women and Girls (VAWG) and abuse,
7. It also suggests improving multi-agency responses by increasing awareness of how different groups experience DA,
8. Domestic Abuse Training ought to be separated out from safeguarding training.

The process for working within both a safeguarding adults and domestic abuse framework is not without its challenges. Discussions can reveal gaps in understanding between agencies, differences in terminology, and difficulties in aligning procedures. For older people, these challenges are further heightened by issues such as isolation, complex health needs, and barriers to accessing support. Addressing these obstacles requires ongoing commitment to clear communication, mutual respect, and a willingness to adapt and learn from one another. Through this joint learning, the partnership can build not only a deeper understanding of safeguarding issues but also drive meaningful improvements in services for older adults experiencing domestic abuse.

Enhancing Safeguarding Adults Activities: The Role of the DWP Joint Working Protocol

Archibald Okolie

DWP Advanced Customer Support Senior Leader
Department for Work and Pensions (DWP)

In the realm of safeguarding adults, collaboration and communication are vital.

The Department for Work and Pensions (DWP) Joint Working Protocol aims to enhance the inter-agency cooperation in ensuring the safety and well-being of vulnerable adults.

Background to DWP Joint Working Protocol

In response to recommendations from National Safeguarding Adult Reviews 'Billy' and 'Valentina' in October 2024, the DWP have created a joint working protocol between the Department for Work and Pensions (DWP) and Safeguarding Adults Boards (SABs) in relation to safeguarding adults under Sections 42 and 44 of the Care Act (2014). It aims to enhance collaboration and information sharing to protect adults at risk of abuse or neglect.

The Safeguarding Adult Reviews for Billy and Valentina highlighted several key recommendations for the Department for Work and Pensions (DWP).

SAR Billy:

main recommendations for the DWP to consider whether any case under internal review may meet the criteria under the Section 44 of the Care Act and to make referrals to the relevant Safeguarding Adult Board. This ensures that any relevant learning is communicated through the appropriate DWP channels, allowing the DWP Internal Process Review Group to be aware of the learning and themes, which can then be considered by the DWP Serious Case Panel to inform organisational change.

SAR Valentina:

emphasised the importance of timely and accurate communication between agencies and the need for a coordinated approach to safeguarding vulnerable adults. The review also recommended that the DWP develop a new joint working protocol aimed at improving collaboration and ensuring that learning from Safeguarding Adult Reviews is effectively integrated into their processes.

DWP's Response to the Recommendations

In response to these recommendations, the DWP has taken several steps to improve their processes and ensure that lessons learned from Safeguarding Adult Reviews are effectively integrated into their practices.

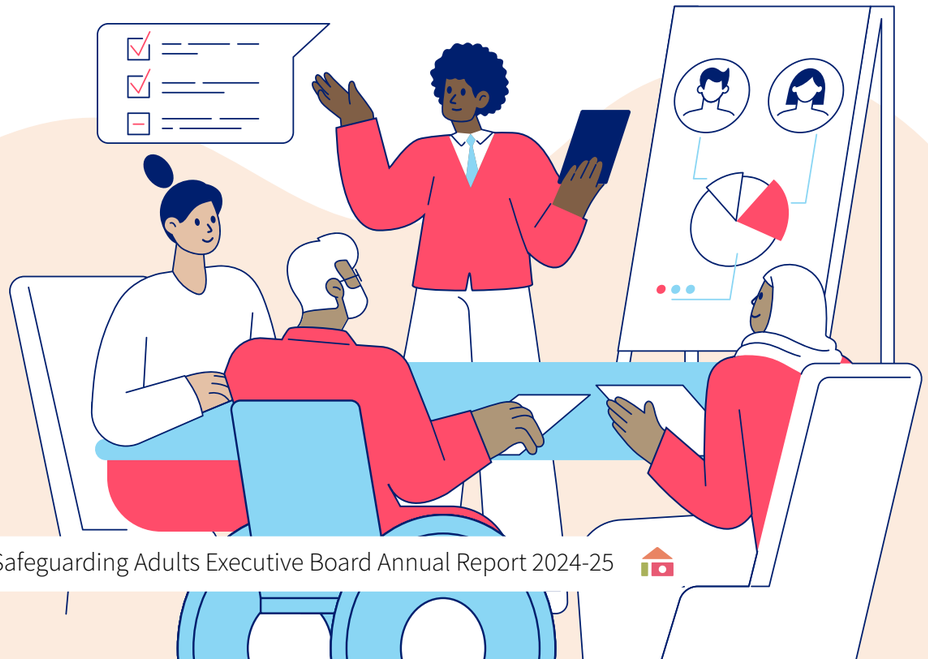
1. The DWP has developed a new joint working protocol that emphasizes the importance of referring cases that may meet criteria under the Care Act section 44 for a Safeguarding Adult Review and ensuring that any relevant learning is communicated through the appropriate DWP channels. This protocol is to be evaluated within 12 months of implementation to understand the effectiveness of its application and the outcomes achieved.
2. The DWP has implemented changes to improve their processes, including updating their Work Capability Assessment procedures to better reflect the needs of vulnerable individuals and ensuring that staff are trained to recognise and respond to safeguarding concerns. These changes are part of broader efforts to improve the DWP's response to safeguarding concerns and ensure that lessons learned from Safeguarding Adult Reviews are effectively integrated into their practices.

Local Activities support by the SAEB to support the implementation of DWP JWP

1. Section 44 Group Attendance: DWP now has a representative attending the Safeguarding Adult Case Review subgroup meetings.
2. SAR Champions Network: DWP have a representative attending this network to share the learning from local SAR's.
3. Training and Awareness
   - The DWP have distributed the Safeguarding Ambassador Learning Briefing to all staff on How to make a good safeguarding referral
   - They are working collaboratively with Adult Social Care to provide an in-person Safeguarding Awareness training session for staff.
   - They have adopted local policies related to safeguarding and ensure their staff are aware of these protocols.

SAEB SAR Protocol and guidance

Escalation Policy for Adult Safeguarding



A Collaborative Effort: Reviewing and Enhancing Mental Capacity Act Compliance through use of Multi-Agency Audit

Frank Butau

Chair, Learning & Development subgroup

Undertaking Mental Capacity Act assessments presents several national challenges cutting across legal, practical, workforce and systemic dimensions. The Mental Capacity Act 2005 is crucial in protecting and empowering individuals who may lack capacity to make certain decisions, but its implementation is not without issues.

In November 2022, the Safeguarding Adults Executive Board (SAEB) published a Safeguarding Adults Review (SAR) for 'Joan', noting minimal evidence of her wishes and a lack of mental capacity assessments in decision-making. In response, the Learning & Development Subgroup conducted a multi-agency audit in 2024 to assess how the Mental Capacity Act was applied and identify areas needing improvement. The audit concluded in December 2024 and was praised for its rigour and multi-agency collaboration.

The Audit Team:

- Frank Butau, Lead for safeguarding Adults & Learning Disabilities, Royal Brompton Hospital, Harefield Hospital, Guy's and St Thomas' NHS Foundation Trust
- Lynn Tan, Mental Capacity Act Lead, Bi-borough, Adult Social Care
- Trish McMahon, Business Manager, Safeguarding Adults Executive Board

The Audit Group included representatives from:

- Royal Brompton Hospital, Harefield Hospital, Guy's and St Thomas' NHS Foundation Trust
- Bi-borough Adult Social Care
- Central and North West London NHS Trust
- Metropolitan Police
- North West London ICB
- WCC Housing
- Central London Community Healthcare NHS Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust

The report outlines key findings from safeguarding cases involving mental capacity issues and ends with recommendations for the SAEB to monitor and review . We showcase 3 cases here with key findings.

Case Study 1

Cuckooing and Financial Abuse

Mr. C, an elderly man with dementia.

Finding: Verification of Lasting Power of Attorney LPA and Enduring Power of Attorney EPA: To ensure compliance with legal safeguards, it is crucial to:

Verify Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) claims through the Office of the Public Guardian (OPG) to confirm that only authorised individuals are making legally based decisions, particularly regarding Best Interests decision making. Too often questions are not asked as to the legal status of families or "friends" where concerns are around in whose best interest they are serving.

Case Study 2

Self-Neglect

Mr. D, living in unsanitary conditions, repeatedly refused external support, leading to significant health risks.

Finding: Record Keeping & Training needs:

There is a need to improve the quality and consistency of Mental Capacity Act Assessment, Best Interest decisions and Safeguarding decision making across all agencies. In some cases, records lacked evidence that individuals' capacity was assessed in a decision-specific manner, including their ability to use and weigh relevant information. Additionally, DoLS processes were not always appropriately followed when required.

To address these gaps:

- Agencies should strengthen internal guidance for recording MCA decisions, especially where individuals are unable to make decisions about care, accommodation, or safeguarding.
- Ongoing multi-agency training is essential to reinforce legal duties under the MCA, DoLS, and safeguarding frameworks.
- All decisions must be clearly documented, legally defensible, and show how individuals' rights and freedoms have been respected through least restrictive and person-centred approaches.

Case Study 3

Self-Neglect

Ms E, a Bariatric Care Patient with complex healthcare needs, faced multiple safety concerns in her flat.

Finding: Executive Capacity:

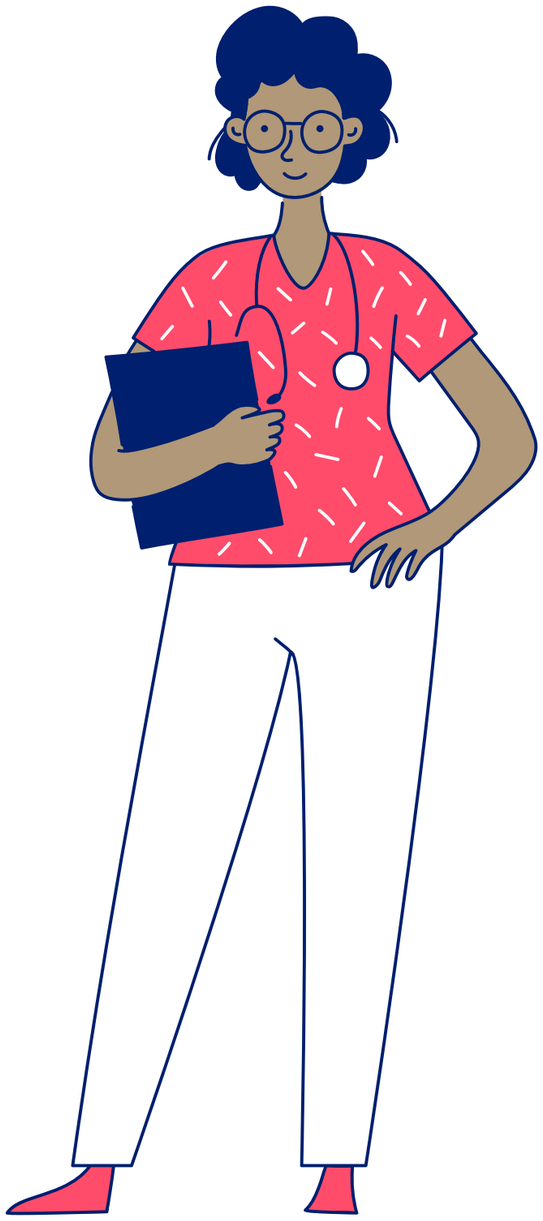
Professionals must assess not only whether a person can understand, retain, and communicate a decision, but also whether they can use and weigh information and act upon their decision – this is critical when assessing consequences of a decision to be made.

There is a risk of superficial assessments where individuals are deemed to have capacity based only on verbal interactions, without sufficient exploration of their ability to implement decisions or manage risks.

To ensure lawful and person-centred practice:

- Staff should consult with others who know the person well,
- Review previous patterns of behaviour and documented risks,
- Document all assessments and rationale clearly, including any concerns around executive dysfunction.

This will support robust safeguarding, appropriate use of Deprivation of Liberty Safeguards (DoLS) where necessary and improved multi-agency working in complex cases.



Audit Findings Summary

1. **Benefits of using MCA & BI templates:** While most partner agencies have access to MCA and BI templates, documentation practices remain inconsistent. Some capacity assessments lack evidence of the five core principles of the MCA (2005), resulting in defensive rather than person-centred practice. There is often insufficient demonstration of the causative nexus—i.e. the link between the individuals impairment and their inability to make a specific decision.

2. **Benefits of MCA having been accurately followed:** Effective implementation requires early identification of potential Deprivation of Liberty, consistent use of advocacy services, coordinated multi-agency input, and high-quality, legally sound documentation. Person-centred approaches improve outcomes and help safeguard individual rights.

3. **Verification of LPA and EPA Authority:** Where individuals claim to hold Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA), agencies must verify this through the Office of the Public Guardian (OPG) before any best interest decisions are made. In all cases involving moves to care settings (including respite), a Standard Authorisation under the Deprivation of Liberty Safeguards (DoLS) should be obtained prior to placement.

4. **Record Keeping & Training:** There are significant gaps in documentation relating to MCA assessments and best interest decisions, particularly in relation to consent to care, safeguarding, changes in accommodation, and financial matters. All partner agencies would benefit from targeted training on the MCA, DoLS, executive capacity, and safeguarding responsibilities to improve lawful and effective practice.

Misinterpretation of the Act

Some professionals wrongly assume a person lacks capacity based on diagnosis such as dementia or learning disabilities. This violates the principle that capacity must be decision -specific and time specific.

5. **Executive Capacity:** Frontline staff require confidence and support to assess executive capacity – i.e. whether a person can not only make a decision but also act on it. There are risks associated with superficial assessments where capacity is presumed based only on verbal reasoning, without evaluating the person's ability to follow through. It is essential to consult those who know the individual well and to consider previous risk history and behaviour patterns when assessing executive function.

> "Some professionals wrongly assume a person lacks capacity based on diagnosis such as dementia or learning disabilities."

Key Recommendations being taken forward by all SAEB Organisations

SAEB partner agencies will participate in an annual MCA Temperature Check to monitor compliance and share best practices. Thanks are extended to all partners for their collaboration on this project

1. **Mental Capacity Act 2005 (MCA) and Best Interests Templates:**
   - Review and update all agency templates to ensure full integration of the five statutory principles of the MCA. Improve the quality of documentation by ensuring decisions are clearly linked to functional impairments affecting capacity (causative nexus).

2. **Staff Adherence to the MCA 2005, Code of Practice, and Relevant Case Law:**
   - Promote multi-agency identification of Deprivation of Liberty Safeguards (DoLS) cases and encourage early legal consideration.
   - Embed person-centred planning, improve documentation, and align decision-making with legal duties under the MCA and DoLS framework.

3. **Verification of Lasting Power of Attorney (LPA) and Enduring Power of Attorney (EPA) Authority:**
   - Implement standard procedures for verifying LPA and EPA status via the Office of the Public Guardian (OPG). Ensure that no decisions are taken under assumed authority without formal verification, especially when making best interest decisions.

Legal and Ethical Complexity

Best interests vs. autonomy

Balancing a persons autonomy with protection can be ethically challenging.

Interface with the Deprivation of Liberty Safeguards (DoLS)

The system for authorising deprivation of liberty is widely recognised as unfit for purpose . The Liberty protection safeguards LPS were supposed to replace DoLs but implementation has been repeatedly delayed (as of 2025 still pending).

This has left professionals unclear about lawful deprivation processes in care settings. We continue to have no backlog in the Bi-borough but many Local authorities struggle in this area placing themselves in a position of being legally non-compliant.

The Learning and Development subgroup are in the process of developing a series of resources on the Mental Capacity Act (MCA) and e-learning as follows

- Learning Together from Safeguarding Audits – SAEB MCA Multiagency Audit Webinar
- The Mental Capacity Act & Bariatric Care across the Bi-borough
- Bite-Size MCA Resource - Enhancement of MCA Assessments and Best Interest decisions documentation
- Understanding Executive Capacity & Self Neglect Webinar

Thematic Fatal Fire – Evaluation and Evidence of impact

For the past couple of years the SAEB has been focusing on the implementation and evaluation of the recommendations coming out of the Thematic Fatal Fire Review.

Previous SAEB Annual Reports have presented summaries and findings and in this Annual Report we present how we have evaluated impact and continued learning in a closing report.

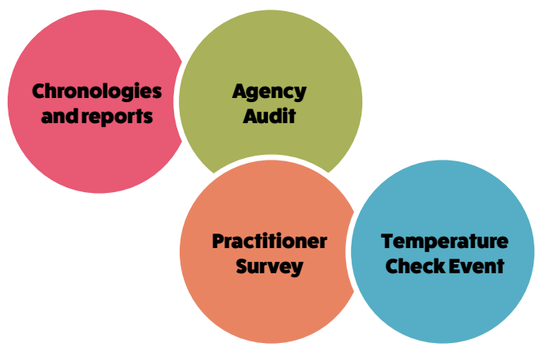
The SAEB hosted a Fire Safety temperature check in February 2025 which was hosted by Independent Reviewers Michael Preston-Shoot Professor (Emeritus) Social Work at the University of Bedfordshire, England and Emeritus Professor Suzy Bray of Social Work and Social Care University of Sussex. The purpose of this event was to evaluate the learning from the Fatal Fires Thematic Review.

SAEB Fire Safety Learning Event

The Action plan outlines a series of initiatives and training sessions which were implemented between late 2022 and 2024 to improve fire safety and safeguarding practices. These have been well documented in previous SAEB Annual Report.

Frontline practitioners have participated in focused workshops to identify their priorities to help shape fire safety webinars and multiagency support for at-risk adults. This co-produced approached has ensure buy in from practitioners to understand immediate risk and how to mitigate . This has led to a re launch of our enhanced SAEB Fire Safety Framework which now includes updated guidance and practical tools for improving fire safety practices across various settings to include:

- Executive Decisional making capacity: executive capacity is about putting decisions into practice and understanding how to handle the consequences
- Telecare: Now with info on equipment, who provides it, and who makes sure it works.
- Feedback Loop: Added details from the London Fire Brigade about what happens after home fire safety visits.
- Home Fire Safety: Clearer on rules for care homes and other living situations to keep everyone safe.
- Self-Neglect & Hoarding: Now includes tips on tackling fire risks linked to self-neglect and hoarding.
- Resources: More helpful info and links for staff and teams.
- Staff Training: Top ten tips for better training and support, made simpler and more practical



Thematic Review Action Plan

December 2022

Safeguarding Ambassador 'Think Fire' Campaign – resources: video, learning briefings, bulletins on Home Fire Safety.

LFB produced a PowerPoint briefing on a **new approach to Home Fire Safety Visits** (HFSVs) and shared it with ASC and Blue Light Services.

April 2023

Community Engagement Fire Safety Event (June)

SAR Champions Network dissemination evidence gathered (practice forums, team meetings, internal communications, training and supervision, clinical groups, and external partners).

June – August 2023

Learning briefing highlighting review findings distributed across the partnership (August).

November 2023

Thematic Review webinar 'lunch and learn' focusing on fire safety and risk.

Evaluation of Changes to Practice to SAEB.

December 2023

Fire Safety Focus Group session for MA front-line practitioners from across the partnership.

SAEB ratified and launched the **MA Fire Safety Framework,** including the Multi-Agency Fire Safety Competency Framework and MCA Guidance.

March 2024

(4 Key Priority Areas identified for development)

Resources: Aide Memoire, Training Pack

Fire Competency Training Webinar for SAEB Members

October 2024

Practitioner Questionnaire launch

Electrical Fire Safety Webinar. Resources: Training Pack

November 2024

Fire Safety Awareness Training for front-line practitioners and managers.

Resources: Training Pack & Q&A

Data Review

LFB referrals (ASC)

HFSV's (LFB)

December 2024

MA Framework revised to incorporate additional key priority areas (tools and resources), identified via training events and development of Fire Safety Toolkit for communities.

Anticipated planning for animated **E-Learning Fire Safety Toolkit** for Communities on SAEB Website.

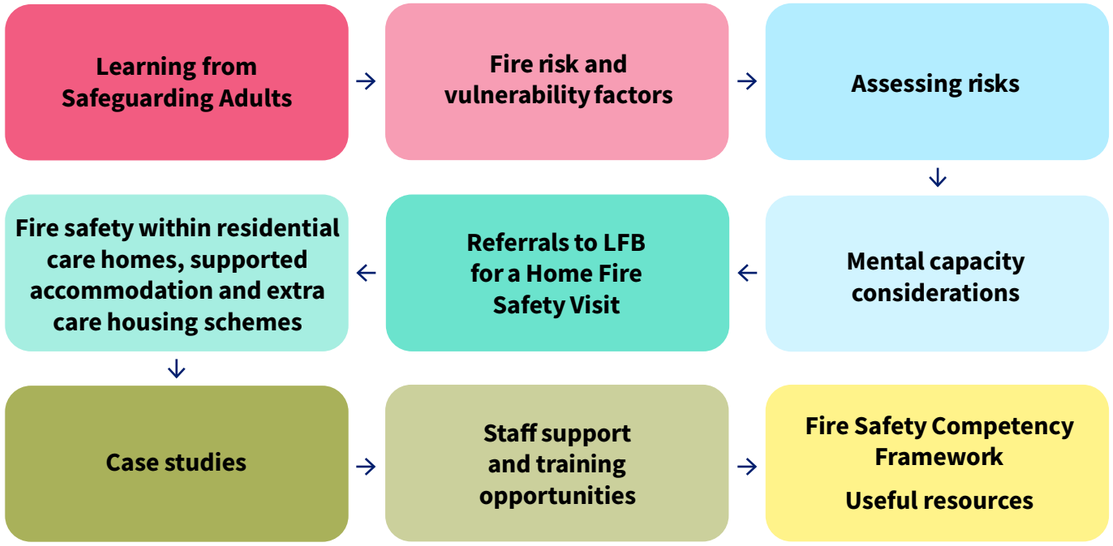
January – February 2025

Fire Safety & Hospital Discharge Meetings for Acute Trusts

Spring 2025

Fire Safety Learning Event 06.02.25

Multi-agency Fire Safety Framework



The evaluation report was very positive and demonstrated that there is clear impact on how the SAEB partnership has implemented actions for the benefit of adults at risk and professionals who are supporting them.

Fire safety integration: Fire safety is now a key part of conversations within and across teams, supported by clear risk assessment tools.

Increased awareness: There is a rise in fire safety awareness, including the Multiagency Fire Safety Framework and discussions about telecare and assistive technology.

Fire risk assessments: More fire risk assessments are being conducted across various agencies.

Safeguarding issue: Fire safety is recognised as a safeguarding issue, with concerns about self-neglect being escalated.

Professional curiosity: There is a greater focus on identifying fire risks.

Capacity assessments: Executive functioning is being considered more in capacity assessments.

Therapist engagement: Therapists are positively engaging in assessing risks around functional skills.

Care plans: Fire risk assessments are increasingly included in care plans, along with safety equipment needs.

Mosaic impacts: The inclusion of fire risk assessments in Mosaic allows direct referrals to the London Fire Brigade.

Home Fire Safety Checker: There is greater use of the online Home Fire Safety Checker, improved communication with the London Fire Brigade, and better post-referral feedback.

Housing and care provider engagement: Active engagement between housing and care providers is improving the addressing of fire risks in properties.

Housing Officers (including Block Designated Officers, Fire Safety Officers, and Tenancy Sustainment Officers) are recognised for supporting multi-agency involvement, particularly for tenants who self-neglect or hoard. Their role is seen as crucial in safeguarding adults at risk.

Training and commissioning: Increased participation in fire safety training, inclusion in safeguarding training, and consideration in commissioning with involvement from fire experts.

Integrated Care Board: Advancing Safeguarding in Health Services: A Collaborative Approach to Health Outcomes

Musthafar Oladosu
Designated Professional for Safeguarding Adults

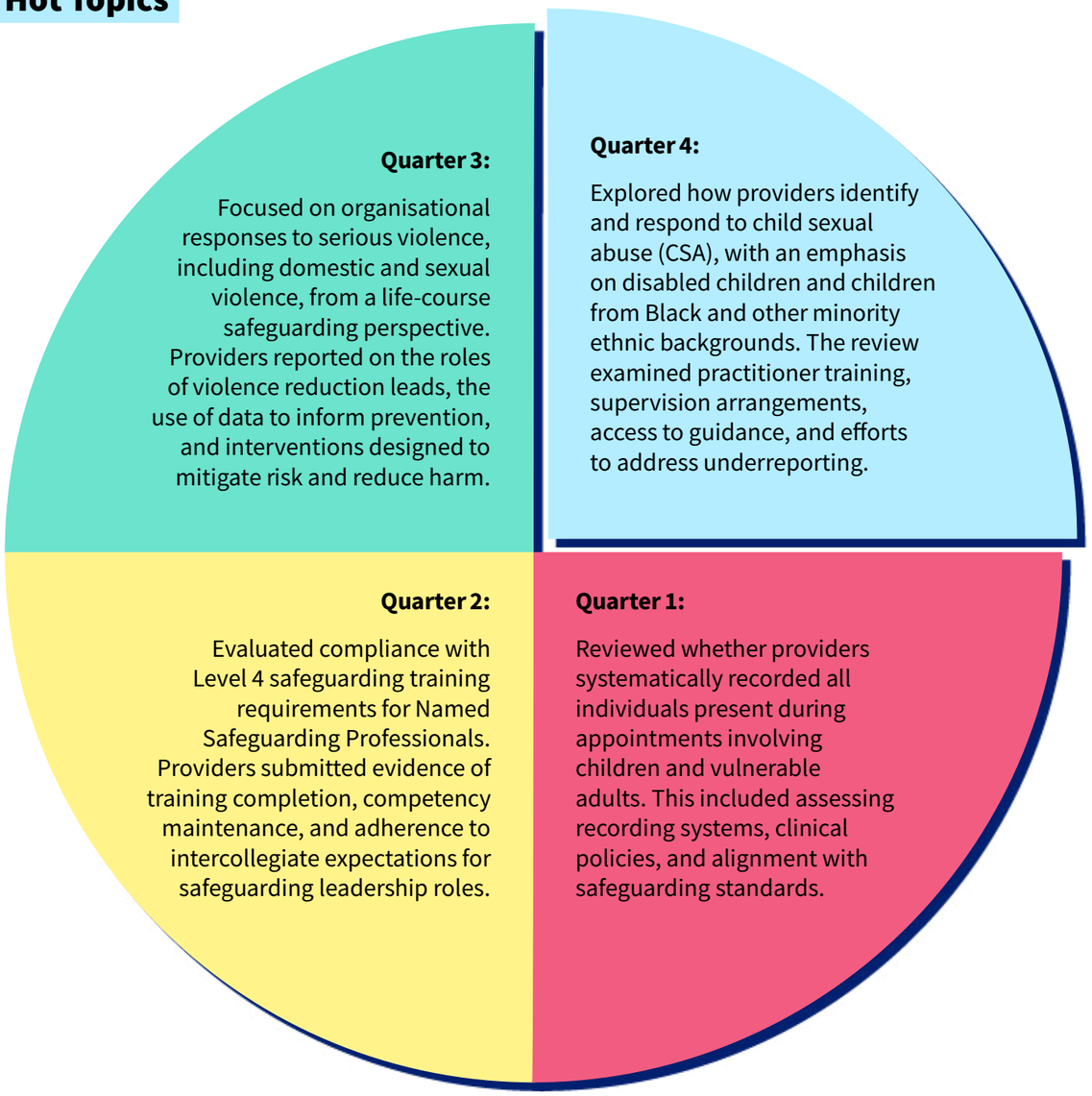
At the Safeguarding Adults Executive Board meeting in December 2024, I shared the significant progress made by the Northwest London Integrated Care Board (ICB) in safeguarding health outcomes.

Our safeguarding commitment has been marked by the continued implementation of the Safeguarding Health Outcomes Framework (SHOF), a tool that embodies our commitment to consistent reporting and assurance for the ICB, providers, and the Board. The framework is comprehensive and collaborative in nature. Over the past two years, we have engaged in a co-review process with providers, fostering shared ownership and a commitment to making the tool fit for purpose.

Our assurance framework covers a broad spectrum of areas, including leadership, training compliance, partnership working, and responses to social issues and vulnerable groups. We have placed a particular focus on critical issues such as Pressure Ulcers/Pressure Ulcer Protocol (PUP) and allegations against staff, ensuring these areas are continuously monitored and improved. Learning from safeguarding reviews and embedding this learning into practice is at the heart of our continuous improvement efforts.

In addition to reporting on safeguarding activities and data, in 2023 the ICB introduced “Hot Topics” which our commissioned NHS partners are able to demonstrate their good work and provide assurance to both their own Board, and the ICB. These initiative has been instrumental in addressing contemporary broader safeguarding issues. Adopting comprehensive children and adults’ perspective, the following four safeguarding topics were covered in 2024-25:

Hot Topics



Across all four topics, several consistent themes emerged:

- Variability in **professional curiosity**, particularly in complex cases,
- gaps in **inter-agency communication**, including record-sharing,
- challenges in the **escalation of safeguarding concerns**, particularly when navigating different organisational thresholds.

Actions initiated to address these include enhanced collaborative working, improved escalation protocols, and targeted professional development activities.

Internally, ICB Safeguarding professionals are consulted and provide expertise in all cycles of contracts, including the re-commissioning or changes in service contracts and in new contracts, to ensure that safeguarding standards and requirements are embedded across ICB activities.

This is to ensure through the contracts process health service providers and healthcare workers contribute to multi-agency safeguarding working.

KEY HEALTH ACHIEVEMENT

- exceeding national targets for Annual Health Checks for people with Learning Disabilities and Autism. This accomplishment underscores our dedication to the health and well-being of vulnerable populations.

The ICB SHOF continues to support improved consistency, reflection, and accountability across provider organisations. ICB values have strong emphasis on partnership working and the well-being of vulnerable populations to drive high standards for safeguarding practices across the Bi-borough.

Other areas of collaborative achievements

1. Focus on Violence Against Women and Girls, VaWg

The NW London ICS VaWG Steering Group was established as a health system response to develop and coordinate improved VAWG work across the region. Chaired by the ICB Assistant Director for Safeguarding, it includes NHS, local authority, public health, and third sector members. Key topics include non-fatal strangulation pathways and a VAWG data dashboard. In March 2025, a new Level 3 Domestic Abuse training for clinicians and primary care was launched, with more sessions planned.

The IRIS (Identification and Referral to Improve Safety) programme is a nationally recognised, evidence-based model designed to support general practice teams in identifying and responding to domestic abuse. NWL ICB commissioned IRIS as a pilot across Westminster and Hammersmith and Fulham for a 18-month period, concluding in December 2024. There were 40 referrals from Westminster service with 63 training sessions delivered and 17 practices out of 39 trained.

Patient feedback highlighted the impact of the programme in reducing stigma increasing access to support and improving confidence in seeking help.

> I really appreciate the support. People in my situation are hesitant to reach out for support due to the stigma, but I am so glad I made that step and made that contact. The support has been great and made things easier to cope with. I feelmore comfortable sharing my story and being able to talk to someone has really helped me. You have been amazing.

2. Mental Capacity Act and DoLs

The ICB was a member of the board's multiagency MCA audit described in this report and ICB patient facing teams and GPs participated in the audit. The Continuing Health Care (CHC) team make Court of Protection applications for community DoLS. ICB Designated Professionals provide advice to Primary Care and CHC on a case-by-case basis, via reflective supervision, and via MCA presentations. ICB staff have access to legal guidance also. Resources, case law updates, training and webinars are routinely shared with CHC, health providers and Primary Care. The NHS NWL ICB Safeguarding team receive assurance of training compliance, and MCA application from providers through the quarterly SHOF, with data on DoLS applications, whilst the collaborative support offered to providers enables themes to be identified to ensure lawful application of DoLS criteria. Close working with the Supervisory body e.g Adult Social Care ensures a collaborative approach .

TRAINING ASSURANCE

The North West London (NWL) Safeguarding Training Group successfully coordinated and delivered the 2024 to 2025 NWL ICB Safeguarding training offer, which included Level 3 Safeguarding Adults training targeting the ICB patient facing teams, GPs and other primary care staff. Five sessions have been delivered in 2024-25 with positive feedback from participants:

> Thanks for your time and expertise.

> The training was beneficial, thank you both.

> Massive thanks once again, and congratulations everyone for carving out time to keep improving practice.

Other training commissioned and delivered by the ICB were Self Neglect and the Mental Capacity Act, MCA and Aftercare under s117, Organ Trafficking, The Impact of Substance misuse on young people and family, Self-Neglect and the Mental Capacity Act; Trauma Informed practice .

Themes identified and work already completed / underway

The group identified 3 pivotal themes:

- the challenges to identifying dual caring and familial roles where DA may be indicated
- the importance of looking beyond the relationship and recognising when something just doesn't look right "professional curiosity"
- the need to continue to highlight domestic abuse in older people and how this needs to be managed differently to younger age groups
- A standout achievement for the group in 2024 was the impactful video collaboration with the Safeguarding Ambassadors and the Community Engagement group. The video, features compelling scenarios of what challenges there are to caring in a familial setting. This is our most watched resource to date.
- The video has received a positive response at a national level and was presented and discussed at:
- National Safeguarding Adults Week in November 2024 to raise further awareness of these themes.
- STAY CURIOUS CAMPAIGN: In June 2025 in collaboration with the Community Engagement Group for World Elder Abuse Day we will launch a further campaign named 'Stay Curious' to further promote the video and professional curiosity resources.

Summary of Recommendations being taken Forward by the SAEB

BME Safeguarding Network: **Safeguarding, Domestic Abuse, and Protected Characteristics to include** 'Voices of the Person', raising awareness, Intersectionality and safeguarding.

Continued Training for staff and promoting and raising awareness of local and accessible services for victims and disabled victims and Independent Domestic Violence Advocates and other support services for older individuals.

Organisations are requested to promote the Macmillan Toolkit which includes research findings on the intersection of Domestic Abuse and Cancer.

1

2

All SAEB organisations to improve the recording of the ethnic group of adults at risk who are 'not known to services' on the referral form.

3 and 4

5

SAEB to promote partnership approaches to Professional Curiosity Resource, developed by the National SAB Managers Network Workstream Group.

6

Stay Curious Upcoming Campaign World Elder Abuse Day

June 2025 in collaboration with the Community Engagement Group we will launch a further campaign named 'Stay Curious' to further promote the 'I am someone please see me' video and professional curiosity resources.

Section 2. Making Safeguarding Personal

Safeguarding Ambassadors

In this section we hear the voices of people with lived experience of safeguarding willing to give up their time and skills to raise awareness of safeguarding in their communites.

We are immensley proud of the dedication of our Safeguarding Ambassadors to keeping people safe and the SAEB thanks,


Mariya


Elaina


Glenda


Shiv


Micheal


Faye


Rose


Hassnna


Phayza


Farida


Rose

Newest Members of the Safeguarding Ambassador Group


Maureen


Jean


Jackie

"I am very happy to have joined the Ambassador Group. I have been warmly welcomed by members who are dedicated to raising awareness of safeguarding to create a safer, more caring community."

Mariya's Report: Chair of the Safeguarding Ambassador's Group

Hello everyone, my name is Mariya, and I have been chair of the Safeguarding Ambassador Group for 8 years.

It has been another very busy year for our group who have been organising and attending local events both online and in person to raise awareness of abuse and neglect . We have learnt a lot about keeping people safe. In this section we have shared some of our highlights which will include:

- Electrical Fire Safety Webinar
- Romance Fraud and online digital safety and scams Webinar
- Celebrating the Winter Season with the London Fire Brigade

Romance Fraud and Online Digital Safety Webinar Highlights

In February 2025 we had over 240 people sign up to our Romance Fraud and online digital safety event.

Romance fraud is a really nasty scam that can happen to anyone. Basically, it's when someone pretends to build a relationship online just to trick you over weeks or even months, and the fallout can be emotionally and unfortunately financially pretty tough.

This year, with romance scams on the rise, the Ambassadors have teamed up with the Police to dig a bit deeper into how these scams work, the sneaky tricks scammers use, and the tech that can help spot them. We'll also chat about what online platforms can do to help keep everyone safe.

Our event was led on by Prez from the Metropolitan Police's fraud and digital assets crime prevention team, who provided an in-depth look into various types of online fraud, with a particular focus on Romance Fraud.

The Seasons of Romance Fraud

Prez explained the stages of romance fraud using a seasonal metaphor which was a very useful guide to understanding the extend to which the fraudsters will draw out their scam.

Spring

The initial phase where the fraudster establishes a connection, using loving language and shared interests to build trust.

Summer

The victim becomes emotionally dependant, sharing personal information and keeping the relationship secret.

Autumn

The fraudster starts requesting money, exploiting the victim's emotional dependency.

Winter

The victim realises the relationship was a scam, leading to emotional devastation and financial loss.

The Case Study below tells the story of Mary a 61-year-old divorcee who fell victim to romance fraud.

Case Study 1

Mary's Story

Mary is 61 and divorced. She has two adult children and lives alone. She went on dating website and matched with a Spanish man called Jose Alvarez. They started talking on dating platform before moving onto WhatsApp. They tried to video call a few times, but Jose said there were issues with his connection in rural Spain. Over the course of 3 weeks, they spoke every day on WhatsApp, sharing deep feelings, intimate photos and Mary told Jose about how her ex-husband used to rape her when he got angry. They shared intimate photographs. Jose said he was an architect and sent photographs of himself from his smart office.

Although they hadn't met, Mary considered Jose her boyfriend. She shared everything happening in her life with Jose and trusted him implicitly.

Jose arranged to stay with Mary over Christmas. He asked if he could bring his daughter as he wanted her to meet Mary. The day Jose was meant to arrive in the UK; he called Mary to say that he had been involved in an accident on his way to the airport. Jose told Mary his medical treatment could cost £5000 and he couldn't pay himself as he was awaiting funds to be released by an overseas investor. Mary offered to transfer money to pay for the treatment. The cost of the treatment increased by £3000 so Mary transferred more money. Jose's passport was also destroyed in the accident. He needed another £6000 to pay for a new passport, flights and a hotel near the hospital for his son. There were more and more requests for money over the next few days. Meanwhile, Jose sent photos from inside the hospital.

Mary's bank became suspicious and refused to allow more bank transfers. Mary convinced her friend to transfer £10,000 to the suspect. She told her friend it was for her husband's VISA. Jose told Mary that there had been a problem with the payment to the hotel. He said he would send the invoice from the hotel again as the incorrect payment details had been included in the first invoice. Mary reported the matter to police because she thought the Spanish hotel had defrauded her. She still trusted Jose. The police tried to convince Mary that Jose was the criminal, not the hotel, but she still believed in him deep down. Mary told police she had met Jose in person because she was embarrassed. She only admitted to have given £4000. Eventually, Mary told her son who found out Mary gave Jose a total of £43,000 over the course of 3 weeks. Mary was now in debt and her pension wasn't enough to cover the repayments.

Mary eventually told her son part of what had happened. Her son did some research online and found a Facebook group of Jose's other victims across the country.

Jose started calling Mary from a new number. Telling her he loved her and would come and prove to her that their romance had been real. He told her he was getting a flight the next day. He said he had a surprise gift with him ready to give her. Mary asked Jose which flight it was. He was vague in his responses but eventually gave a flight number. Mary got the bus to the airport to meet him off the plane. Jose didn't arrive, but messaged Mary a few hours later to say he had been deported after arrival. He blamed Mary for reporting him to the authorities.

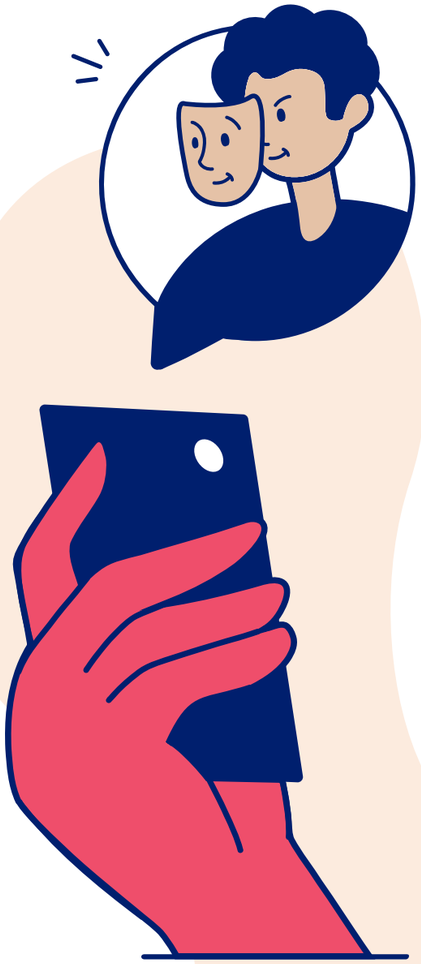
Jose never existed. The passports he had sent photographs of were fake. His profile photograph on a dating website had been generated by AI and the photographs he had sent from the hospital and from Spain were images from the internet. 'Jose' was based in Ghana and had used a deep fake website to generate a Spanish accent. He only ever used overseas phone numbers and VPNs. The funds Mary sent had been moved from a UK-based mule account into digital assets. They had been washed through several wallets before ending up in a Panama-based cryptocurrency exchange, where the funds had been off-ramped into USD and then sent via a money-service bureau to Ghana in Ghanaian Cedi.

What we learnt from Mary's Story

Victims of romance fraud can be diverse, ranging from young professionals to retirees, and may include those who have experienced past traumas. Fraudsters use general and niche dating apps, often with multiple profiles and AI-generated images. They communicate via WhatsApp with spoofed or overseas numbers and may use deep-fake technology for voice manipulation.

Fraudsters exploit victims' shame and embarrassment over explicit photos, convincing them of their fabricated wealth and romantic promises. They use emotional manipulation and guilt trips to extract money, often reassuring victims of repayment. Victims may disclose past traumas, which fraudsters exploit to maintain control.

Victims are encouraged to find alternative ways to send funds, sometimes committing fraud themselves. They may feel isolated and ashamed, making it difficult to report the fraud. The same suspects can have multiple victims, and characteristics of romance fraud overlap with domestic abuse, including victim-blaming and emotional control. Victims may struggle with debt and shame, sometimes resorting to extreme measures to cope.



The webinar also highlighted several key points around digital and online safety:

- **The Emotional Impact of Fraud:** The emotional toll on victims of fraud and cybercrime was discussed, highlighting feelings of anger, stress, and anxiety.
- **Social Engineering:** Techniques used by criminals to manipulate individuals into giving up confidential information were explained
- **Common Types of Fraud:** recruitment fraud, courier fraud and investment fraud

We found the training informative and where surprised about the extent to which criminals manipulate emotions. We learnt that we need to be vigilant because criminals are tricky and very resourceful. We felt that a Romance Fraud Briefing would really help communities and Voluntary Sector Organisations to spread messages. Thanks to the police and Prez for supporting our briefing below.

Safeguarding Ambassadors - Romance Fraud – 7-minute briefing

METROPOLITAN POLICE

1 Romance fraud

Romance fraud happens when you think you've met the perfect partner through an online dating website or app, but the person is using a fake profile to form a relationship with a victim and then asks for money or personal information to steal your identity.

2 How it happens

Romance fraudsters are masters of manipulation and will go to great lengths to create a false reality in which the victim feels that they are making reasonable and rational decisions.

3 Denial

Family and friends of romance fraud victims may find it challenging to disrupt the false reality created by the fraudster and enable the victim to see the situation for what it really is – fraud.

4 The Set up

People who trick others in fake relationships use words to control and trick them. They make their victims see things differently, like in bad relationships. The victim thinks they are making good choices, but they don't know they are being tricked. It's hard for them to see what's happening, even if others can see it.

REMEMBER: Romance fraudsters use words to trick and control people and disguise their requests with stories that seem reasonable. They build trust and they deceive victims to gain money by fabricating bad luck stories.

5 Isolation

Methods that romance fraudsters use to cut off their victims from external sources of support.

Fraudsters try to cut off their victims from people who can help them. This makes it easier to trick the victim. Fraudsters can do this by:

- Making the victim feel guilty for asking for advice
- Getting angry when the victim asks for advice
- Saying the victim is hurting the relationship by asking questions

This is similar to how domestic abusers act. So, romance fraud can feel like domestic abuse.

It can be hard for someone who has been tricked by a romance scam to see that they are being hurt. The scammer makes the victim believe that everything is perfect. The scammer uses tricks to make the victim feel many emotions. When the victim finds out the truth, it can be very hard for them. They may feel very different than they did before.

6 Always

- Be wary of revealing personal information about yourself online.
- Remember that anyone can pretend to be anyone they want to be online.
- Be wary if you are encouraged to keep things from your family and friends.
- **STOP:** Taking a moment to stop and think before parting with your money or information could keep you safe.
- **CHALLENGE:** Could it be fake? It's ok to reject, refuse or ignore any requests. Only criminals will try to rush or panic you.
- **PROTECT:** Contact your bank immediately if you think you've fallen for a scam and report it to Action Fraud.
- **REMEMBER:** If you meet someone on a dating site, keep chatting with them on that site. Don't switch to other messaging apps.

7 Help available

If you believe that you have been a victim of a romance fraud, please remember that you are not to blame, are not alone, and you should not feel ashamed. Support and help is out there.

Victim Support helps anyone affected by crime. Get in touch anytime for independent, free, and confidential advice:

- Call Supportline on 08 08 16 89 111
- Text Relay: use the Relay UK app or contact us in BSL
- Start a live chat

In an emergency you should always call 999.

You can talk to Victim Support on 08 08 16 89 111 whether or not you've reported the crime to the police. They can support you without the involvement of the criminal justice system.

Please report Romance Fraud to: www.actionfraud.police.uk or contact 0300 1232 040.

If you have any information about those behind Romance Fraud Scams and want to remain 100% anonymous you can contact the independent charity Crimestoppers on 0800 555 111 or on the online reporting tool.

Electrical Fire Safety Week Webinar – December 2024

In December we supported the London Fire Brigade's Charge Safe Campaign and held a webinar on Electrical Fire Safety.

The growing risk of e-bike and e-scooter fires is a key area that the Electrical Fire Safety Webinar highlighted.

Lithium battery fires are the fastest growing fires in London. These batteries are found in e-scooters and e-bikes Once they start, they spread extremely quickly and are really difficult to escape from. You can help reduce the risk of a lithium battery catching fire by:

- Charging your batteries safely
- Spotting the warning signs that a battery is dangerous
- Having your bicycle converted to an e-bike by a professional

You can also use the London Fire Brigades Home Fire Safety Checker to identify risks in your home.

Borough Commander of Kensington & Chelsea, Ben King shared the story of Sofia Duarte who was just 21 years old when she lost her life in an e-bike fire and how important it is that we continue to raise awareness of the risk of fires caused by unsafe charging and lithium batteries. You can read the full story here.

Celebrating the Season: Snapshots of Festive Fun

This section concludes with highlights from our December 2024 Festive Party at Kensington Town Hall, where Adult Social Care, Local Account Group members, and Safeguarding Ambassadors enjoyed food, activities, and a Safeguarding and Fire Safety Quiz led by London Fire Brigade's Borough Commander Ben King.

I really hope you have enjoyed reading this year's update.

Warm wishes,

Mariya

Members of the Adult Social Care Local Account Group and our Safeguarding Ambassadors came together in December at the Kensington Town Hall for some festive fun with our Senior Management Team.

The highlight of the evening was undoubtedly the 'Think Fire' Festive Quiz, masterfully hosted by Borough Commander Ben King. The quiz not only tested our knowledge but also added a spark of excitement to the festivities. Here are some of the intriguing questions that had everyone scratching their heads:

- Which two sporting rivals had a rivalry nicknamed "Fire and Ice"? (Answer: Bjorn Borg and John McEnroe)
- How often should you test the smoke alarms in your home? (Answer: Weekly)
- What two colours are emergency exit signs in the UK? (Answer: Green and white)

The event provided a fantastic opportunity for us to further promote our 'Think Fire' Campaign with the London Fire Brigade which has been running for over 4 years now. Service Users, Residents and Senior Management all passionate about safeguarding all-together, the room was filled with laughter, festive cheer, and was a perfect blend of safeguarding conversations, vibrant relationship-building, and a lot of fun.

Section 3. Community Engagement

Community Engagement: "Together We Thrive"

In this section:

Advancing safeguarding through diverse perspectives and lived experience

The Community Engagement Group is co-chaired by Ben King Borough Commander London Fire Brigade Kensington & Chelsea and Sonia Benitez.

The Community Engagement Group has had another very active year, highlighted by the successful National Safeguarding Adults Week Campaign and delivery of numerous learning events both online and in person. Our membership continues to expand, bringing together representatives from a diverse array of organisations and communities (see list opposite). It is a privilege to Chair this group. The strong community engagement we have cultivated continues to bolster community resilience and trust, empowering our communities and residents to actively participate in their own protection and the well-being of others. This collective effort fosters a safer and more resilient environment for everyone, leading to enhanced safeguarding outcomes for all. We hope you find this section insightful and enjoy learning about our activities and achievements over the past year.

Ben and Sonia

Carers Network

LFB LONDON FIRE BRIGADE

Sonia Benitez
Head of Services, Carers Network, Kensington & Chelsea

Ben King
Borough Commander, London Fire Brigade

Membership of the Community Engagement Group

- Action Disability Kensington & Chelsea
- Age UK
- All Souls
- Bi-borough, ASC
- BME Safeguarding Network
- Carers Network
- Chelsea Pensioners
- Dalgarno Trust
- Department for Work and Pensions
- Healthwatch
- Kensington & Chelsea Over 50s Forum
- London Fire Brigade
- Metropolitan Police Service
- NWL ICB
- Older People's Voices Group
- SAEB Safeguarding Ambassadors
- Social Interest Group – St Charles Centre
- Standing Together
- The Abbey Centre
- The Advocacy Project
- Turning Point
- Volunteer Centre Kensington & Chelsea
- Westminster Abbey

Safeguarding is Everybody's Business – "I am someone, please see me"

The highlight of this years efforts was the powerful video collaboration with the Quality Assurance Group and Safeguarding Ambassadors . The video shows 3 compelling real life scenarios to raise awareness among both professionals and residents of what Domestic Abuse can look like when related to older people. It turns on its head the out dated notion of domestic abuse relating to couples in a relationship and explores familial abuse and in doing so the challenges for professionals in naming the issues as Domestic Abuse. The video addresses critical issues affecting older adults at risk in our community, focusing on the role and challenges faced by unpaid carers. It highlights

- the need for a "Think Family" Approach to understand individual circumstances within the family context
- Professional Curiosity to look beyond the surface and understand wider family dynamics
- The importance of early intervention and proactive measures in safeguarding to prevent abuse or neglect.
- The video had 281 views on YouTube in just over three weeks
- We had direct positive feedback from across 42 organisations.

Comments below highlight the video's effectiveness in bringing different types of abuse to life, providing valuable insights, and being both moving and thought-provoking. The comments demonstrate the usefulness of video in getting key messages across and it can then be used as a useful training tool to upskill staff easily.

www.youtube.com/watch?v=owaqDc1Ax94

Volunteer Centre Kensington & Chelsea

"Very powerful and clear - have shared it widely."

"This is a very well put together and thought-provoking video. The scenarios are well acted and help highlight some of the situations we encounter. The discussion after each video helps with understanding the situation and highlight what adult social care can provide. It was excellent. In particular, it gave a balanced view and avoided trying to apportion blame. I will share with my team via email and remind this that it couns towards their mandatory safeguarding training."

Dr Melanie Mountain, GP Safeguarding lead, Kings College Health Centre.

KING'S College NHS HEALTH CENTRE

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

"The personal stories brought to life the complexities of these situations, deepen the understanding around safeguarding matters! This video highlighted the importance of essential aspects of safeguarding professional curiosity, understanding individual circumstances, and early intervention. The video did an excellent job of emphasising how proactive measures can help prevent abuse and neglect and is extremely helpful in raising awareness and improving our understanding of safeguarding issues. Thank you for providing this important resource as Many people might not report abuse simply because they are unsure about what constitutes abuse. The video was an important reminder of how crucial it is to educate the wider community, especially when some might not even recognise the signs of abuse. These types of resources really help to build awareness. Tristan Griffiths, Chelsea and Westminster Hospital NHS Foundation Trust.

What our community groups got up to this year for safeguarding

BME Health Forum

BME Health Forum got together with the Advocacy Project and Safeguarding Team.

> We delivered safeguarding adults' training to 12 grassroots organisations across Westminster and RBKC. Additionally, we have been circulating information and training opportunities to BME grassroots organisations via our weekly newsletter. Some of these organisations are unable to attend the BME Network so we need to think about how we engage differently with them.

The Kensington & Chelsea Forum

The Kensington & Chelsea Forum Have held a wide range of safeguarding activities where members could hear about essential safeguarding information, learn, and share.

> Working with the police, Trading Standards, and the Community Safety Team has been instrumental in highlighting awareness about adult abuse and tackling related issues, We feel that the consistence of activities on the topic has been a tremendous help in keeping older people on top of the issues. We are grateful to the police in North Kensington for the support they gave us in resolving a safeguarding issues that was extremely sensitive. As a result we have been able to develop an approved system that will be used if the issue recurs.
>
> **Zara Ghods**, Chief Executive, Kensington & Chelsea Over 50s Forum.

The Dalgarno Trust

The Dalgarno Trust highlighted their efforts in updating safeguarding staff training for new and existing staff, including their safeguarding policy.

DAWS London – (Turning Point)

DAWS London – (Turning Point) the importance of ensuring teams attend partner Safeguarding training offers on policy, procedures, and professional practices.

> Working together with partners and organisations supports our collective responsibility for safeguarding adults.

The London Fire Brigade

> Our involvement in the Thematic Review relating to fatal fires has been crucial in identifying learning and beginning to improve systems to better support service users in the future". We focus on safeguarding referrals for high risk cases we identify.

Open Age

Open Age shared their success in supporting members with mental health concerns through good and swift communication internally and with health partners.

> We apply learning from the SAEB Community Engagement events , such as using the Fire Prevention and Safety toolkit information during home visits. Our Adult Community Learning Courses on keeping safe online and Outreach Tech support have also been beneficial to ensure older people are kept aware of how to be safe online.

K&C VSC

> We have participated in the joint RBKC/WCC + VCS Safeguarding group and that has helped us both as an organisation and as part of the local sector to identify good safeguarding practice, promote it locally, connect with resources that can help us deliver to the correct standards, and help statutory colleagues appreciate our strengths and weaknesses.

Brew with the Crew Event in June 2024

What better way to engage with our communities than with a cup of tea.

On 16th June 2024, the Community engagement Group hosted an in-person event with the London Fire Brigade.

What our communities learnt over a cup of Tea!

- I had no idea that people sell over clocked batteries to make electric bikes go faster!
- I asked about the locked cabinet in my hallways and what it could be? LFB explained that it can be a register of all the people living in the building and is used by the crew when and if they attend to see who lives in which flat and whether they are vulnerable – Much easier to access in some cases than waiting for computer to load information!! Brilliant!
- There are Fire Officers who do community outreach for the LFB
- LFB can evacuate or help transfer bariatric people out of their homes with a special rescue loader
- I learnt why it is important stay in place for most fires unless the fire brigade give you a special fire hood (if you need to get out as the fire in not always contained to one place)
- We learned that sprinkler systems can cause more damage than fires if they do not work properly!
- Ethnic minority fire fighters has grown by 17%
- We should not overload our plug holders
- There are Translations for all nationalities on LFB website
- I learnt about the Fire Safety Checklist, Battery fire safety and Prevention Detection Escape - Blanket and towel fire safety, Open the windows!


sabeb.org.uk
Safeguarding Adults Executive Board
Marcyline Ndeti , Maureen Brewster
PULLING TOGETHER everyone's THOUGHTS
YOUR VIEWS... YOUR PERSPECTIVES!
Thankyou for gracing us with your presence!
The Advocacy Project
MEETING
• Meet every 3 months
• In person & online
• PLEASE KEEP ATTENDING!!
SAFEGUARDING IN THE HOME
SELF NEGLECT
DOMESTIC ABUSE
IMPORTANT
SAFEGUARDING TOPICS
Say No to Abuse
What other languages
Google translate will ALSO work!
No... it doesn't make SENSE
Farsi!
Somali!
French?
But LOTS of community needs this!
or a video?
we need a WIDER range of languages!
COMMUNITY VOICES IN SAFEGUARDING
GETTING TOGETHER to LAUNCH our NETWORK!
OUR CHOICE OF NAME IS:
BME SAFEGUARDING NETWORK
4th MAY 2024
It's great to finally meet in person!
Let's keep meeting every 3 months in person + online. premise.
R.B.K.C.
A well-protected Borough!
L F B
LONDON FIRE BRIGADE
Always used to be built next to a PUB!
WE DO A LOT OF WORK AROUND HOARDING TOO!
Chris Haggar
I've been a fire officer for 30 years things have changed
It used to be a reactive service...
I'm nearly blind in here!
Smoke DETECTORS are OVERLAY!
WE'RE HERE for you!
Smoking is a risk factor so is age + living alone.
Please fit this smoke alarm!
Don't worry... I'll do it!
COMMUNITY FOCUSSED!
A "HELLO" FROM LOCAL SERVICES!
We need to keep SHARING info + work with our PARTNERS
LET'S WORK TOGETHER TO KEEP YOUR COMMUNITY SAFE
METROPOLITAN POLICE
Lucy O'Connor
IMPORTANT TO BUILD TRUST together!
There is a lack of trust with BME women + the police!
Let's work well together. Please call us if you need to!
SCHOOLS
outreach work & understanding CONSENT for children & young people!
Please also include PARENTS (or carers / village?)
Carers Network
Sonia Benitez
It's a round the clock job!
SUPPORTING UNPAID ADULT CARERS
ADVOCACY
Giving you your voice & rights
MENTAL & PHYSICAL
End of LIFE PROJECT
Better Bow Looking Project
ADDITIONAL RESOURCES
Blessings from healthwatch
our survey covered Women aged 29-44
MORE VARIETY of languages needed + more dialects
IMPROVE LANGUAGE SUPPORT AWARENESS
LACK OF RESOURCES for TRANSLATIONS
Please also MEASURE the QUALITY of the service!
EMPOWER NON-NATIVE SPEAKERS
Promote awareness for those who can't read or write!
e.g. DOMESTIC ABUSE CASES! A relative or friend may not be the appropriate translator!
ACCESS is KEY... and knowing HOW to access information!
USE PLAIN LANGUAGE - NOT JARGON
KEEP A RECORD OF THE INTERACTIONS & LANGUAGE SUPPORT NEEDS
I know you're my friend, but I need this health issue to STAY private
HOW CAN WE BUILD THRIVING & flourishing COMMUNITIES for future generations working towards adulthood!
LET'S REDUCE HATE CRIME
Lets we can do together and get advocacy + support with.
A place where everyone feels SAFE & SECURE
SHARING EXPERIENCE IS POWERFUL
STANDING TOGETHER against domestic abuse
FRAN RICHARDS
& angelou PARTNERSHIP
SUPPORTING FAMILIES WITH CULTURAL COMPETENCE
Don't JUMP to WHO the word ABUSE!
Is it abuse or a culturally accepted practice?
LGBTQ+ 16yrs
access to services
SUPPORT FOR HOUSING, COUNSELLING & other access to JUSTICE
I've had to leave home... but am getting the support I need!
I need help to ACCESS the support I need
DOMESTIC ABUSE IS EVERYONE'S business
partner with GALOP, Women's Trust & many OTHERS
Refuge
Respect
FORWARD
AWRC
No PROBLEM... The referral will ALWAYS be passed on QUICKLY
DOMESTIC ABUSE
This also affects MEN and there is help available!
AWARENESS RAISING IS VITAL
I thought that was "normal"
WOMEN NEED TRAINING & THE KNOWLEDGE!
EXAMPLE OF HARMFUL PRACTICES:
F.G.M. Female Genital Mutilation
FORCED MARRIAGE
FINANCIAL CONTROL
DOMESTIC ABUSE
RESPECT helpline is helpful!
RBKC
LOUISE BUTLER
Head of Safeguarding Quality Assurance & Engagement
IMPORTANCE OF HAVING REPRESENTATION
How can we keep single occupiers SAFE
MOVING FORWARD TOGETHER WITH COURAGE, COMPASSION & ACCOUNTABILITY
Let's intervene EARLY!
So houses are safe & people stay alive!
Put the right MODEL in... don't use the fake ones!
Charge SAFE: make sure the replacement charger is SAFE!
PROTECT WHAT YOU LOVE
We'll visit your forums!
We'll replace the smoke charger for you!
CONNECTING WITH THE LONDON FIRE SERVICE
SOME DISABILITIES ARE HIDDEN
POLICE FEEDBACK: Closing up a right to review...
EMOTIONAL ABUSE & BULLYING BY FAMILY... it needed to be addressed
My poor zombie... weighed only 38 kilos
IMPORTANCE OF BUILDING TRUST together!
PREVALENCE OF HATE CRIME needs investigating!
I don't feel right about this...
Is it abuse or just mean words...
What does DISCRIMINATORY ABUSE mean to you?
WORKING TOGETHER WITH
COURAGE, COMPASSION & ACCOUNTABILITY:
EMPOWERING You To SUPPORT YOUR COMMUNITIES

Chairs of the BME Safeguarding Network

Mercyline Ndeti

Organisation Development Manager, BME Health Forum

Maureen Brewster

User Involvement Coordinator, The Advocacy Project

The BME Safeguarding Network is jointly chaired by Mercyline Ndeti from the BME Health Forum and Maureen Brewster from The Advocacy Project, who represent the group at relevant SAEB meetings.

The Network meets quarterly, with meetings held virtually or in person. This section of the report describes the years activity of this new network and impact upon raising awareness of safeguarding within a cultural context.

Our Journey so far - SAEB, The 'Staying Safe' Project – A recap

BME Health Forum Safeguarding Agenda – To create Safer Communities – identify needs and share feedback in collaboration with The Advocacy Project to SAEB

Delivery of **Train the Trainer** workshops and implementation of resource packs

Ongoing Safeguarding Activities and Translation of **Say No to Abuse** booklets

2021 | **2022** | **2023** | **2024** | **2025**

Safeguarding Awareness
Co-design of 'Train the Trainer' Training for BME Health Forum organisations

Launch of **BME Safeguarding Network**

- In 2021, the SAEB and The Advocacy Project worked collaboratively together with us to identify the safeguarding needs of our diverse organisations
- By 2022, we had begun co-designing safeguarding content to be included in the training to be delivered to community groups in a language of their choice
- In 2023, the co-designed workshops were delivered and translated, accompanied by a comprehensive library of resources, including a model safeguarding policy for organisational use.
- In May 2024, we launched our BME Safeguarding Network.

The BME Safeguarding Network is committed to fostering a culturally safe environment by raising awareness of adult safeguarding within diverse communities. The network operates with cultural humility, prioritising respect for different backgrounds, traditions, and lived experiences as it identifies and addresses safeguarding concerns. It actively facilitates inclusive training for staff and volunteers, ensuring that policies, procedures, and professional practices are responsive to the cultural identities and values of those they serve.

In partnership with communities, the SAEB recognises and values the unique strengths, voices, and expertise of each cultural group. By promoting open dialogue and embracing cultural diversity, the network advances a safeguarding culture rooted in dignity, trust, and cultural understanding, making protection accessible and relevant for all.

Objectives and Aims

The Network serves as a forum for managers, staff, and volunteers from local organisations to discuss safeguarding issues within a cultural context. Its primary objectives include:

- Raising public awareness of adult abuse and safeguarding.
- Enhancing local knowledge and understanding of adult safeguarding.
- Providing opportunities for staff and volunteers through local safeguarding events.
- Disseminating key national, regional, and local policies, guidance, training, and learning related to safeguarding topics.
- Discussions on keeping safe within a culturally safe environment

Key Tasks and Activities

The Network facilitates communication and feedback between the Safeguarding Adults Executive Board (SAEB) and those affected by safeguarding issues, with an explicit emphasis on cultural sensitivity and inclusion. It is dedicated to capturing and improving safeguarding experiences and outcomes for individuals from diverse backgrounds, recognising the importance of cultural identities and traditions in shaping people's needs and perspectives.

Additionally, the Network develops an Annual Group Action Plan rooted in cultural awareness and provides an annual update report to the SAEB, reflecting progress in promoting safeguarding within its communities.

Our Activities 2024/25

Launch event

May 2024 → **August 2024** → Prevent Training **November 2024** → **March 2025**

Championing Discriminatory Abuse and Hate Crime

Putting Safeguarding Policies into Practice Workshop to include safeguarding and protected Characteristics

This year, the team collaborated with the SAEB to translate the “Say No to Abuse” safeguarding leaflets into seven local languages identified by the network. These are **Kurdish, French, Somali, Tigrigna, Arabic, Bengali and Farsi**.

We are enthusiastically planning an in-person launch event to our wider communities which will take place in early autumn 2025.

Additionally, the network is taking steps to enhance collaboration with other agencies, and communities have indicated increased clarity regarding reporting procedures. These efforts include clearer guidance on when, how, and to whom reports should be made, which helps ensure that each report is addressed appropriately and contributes to community safety. Through these efforts, the network is working to break the cycle of acceptance and encourage proactive reporting.

This section includes :

What Is Discriminatory abuse?

It is when someone picks on you or treats you unfairly because something about you is different. This can include unfair or less favourable treatment due to a person’s race, gender, gender identity, age, disability, religion, sexuality, appearance or cultural background.

Promoting preventing and addressing Discriminatory Abuse

The BME Safeguarding Network is actively working to dispel fears and address the barriers to discriminatory abuse. This is how they describe what discriminatory abuse means to them.

We recognise that discriminatory abuse, whether personal or within families and communities, can strongly affect a person’s decision to report it. One of the most significant barriers to understanding safeguarding—and how to identify and report concerns—is language. When people are not able to access information in their preferred language, vital safeguarding messages can be misunderstood or missed entirely. To counter this, the network fosters a supportive environment that encourages individuals to come forward without fear of judgment or repercussions, and actively seeks to overcome language barriers.

Across our wider communities, we have identified that a lack of accessible information in different languages often prevents people from knowing how to report safeguarding issues. The SAEB Team, working in partnership with the BME Safeguarding Network, is addressing this challenge by providing tailored workshops, resources, and training in multiple languages to ensure everyone understands when and how to report incidents. The network’s organisations are tackling these issues by offering multilingual support and clear guidance on reporting incidents, making information about safeguarding widely accessible.

This means that language is no longer a barrier to seeking help, and individuals can feel confident that they will understand what to expect after making a report.

Joint workshop to raise awareness of aspects of Discriminatory Abuse

In August we held a workshop with Adult Social Care, Community Safety, the Police, and the Bi-borough Prevent Teams. It was a collaborative event in which we discussed issues which effect our communities such as: Hate Crime, Antisocial Behaviour, and Radicalisation.

The discussions focused on lowering barriers and tackling local concerns. Through training and awareness efforts with SAEB Partnership, the BME Safeguarding Network is working to create a safer, more informed community.

The Workshop to Raise Awareness of Prevent (WRAP)Training covered several important topics, including an introduction to Prevent and CONTEST, radicalisation, extremism, ideology, and terrorism. Participants learned about identifying risk factors and understanding susceptibility through individual case studies.

The training also addressed making referrals through the Channel process, as well as the local and national threat picture.

The workshop was well received and offered practical guidance to help the Network understand Prevent and support community safety against extremism.

Thanks goes to Detective Superintendent Owen Renowden from the Met Police who is the lead on Hate Crime.

SAEB 'Putting Policy into Practice' Workshop

In March we had a second workshop where we partnered with Adult Social Care Safeguarding Team who presented for our organisations a focus on implementing Safeguarding Adults Policies. The session addressed protected characteristics, core principles, and the Care Act 2014 . Participants identified key challenges, and discussed strategies for effectively preventing discriminatory abuse within our communities.

The Challenges for communities working within a cultural context

- Sense that going to statutory services can feel like disloyalty to the community: "Communities work together and don't like it when concerns are raised with the authorities. The person who raises the concern gets questioned by their community for doing so".
- Complicated, bureaucratic local authority structures: even harder to navigate in a second language – e.g. 'safeguarding' is not a well-understood term.
- Interpreters: not always the right community, dialect etc. Can lack the skills to translate emotional and technical/medical language.
- Discriminatory abuse – very often hidden and only makes up 2-3% of concerns locally (nationally this is 1% 2023). Abuse may be normalised or difficult to distinguish from every day experience leading to low reporting. This is particularly relevant with established familial abuse.
- "Forms of harassment, slurs, or similar treatment, because of race, gender and gender identity, age disability, sexual orientation, religion" DHSC 2022.
- Discrimination hinges to some extent on motivation/attitudes of the abuser, which they will be unlikely to declare.
- Abuse may be normalised or difficult to distinguish from everyday experience, leading to low reporting.
- Fear that services will not be receptive, in part because of experience of discriminatory practices from services themselves.

The way forward

- Intersectional approaches, and discussing the possibility that the abuse a person has suffered was discriminatory. Support to staff in identification and having sensitive conversations
- Specialist, culturally specific or local voluntary sector services can be important – e.g. person-centred and sensitive advocacy and peer support
- Discriminatory abuse involves power, rights and inclusion, and links to ethics and values – this needs space in team meetings and supervisions.
- Reflecting on discriminatory abuse involves professional curiosity and a willingness to challenge familiar ways of working.

The workshop was very well received with much discussion. It has supported the BME Network organisations to embed safeguarding Policy into Practice.

- Every voluntary sector organisation within the BME Safeguarding Network now has a policy that sets out what organisations will do to keep people safe and that everyone, no matter what their role, understands Policy and how to apply it.
- All our staff, volunteers and people we work with are aware of how to manage safeguarding.
- Policies and procedures are easily available, either online or on paper (or both).

Positive comments from the session

> This was a great refresher following the initial safeguarding training that was much needed and will really support our staff.

> It was very informative and the wide range of speakers covering the different areas was very useful in approaching safeguarding as a holistic practice.

> I really appreciated the space we had to ask questions and raise concerns and how comfortable the presenters made us feel.

Community Engagement Group Development Day– A Day of reflection and insights

> The Community Engagement Group Development Day was an afternoon of collaboration and shared commitment to making a positive impact on our communities throughout 2025/26.

Ben King, Borough Commander, Kensington & Chelsea London Fire Brigade & Co-Chair of the Community Engagement Group.

Setting Priorities for the Coming Year

The Community Engagement Group Development Day brought together community organisations, partners, and stakeholders to collaborate and plan for the year ahead. With both local and national priorities in mind, presentations and discussions were held on how best to support well-being and safety across our communities in 2025/26.

A total of 14 organisations participated, including Healthwatch, Bi-borough Public Health, Kensington & Chelsea Over 50's Forum, Metropolitan Police, London Fire Brigade, the BME Safeguarding Network, Open Age, Adult Social Care, Action Disability Kensington & Chelsea, Age UK, NWL ICB, and Safeguarding Ambassadors.

Community Priorities and Planned Actions for 2025-2026

Through sector surveys and direct community engagement, five central priorities emerged for the coming year: safeguarding and digital awareness, modern slavery and human trafficking, self-neglect and hoarding, the cost of living crisis, and supporting diverse communities.

To ensure these priorities are effectively addressed, the Community Engagement Group has committed to a coordinated set of actions and initiatives tailored to each area:

- Safeguarding and Digital Awareness: Ongoing education on digital safety, scams, and financial abuse will be prioritised. In-person sessions and workshops—such as on romance fraud and the BT digital switchover—will empower community members, particularly through the training of Community Digital Champions.
- Modern Slavery and Human Trafficking: Awareness campaigns and webinars will provide vital information on exploitation, servitude, and support available to those at risk.
- Self-neglect and Hoarding: The group will increase efforts to inform and support individuals who may not meet traditional care thresholds, working closely with housing and landlord providers.
- Cost of Living Crisis: Joint sessions—facilitated by Healthwatch—will focus on collaborative solutions and support for vulnerable residents, particularly during colder months.
- Supporting Diverse Communities: Culturally sensitive approaches will ensure all communities have access to tailored resources, events, and peer support. Initiatives like "Knowing Your Rights" seminars and Dementia Awareness events with key partners will be featured throughout the year.

Regular campaigns, events, and bulletins will keep communities engaged and informed, reinforcing the group's commitment to address these priorities with practical, coordinated action across 2025/26.

Section 4.
Leading, Listening and Learning - Safeguarding Adults Case Review Group

Always learning, always improving, and always aiming to keep adults safer in the future.

In this section:

- Creative Commissioning of a SAR
- Collecting and Triaging new SAR Referrals
- Learning from National and Local SAR's
- Learning from other investigations across the partnership
- Homelessness deaths and prevention in Safeguarding adults
- SAEB Learning Programme
  - SAEB Mental Health Learning Programme move to data section under MH data and what we are doing about this.

Catherine Knights

Director of Quality, Central and North West London NHS Foundation Trust, Co-chair of the Safeguarding Adults Case Review Group

Louise Butler

Head of Safeguarding ,Quality Assurance and Engagement, Royal Borough of Kensington & Chelsea and Westminster City Council, Co-chair of the Safeguarding Adults Case Review Group

The Chairs of the Safeguarding adults Case review group lead on ensuring that the SAEB meets the legal requirements of the Care Act 2014.

Below are some of the key responsibilities of the Chairs of the Safeguarding Adults Case Review Group:

1. **Governance**
2. **Action Plans**
3. **Learning and improvement**
4. **Collecting Referral Information**
5. **Decision Making**
6. **Conducting SARS**
7. **Making Safeguarding Personal Information**
8. **Triage Meetings**

Making Safeguarding Personal: Meeting with those close to the adult to understand their perspective on the services provided (supporting families and friends throughout the SAR process) providing valuable information on procedures and expectations.

Collecting and Triaging Referral Information: Gather and triage information from different agencies to see if the case meets the criteria for a SAR. Hold meetings with referrers and other key agencies and stakeholders.

Decision Making: Ensure other reviews, investigations, or court proceedings are considered in decision making. After commissioning a SAR, hold scoping meetings to select the right methodology and draft the Terms of Reference (TOR).

Conducting SARs: Ensure SAR findings are used to improve future safeguarding practices and prevent similar incidents and can evidence impact.

Governance: Ensure SARs are conducted effectively and ethically. This includes clear lines of accountability, robust decision-making procedures, and appropriate oversight of the review process. Oversite by the Safeguarding Adults Executive board and liaising with Legal Services as/when required.

Learning and Improvement: Oversee the creation and monitoring of Action Plans and holding partners accountable. Leading on oversight of learning briefings, confidence building across the partnership - reviewing the work of the SAR Champions Network to embed learning into practice.

Chairs Summary 2024-25

The SAEB continues to drive forward its culture of learning.

We have learnt over the years that commissioning of SAR's can be challenging and expensive and have therefore have reviewed and put in place a more effective commissioning response to Section 44 enquires which is described in more detail in the creative commissioning section.

Section 44 of the Care Act 2014 mandates local Safeguarding Adults Boards to arrange a Safeguarding Adults Review (SAR) when:

- An adult, with needs for care and support, (whether or not the local authority was meeting any of those needs) in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult
- An adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

During 2024 – 2025 the Safeguarding Adults Case Review Group met 8 times. The active engagement of the partnership has been essential in making this group both successful and dynamic, with partners consistently contributing expertise and perspectives to its work. The group places a strong emphasis on staying up to date with national and regional developments in safeguarding, regularly incorporating new learning into its discussions and practice.

Through ongoing learning and a commitment to collaboration, the group ensures that SARs are conducted effectively by focusing on areas which will have the greatest impact locally, and which avoids unnecessary duplication from previous SAR's . We have done this by building on existing knowledge and by reviewing relevant cases in The National Safeguarding Adults Review (SAR) library. This library is coordinated by the National Network for Chairs of Adult Safeguarding Boards, it contains reports dating from April 2019.

This section starts by describing our commissioning approach to SAR's to ensure we remain compliant with the Care Act but at the same time look for innovation and efficiency in our learning outcomes. We then explore how we incorporate local learning from the 2nd National SAR analysis which was completed at a National Level commissioned by the Local Government Association and Association of Directors of Adult Social Services.

Creative commissioning in Safeguarding Adults Reviews (SARs)

Referrals for Safeguarding Adults Review are increasing , and budgets of Safeguarding Adults Boards are having to stretch further. The challenge of getting value and impact from SARs is therefore a focus for the SAEB.

When the second national analysis of SARs came out, which will be discussed in more detail in the next section, it pointed out something we try to avoid but often see at a national level — that boards sometimes treat each new SAR like it's the very first, without really checking what's already been learned from earlier reviews. The SAEB has been reflecting on adapting its own approach to try to build on lessons from SAR's that have happened locally, regionally, or even nationally. Bringing the learning already identified into the Terms of Reference of a new SAR helps keep our reviews focused, more concise, relevant locally and avoids duplication.

For instance, if there's been another review about a similar situation either locally or nationally, it's important to look at:

- An adult, with needs for care and support, (whether or not the local authority was meeting any of those needs) in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult
- An adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

Reflecting on this helps everyone see the bigger picture and makes sure we're not just repeating old mistakes but remain relevant .

We also try to avoid doing SAR commissioning in isolation. Instead, we find out what commissioning arrangements across the partnership are under review and set up our Terms of Reference to link each review to broader learning, so we can really dig into how things are running right now in the system and spot any patterns or recurring issues. By approaching SARs this way, we're better able to get to the root of problems and come up with ideas that can truly make a difference - not just for the people at the centre of a particular review, but for safeguarding practice across the board. This approach means we're:

- always learning,
- always improving,
- and always aiming to keep adults safer in the future.

The role families, friends and representatives play in the review has also been a focus. We have learnt over the years that being transparent and proactive in building a relationship with families can make for a more rewarding experience for people who are grieving and helps in building trust. We support families by offering a number of face to face meetings to discuss expectations. We ask if families want to engage in the learning by voicing their experience. This can be a powerful experience for both families and practioners aiding recovery in both parties.

Our Safeguarding Ambassadors have helped create a leaflet for families and friends to explain what happens when there's a Safeguarding Adults Review. This leaflet tells families what to expect from the review and how if they wish they can get involved.

The SAEB always tries to make sure families and friends are included and listened to during a Safeguarding Adults Review. Personal views are important for understanding the person's life and making things better for others in the future. It can also aid in supporting a healthy grieving process.

Family and Friends Leaflet

Second National Analysis of Safeguarding Adults Reviews (2019-2023)

The Second National Analysis of Safeguarding Adults Reviews builds on the findings of the first analysis (2017-2019).

Commissioned by ADASS and LGA, this analysis aims to improve SAR processes and drive systemic change in adult safeguarding in England.

The Safeguarding Adults Executive Board discussed how we plan to address local improvements based upon our own analysis. The Safeguarding Adults Case Review Group (SACRG) agreed on the following areas of focus in October 2024:

- Greater focus on unpaid carers and safeguarding, which is a national priority.
- Build on our understanding of protected characteristics and discriminatory abuse.
- Continue to support improvements to mental capacity practice across the partnership.
- Support Central Government in role the SAEB plays in Safeguarding, Housing and Homelessness.
- Continue to work on ensuring we are developing our relationship or strength-based practice.

How we have taken these forward:

1 Carers and Safeguarding

We will: Ensure that we have assurance that Carers Assessments are being completed in a timely manner and that we have meaningful engagement as to challenges and barriers if this is not happening. Data on carers assessments will be shared with the Quality Assurance Subgroup for consideration of whether any additional data or work is required to consider carers issues in relation to safeguarding.

We have done: The Safeguarding Ambassador Video 'I am someone please see me video' highlights the role and challenges faced by unpaid carers and the cared for person. This Video raises awareness and has been widely viewed and shared across the partnership.

2 Protected Characteristics and Discriminatory Abuse

We will: The SAEB will review the work it is undertaking on how safeguarding is seen within a cultural context and adopt practice guidance which supports intercultural empathy.

We have done: The SAEB led on a national presentation at the Local Government Association event in February of the work undertaken on the "Staying Safe project" and by the BME Safeguarding Network on Discriminatory Abuse and Protected Characteristics. Plus:

- SAEB Safeguarding Ambassadors released their Summer Bulletin to raise awareness of these topics please view here.
- The SAEB learning and development programme delivered bespoke training to the BME Safeguarding Network.
- The QA Subgroup reported on Domestic Abuse and Older People.
- All SAEB reports now request ethnicity profile breakdown.

3 Mental Capacity Practice

We will: Continue to embed MCA practice into the workings of day to day practice and evaluate the effectiveness of the recent MCA audit within the next 12 months to see if we have had an impact

We have done:

- Fire Safety and MCA E-Learning Launched November 2024.
- Enhanced content on MCA considerations is included in the Fire Safety Framework and the SAEB Self Neglect and Hoarding Strategy.
- Run learning and development sessions for the partnership on MCA in practice.

4 Safeguarding and Housing / Homelessness

We will: In May 2024, all Safeguarding Adult Board chairs received a letter requesting confirmation of the actions taken at local level to implement recommendations in 'Ending Rough Sleeping for Good' report.

The SAEB have a number of actions and strategies in place to address the issues related to rough sleeping and homelessness, with a strong emphasis on governance, accountability, and multi-agency collaboration at a local level

- We will seek assurance from our Housing teams that our local need is being met by working in partnership.

We have done:

- Since 2019 a multi-agency process is in place to review deaths among rough sleepers and consider learning and eligibility for statutory review processes.
- The SAEB has senior-level housing and commissioning representatives who attend meetings to provide updates on risks, concerns, and plans for reducing rough sleeping.
- We have a dedicated homelessness section to the Safeguarding Referral Practice Guidance.
- Continued compliance work regarding the ministerial letter and the role of SABs in the Rough Sleeping agenda.

5 Relationship/Strength-Based Practice

We will:

- We are committed to reviewing Making Safeguarding Personal to ensure impact is recognised by adults at risk who feel they are being heard and understood.
- We are committed to holding SAEB meetings in person as often as possible.

We have done:

- We provide ongoing networking opportunities through SAEB events (including community events) and the SAR Champions network.
- We promote reflective practice through our SAEB Learning Programme.
- We have specifically led a number of campaigns and bulletins to promote professional curiosity to include:
  - National Safeguarding Adults Week in November 2025.
  - "Staying Curious" initiative during World Elder Abuse Week in June 2025.
  - SCIE's Professional curiosity in safeguarding adults Strategic Briefing.
  - The Professional Curiosity Resource developed by the National-SAB-Managers Network Workstream-Group.

Safeguarding Adult Review, SAR, activity 2024-25

There were 5 referrals made this year.

Four SAR referrals were discussed but found to be not eligible for qualifying for a Safeguarding Review. The table below outlines the eligibility decision process to ensure transparency.

All referrals follow the SAEB SAR Protocol and Guidance. Referrals are triaged by the Safeguarding Adults Case Review Group, which makes recommendations to the SAEB Independent Chair for a final decision.

The process considers how best to involve the individual, family, or carers and professionals. If criteria are not met, alternative actions such as a Learning Event or briefing may be implemented.

Source of Referral
London Fire Brigade

Age range
65+

Gender
Female

Ethnicity
White British

Theme(s)
Fatal Fire

Outcome
Did not meet criteria.

This Fatal Fire case was progressed under S42 to determine if a S44 referral was required. The S42 determined that the death was not due to multi-agency failure and the case did not meet SAR Criteria. We decided to pick up learning within the Fire Safety framework.

Source of Referral
Westminster Adult Social Care

Age range
24-45

Gender
Female

Ethnicity
Black Caribbean

Theme(s)
LeDeR Review

Disengagement

Self-neglect (eating disorder)

Complex needs high functioning

Outcome
Did meet criteria.

SAR Commissioned 'Aiysha'.

Source of Referral
RBKC Housing

Age range
65+

Gender
Male

Ethnicity
Black British/ Caribbean

Theme(s)
Mental Health

Drug and Alcohol use

Poor engagement

No multiagency involvement

Outcome
Did not meet SAR criteria.

Learning picked up internally.

Source of Referral
NWL ICB

Age range
46-65

Gender
Female

Ethnicity
White British

Theme(s)
LNot known to care services

No care and support needs established

No abuse or neglect identified

Outcome
Did not meet SAR criteria.

Further Action: The referrer will present this case to the Bariatric Care T&F Group who will incorporate any learning identified into the Bariatric Care Guidance document.

Source of Referral
Connection at St Martins

Age range
25-45

Gender
Male

Ethnicity
Mixed White and Asian

Theme(s)
Street homelessness

Died post prison-release

No multiagency involvement

Outcome
Did not meet criteria.

Prisons and Probation Ombudsman (PPO) Investigation underway.

Any learning identified to be included within the Action Plan for Malcolm's Legacy.

Shared information with borough of residence
Did not meet criteria

Eligible SAR referrals

1 A 'Safeguarding Adults Review' for the case of Aiysha

RATIONALE AND RECOMMENDATION FOR A SAR

The group recommended that a SAR be commissioned to explore several Key Lines of Enquiry:

1. Challenges in working where the person has difficulty accepting support from services and disengages
2. Working arrangements over Covid-19 and how this impacted service engagement
3. Exploring the barriers and enablers for services managing cases where individuals present as high functioning and therefore do not meet the eligibility criteria for learning disability and autism services but have complex needs that would benefit from specialist services.
4. Did services work within a cultural context and consider twin behaviour dynamics in the expense of MSP

THE METHODOLOGY WILL COMPRISE:

a. A desktop review of existing documents to include the LeDer review

b. Map out what systems were in place over Covid and what has changed since that time

c. Facilitation of a practioner event to gather further insights and discussion as to potential barriers and enablers to working with highly-functioning, neuro-diverse people.

d. The SAEB will contact family who provided support to Aiysha and seek their views and support in developing a pen picture

TIMESCALES AND GOVERNANCE

The SAR process is overseen by the SAEB and supported by an external independent reviewer and a SAR panel composed of senior managers from relevant agencies involved in the case. A summary of the SAR report will be shared in next year's annual report.

2 Safeguarding Adults Review: The case of Malcolm

Dr Sheila Fish

> "It was inspiring to see the dedication of professionals working directly with individuals like Malcolm, often at personal expense, to mitigate risks and secure necessary support."

Following on from last years SAEB Annual Report 2023-24 we report on findings from the work undertaking by Dr Sheila Fish Independant reviewer. Dr Fish took a close look at Malcolm's case to find out what worked and what didn't for people with multiple challenges like homelessness and cognitive issues.

Malcolm's story made us think about how we work with other people who are multi-disadvanged and what improvements to systems can support both people in need and the staff helping them.

Using the "learning together" model helps us see what worked, what didn't, and where our systems need fixing.

Malcolm

WHAT WE LEARNED

Westminster has some established services to support people like Malcolm.

Established Services and Projects in Westminster

WESTMINSTER BLUE LIGHT PROJECT - WORKING AS PART OF CHANGING FUTURES

Date established: December 2021

In partnership with Alcohol Change UK to adopt their Blue Light Protocol initiative to develop alternative approaches and care pathways for the group of change resistant, alcohol dependent drinkers in Westminster.

COGNITIVE IMPAIRMENT AND ALCOHOL NETWORK (CIA) (PART OF THE BLUE LIGHT CHANGING FUTURES WORKSTREAM

Date established: April 2022

Each meeting we hear different view points in the syhstem and try and skim off quick wins, provide a space for anonymised case discussion, better understand the nature of gaps and find opportunities for join up.

The Homeless Neuropsychology Pathway, in the Psychology in Hostels Team (SLAM)

Date established: February 2023

A service aimed at working with people experiencing homelessness with a diagnosed or suspected brain injury in Westminster. Team of clinical psychologists and a neurospecialist GP.

Network for brain injury and homelessness in Westminster. Homelessness and Brain injury network

Date established: April 2024

Rationale:

- to work better together and enhance/ optimise the pathways for this client group.
- to think about ways in which we as health providers (rather than housing providers) can enhance the negtwork to get the best outcomes.

But when people experience multiple exclusions, such as homelessness and cognitive decline risks are heightened services can struggle to cope with multiply issues requiring involvement from multiply organisations to include safeguarding. The SAEB has set up a steering group led by housing and health to oversee the recommendations from the report. The series of slides below provide an overview of findings.

Cognitive Decline - Causes and Impact

CAUSES

- Traumatic brain injury.
- Alcohol-related brain damage (ARBD)
- Neuro-degenerative conditions such as Alzheimer's, Parkinsons, Huntington's and Motor neuron disease.
- Hypoxia, other toxic insults and Vascular causes
- Schizophrenia, depression and or other serious mental illnesses

IMPACT ON EXECUTIVE FUNCTIONING AND FUNCTIONAL CAPACITY

- Memory problems
- Confusion/disorientation
- Falls
- Socially inappropriate behaviour
- Disinhibition including secually inappropriate behaviours
- Self-neglect
- Inappropriate spending and management of money
- Changes in personality
- Difficulties concentrating and motivating oneself.

Malcolm's Experience: Unveiling Systemic Gaps and Weaknesses in Service Provision

This graphic provides a visual representation of the various areas, services, providers, and commissioners active in this field, which we can reflect on and illuminate through this SAR.

The four central boxes represent the individuals and roles most directly involved with someone in circumstances similar to Malcolm's. They undertake the most challenging practical and emotional work to access, secure, and make support available as the individual's cognitive condition deteriorates.

The surrounding white boxes symbolise the necessary services and supports, which are often commissioned separately from those providing them.

Commissioners

- Adult Social Care
- Rough Sleeping Commissioning
- Memory Service
- Hospital Neurology
- Safeguarding
- Accommodation Support worker
- Care Navigator
- Hospitals
- Dual Diagnosis Team
- Case Management
- Specialist GP Practice
- CGL - Alcohol Service
- Older Adults Community Mental Health Team (OA-MCMHT)

The picture that emerged of ordinary practice and its systemic conditions

Currently service commissioning and ways of working mean that people who have experienced multiple-exclusion homelessness and have deteriorating cognitive impairments can be overlooked.

This tends to leave those working directly with the person, particularly housing support workers, holding and desperately trying to mitigate the various and escalating risks the person faces, often a huge personal expense to them both.

The Challenges

- Difficulty in securing timely help and support for individuals like Malcolm.
- Accessibility issues despite available expertise and interventions.
- Gaps in expertise, especially regarding cognitive impairments.
- Skewed assessments of mental capacity, underplaying risks and blocking legal intervention options.
- Dedicated professionals creating flexibility and accessibility in rigidly commissioned services.
- Individuals bouncing between services due to eligibility criteria, leading to overlooked needs.
- Small group of professionals, particularly housing support workers, working intensely to mitigate escalating risks at personal expense.

Systems Findings Overview

Mental Health Diagnosis: While crucial for explaining cognitive deterioration, obtaining a diagnosis can be challenging. Malcolm's ability to receive a diagnosis was exceptional.

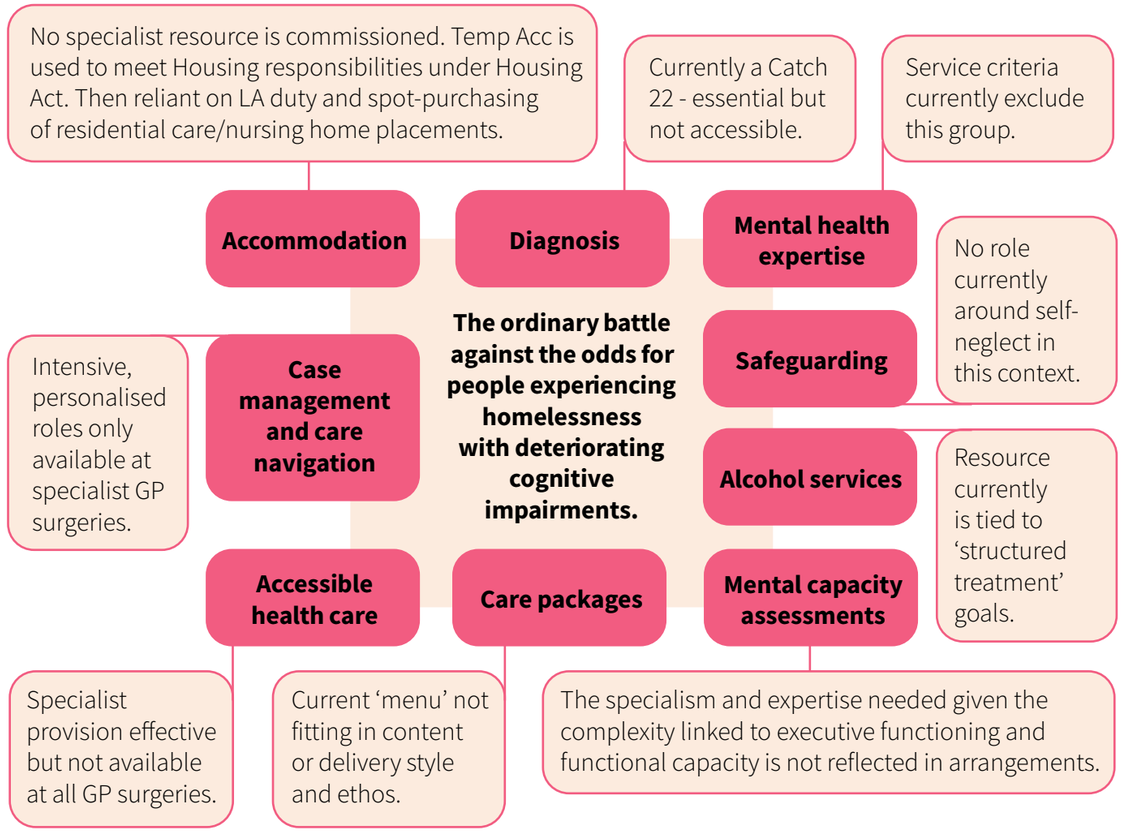
Community Support: Although support exists within older adults' mental health teams, service criteria often hinder accessibility, particularly for individuals with long term alcohol dependency like Malcolm.

Safeguarding: At the time of the review, there was no role for safeguarding in cases of self neglect.

Alcohol Services: Despite ongoing use, alcohol services were absent as commissioning is linked to structured treatment programs, which are unlikely to engage someone like Malcolm.

Mental Capacity Assessments: These assessments can be skewed due to their complexity and the difficulty in accessing necessary expertise.

Accommodation: Temporary accommodation meets housing responsibilities, but reliance on local authority duty leads to spot purchasing of residential care and nursing home placements. This approach often does not provide a personalised match for individuals like Malcolm.



Conclusion

This SAR has been presented using a collaborative process of understanding ordinary practice in the Westminster context, through a detailed analysis and reflection on what happened and why in Malcolm's case. It revealed through workshop discussion a practice environment which is made up of multiple overlapping and interacting issues. This systems finding has highlighted how current services are commissioned and ways of working mean that people who have experienced multiple-exclusion homelessness and have deteriorating cognitive impairments, will experience challenges. While there are real strengths in existing specialist housing and specialist GP provisions, there are notable barriers to accessibility of other services. Thanks goes to all agencies involved and committed to this piece of work and their continued engagement to making improvements to current service provision which will be reported on in next year's report.

Published SAR'S in 2024-25

Professor Richard Shannon 'Dick' – Now published and accessible on the SAEB website.

Although not mandatory, the SAEB undertook this review to further learn from the case and enhance safeguarding practices. The SAR was conducted in response to the Prevention of Future Deaths (PFD) report from the Coroner. The report delves into the various discharge options available to hospital patients in the North-West London Bi-borough area.

An audit of practice was completed which reflected that hospital discharge pathways in place across the Bi-borough is working well. However, there are some areas which could be strengthened which will be led on by Health. The Executive Summary and Learning Briefing provide an overview of the findings and recommendations from the review.

Other learning reviews

In this next section we look at 4 learning models from different organisations which have been presented to the Safeguarding Review Group.

1. The Patient Safety Incident Response Framework (PSIRF):Bariatric Care – Ensuring Dignity and Safety in Bariatric Care CNWL
2. An example of applying the Equality Act (2010) in Health Services Related to people with learning disabilities, autism and or Dementia
3. Learning from Lives and Deaths Reports: People with a Learning Disability and Autistic People (LeDeR) ICB
4. Rough Sleeping Fatality Annual Review : Learning related to Homelessness deaths

The cases presented may not reach the criteria for a SAR but nevertheless the learning can be significant in our understanding in supporting front line staff in prevention interventions.

Bariatric Care T&F Group

Ensuring Dignity and Safety in Bariatric Care: Catherine Knights.
An Example of the learning from the National Health Service use of The Patient Safety Incident Response Framework (PSIRF)

Case Study

Ms C, a bariatric patient with complex health issues, was referred to the SAEB Safeguarding Adults Case Review Group after a fall in her flat left her unable to get up without the help of several people. She was found to have a fracture and needed hospitalisation, but transferring her posed risks such as potential respiratory arrest due to her condition. Capacity assessments confirmed she could make her own decisions, including continuing to use emollient creams despite staff's safety concerns which included smoking. Ms C's behaviours raised safety risks for herself and others.

The primary issue was safely removing Ms C from her flat, complicated by an unsuitable stair lift and narrow doors. After another fall, she became unconscious, was taken to intensive care, and sadly passed away the following summer.

The group discussed and agreed the learning points from this case included

Challenges

- Providing care for a Bariatric Care Patient with complex health care needs.
- Difficulty in transferring the patient to the hospital due to their size and complex healthcare needs.
- Concerns about the patient's Ms C's capacity to make decisions and executive functioning, consequences of decision making
- The patient's behaviour posed a risk to herself and other residents.
- Difficulty in accessing the patient and removing her from the building

Key Learning

- The need for a multi-agency approach in providing care for Bariatric Care Patients.
- The importance of considering the patient's capacity to make decisions and executive function.
- The need for clear protocols and infrastructure for Bariatric Care Patients.
- The importance of staff support in managing challenging cases.

Key findings included

- Gaps in the care pathway for Bariatric Care Patients, such as lack of specialist equipment and training.
- Insights into the care and support of Bariatric Patients in the community.
- Areas of good practice, including the use of personal health budgets and effective multidisciplinary team collaboration.
- The need for Sensitive Approaches to be developed for staff supporting Bariatric Care Patients.

Conclusion

The Safeguarding Adults Case Review Group concluded that while there was no multi-agency failure, the case underscored the challenges of caring for Bariatric Care Patients with complex health needs. It emphasised the importance of a multi-agency approach and infrastructure for such patients, leading to the formation of a Task & Finish Group to develop guidance for practitioners.

As the Chair of the Task & Finish Group that has been dedicated to this task, I am pleased to share our Bariatric Care for Adults – Guide for Professionals which underscores our commitment to safeguarding adults by ensuring they receive appropriate care and support. The guidance is a testament to our dedication to minimising risks of abuse and neglect, and to working in partnership with various agencies to ensure the safety and well-being of individuals with bariatric needs.

Bariatric patients often face unique challenges that can make accessing healthcare difficult. Our guidance emphasises the importance of respecting their dignity and ensuring equality in treatment. Our guidance is grounded in several key legal frameworks that safeguard the rights and dignity of bariatric patients. The Care Act 2014 emphasises personal dignity and protection from abuse, while the Mental Capacity Act 2005 provides a framework for decision-making, ensuring that capacity is presumed unless proven otherwise.

Catherine Knights

Chair, Bariatric Care Task and Finish Group

An example of applying the Equality Act (2010) in Health Services Related to people with learning disabilities, autism and or Dementia

Emma McGowan

Specialist Safeguarding Advisor

The Royal Marsden NHS Foundation Trust

Learning from Joan's Legacy

This work has been directly influenced by the learning from Joan's Legacy, which powerfully highlighted the critical need to make and record reasonable adjustments to support effective communication and engagement with adults with disabilities. The review demonstrated how the absence of such adjustments can lead to significant health inequalities and poorer outcomes. The below example evidences how The Royal Marsden is actively embedding this learning into practice to better protect and promote the rights of people with disabilities.

Why the Equality Act (2010) is important

People with a disability such as a Learning Disability, Autism and Dementia face significant health inequalities. The Equality Act (2010) says that organisations have a legal duty to identify and protect the rights of people with disabilities to ensure that they can receive equitable and accessible care. This can be done by identifying, recording and applying reasonable adjustments. This ensures that the wider human rights of people with disabilities are respected and protected.

Despite its significance we know that people with a Learning Disability die on average 22 years younger than the general population (LeDeR, 2021). Adults admitted to hospital who have dementia stay longer and are more likely to die than patients without dementia who are admitted for the same reason (DoH, 2020).

Why are we testing our responses to patients with disabilities

As part of its quality assurance process, the Royal Marsden NHS Foundation Trust conducted a Trust-wide audit to assess staff confidence in recognising and responding to the needs of patients with disabilities. The audit involved a review of a sample

of patient records for both children and adults with a diagnosis of either a Learning Disability, Autism or Dementia. The primary goal was to identify areas of strength and use these insights to enhance the quality of practice and improve patient care.

Findings from audit

Example of good practice. One of which included a young adult with autism who received input from the psychological support service to explore how their disability impacts on them. A digital flag was used to record how the patient finds delays to appointments stressful and that reassurance in the form of touch or conversation is counterproductive, they prefer a quiet environment without conversation. The digital flag makes sure that everyone a patient encounters can easily see and apply the reasonable adjustment.

However, the audit also identified areas for improvement. A lack of confidence and curiosity in staff exploring in detail how someone's disability impacts on them and what if any reasonable adjustments might be required. Hospital Passports were not always considered. There was one complaint from someone with high functioning autism highlighting the importance of not making assumptions that could result in health inequalities. Whilst there were gaps in recording disabilities and reasonable adjustments overall patients and families reported being happy with the care and treatment provided.

Next Steps

Looking ahead, the Trust has an established group of Learning Disability and Dementia Link Practitioners that include staff at all levels to represent clinical services and wards. They meet quarterly to share examples of good practice and to reflect on areas of development and learning, feeding back to their clinical services and wards. A 7-minute briefing on reasonable adjustments has been created as a quick and easy guide for staff to recognise and respond to their Equality Act (2010) duties. The Trust are exploring digital options to improve the quality of information sharing between the GP and the Royal Marsden so that we know early on if a patient has a disability and what reasonable adjustments they require.

Reasonable Adjustments 7-minute briefing

The ROYAL MARSDEN

1 Why it Matters

People with a disability such as **Learning Disability (LD), Autism** or **Dementia** face significant health inequalities. A recent review revealed that people with an LD die on average 20 years earlier than the general population and 42% of deaths of people with an LD were avoidable. Adults admitted to hospital who also have dementia stay longer and are more likely to die than patients without dementia who are admitted for the same reason (DoH, 2020).

2 Our Legal Duty

The Equality Act (2010) says that all organisations have a legal duty to ensure that services are as accessible to people with disabilities, as they are for people who are not disabled. This is done by making changes, often quite small, to the way that we care for people. These changes are called 'reasonable adjustments'. This ensures people with an LD, autism or dementia receive fair and quality care.

3 Person-Centered Approach

Every patient with an Learning Disability (LD), Autism or Dementia will have unique needs, so understanding the individual is key. Here's how to start:

- **Ask and Record.** Always ask if the patient has a diagnosed disability and note it under their **'Problem List'** in EPIC.
- **Understand Their Needs.** People with disabilities may need extra support with new or complex information and may feel more stressed in clinical environments.
- **Avoid Assumptions.** Disabilities like dyslexia may impact certain skills but does not indicate a wider intellectual impairment such as a Learning Disability.
- **Adjust Communication**. This might include speaking slowly, using simple language, or providing information visually or in Easy Read

4 Types of Reasonable Adjustments

Information explained slowly without medical jargon.

Information explained slowly without medical jargon

- Double Appointment
- First or last appointment
- Quiet area arranged
- Dimmed lighting
- Carer / support to accompany patient
- Patient Information Library accessible information tool, click here
- Easy Read Cancer Information click here 8

5 The Role of Hospital Passports

This is a document, owned by the patient. It provides information about their health needs as well as other useful information such as interests, likes / dislikes, communication preferences and reasonable adjustments. If the patient does not have a Hospital Passport you must complete this with the patient, their family, friends and /or a carer.

For hospital passports click the link

Dementia hospital passport

Learning Disability hospital passport

6 Using the Digital Flag System

If you have identified that a reasonable adjustment is needed, this must be added to the patient's EPIC record using the "**FYI Reasonable Adjustment Digital Flag**", so that the information is visible to everyone.

7 5 Key Steps to Remember!

1. **Check** for digital flags on a patient's record first. If there are none, ask the patient and their family or carers if they have a disability and what their individual needs are
2. **Record** their diagnosed disability on EPIC under the patients 'Problem List'
3. **Flag** Seek consent to add the 'FYI Reasonable Adjustment Digital Flag'
4. **Action** if you see a digital flag, you should make all best efforts to meet the reasonable adjustment need. It is all staff members responsibility to make every effort to meet the adjustment
5. **Review** reasonable adjustment needs as they might change over time depending on the persons medical or social needs that a person has and the care setting

Learning from Lives and Deaths Reports - People with a Learning Disability and Autistic people (LeDeR): Focus on Autistic People

Thanks goes to our colleagues in the Integrated Care Board in providing this report and in particular Lesley Tillson, LeDeR Coordinator NWL ICS NHS North West London who has provided the focus on Autistic People.

LeDeR is a service improvement programme for people with a learning disability and autistic (LDA) people. It contributes to improvements in the quality of health and social care for people with LDA in England by supporting local areas to carry out reviews of deaths of people with learning disabilities and/or autism using a standardised review process. This enables the identification of good practice and what has worked well, as well as where improvements to the provision of care could be made.

- North West London, ICB, received 88 notifications in total across 8 local authorities including Kensington & Chelsea and Westminster, 4 were marked out of scope.
- In the year 2024/25 Hillingdon had the highest number of notifications (25%) which is a significant increase from the previous year. Ealing (18%) Brent (15%) and Hounslow (16%).

We present bi-annual reports to the Safeguarding Adults Case Review Group for discussion and shared learning.

LeDeR reviews are required for people with learning disabilities and autistic people. The criteria for a focused review which is more in depth includes :

- All autistic people who do not have a learning disability aged 18 and above
- People from ethnic groups other than white British (including travellers, Jewish people and other white backgrounds)
- People who have been in a detained setting in the criminal justice system / or who have been under a Mental Health Act restriction within five years of death
- Where there is likely to be learning from the life of the person to inform service improvements
- Local priorities for focused reviews
- Where the family have requested a focused review
- Where there are any concerns about the care the person received.

2024-25 LeDeR Reviews across the Bi borough

In the Bi-borough, 10 deaths of individuals with learning disabilities were reviewed .Of these, 3 underwent an initial review and 7 received a focused review. No cases met the criteria for a Safeguarding Adult Review.

- Westminster – 9
- Kensington & Chelsea – 1

Focus on Autistic People

This year is the first opportunity to include findings from reviews of people with Autism who may not have a learning disability from across NWL, a small sample size of ten reviews identified the need to improve on care and support needs for this cohort.

This is important as one death reached the criteria for Safeguarding Adult Review SAR "Ayisha" which has been mentioned earlier in this section and identified challenges for organisations in offering support where learning disability is not identified and the criteria for care and support is not easily identified.

The series of slides below provide some key findings from LeDer Reviews on Autistic people completed across NWL.

Autistic people findings for 2024/25: Gender and ethnicity

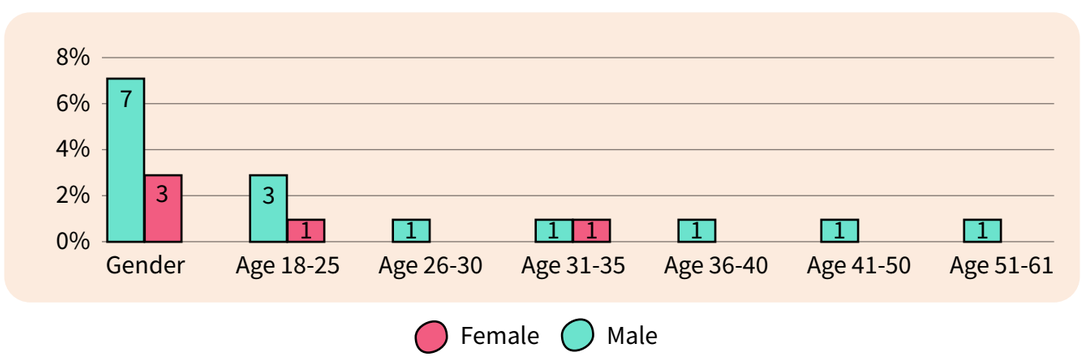
Every year, we are required to conduct a focused review on all notifications where there is a diagnosis of aurtism. The criteria for notifications of a dual diagnosis remains the same. All notifications met the criteria for a focused review. NWL produces an annual report to provide an update on the learning emerging from reviews to include autism reviews.

OVERVIEW OF LEDER AUTISM NOTIFICATIONS

- 10 notifications of autistic people were subject to a focused review. This is a significant increase from the previous year. This is the first year NWL has some tangible data to report on.
- 3 reviews had a dual diagnosis with autism as the main diagnosis so were included in the findings.
- 3 reviews remain incomplete.
- The median age of death for our autistic and dual diagnosis in the male population was 29 years.
- The median age for females was 34 years.

50% were white British and **50%** were from an EMG.

GENDER AND ETHNICITY OF AUTISM REVIEWS IN 2024/25

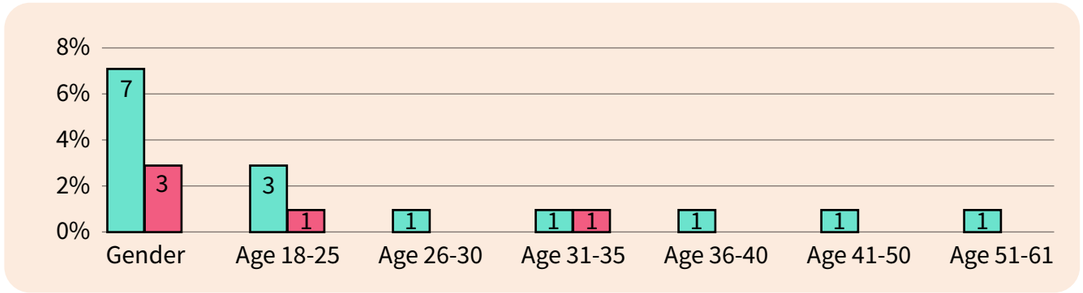


Autism review of median age - 2024/25

ETHNICITY AND AGE

- The youngest autistic person was 18 years old and the eldest was 61 years old.
- Although this audit is a small sample size the life expectancy for nthis cohgort is 29 years for males and 34 years for females.
- Either self neglect, self harm, risk taking behaviours and mental health feature in all the reviews with some having a combination of all.

MEDIAN AGE OF AUTISTIC NOTIFICATIONS IN 2024/25



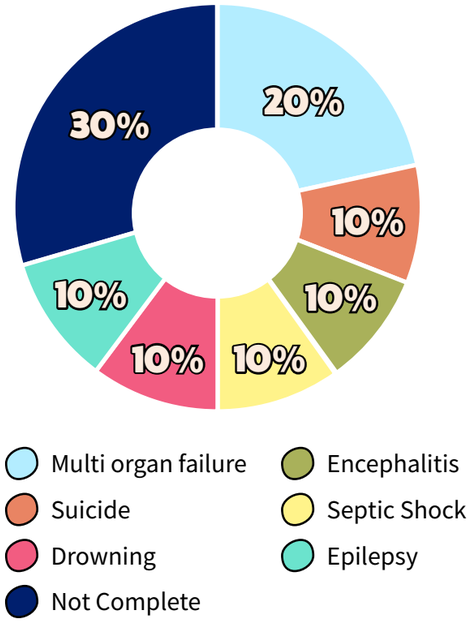
Causes and place of death in autism reviews - 2024/25

CAUSES OF DEATH

- Two people died of multi organ failure.
- One died from Epilepsy.
- One from suicide.
- One from Septic shock.
- One from Drowning.
- Encephalitis was the other cause of death with 30% of reviews not complete at the time of this report.

PLACE OF DEATH

- 50% died at home, and 30% died in hospital, 20% unknown.
- One person passed away in a crisis centre.
- One person passed away in a homeless hostel.



Positive Practice - SAR Referrals

- (29477) **Westminster**, 34 year old, lived at home with twin sister as main carer. Not known to social care at time of death. Diagnosis of eating disorder, mental health, history of child abuse, and autism. **Threshold met for SAR** - currently progressing, learning will be shared with panel.
- (30749) **Westminster**, 49 year old female lived alone, diagnosis of autism, diabetes, mental health and complex medical issues. Not known to social care. **SAR threshold not met** - learning identified around bariatric patients. Learning will be shared with panel.
- (31146) **Harrow**, 29 year old male lived at home with family members, diagnosis of autism, known to social care required 1-1 carers. **Currently at decision making stage**.
- (31277) **Ealing**, 25 year old male lived at home with family, diagnosis of autism, mental health and diabetes. Suicidal ideations not known to social care. **Awaiting care review group date**.

Further areas of good practice where identified demonstrating improvements in working with this client group particularly if liaison with statutory services such as learning disabilities, primary care and adult social care liaison had taken place.

- Mental health reviews were conducted with good documentation of plans.
- Good examples provided to families to support positive behaviour management.
- Safeguarding concerns regarding neglect and care, and support needs shared with Safeguarding Adult review groups.
- In some cases there were excellent examples of primary care intervention and liaison.
- Many carer's were providing a safe haven for their loved one.
- Where LD/A liaison professionals were involved, there were good outcomes and a positive experience for family members.

Priorities for the year ahead

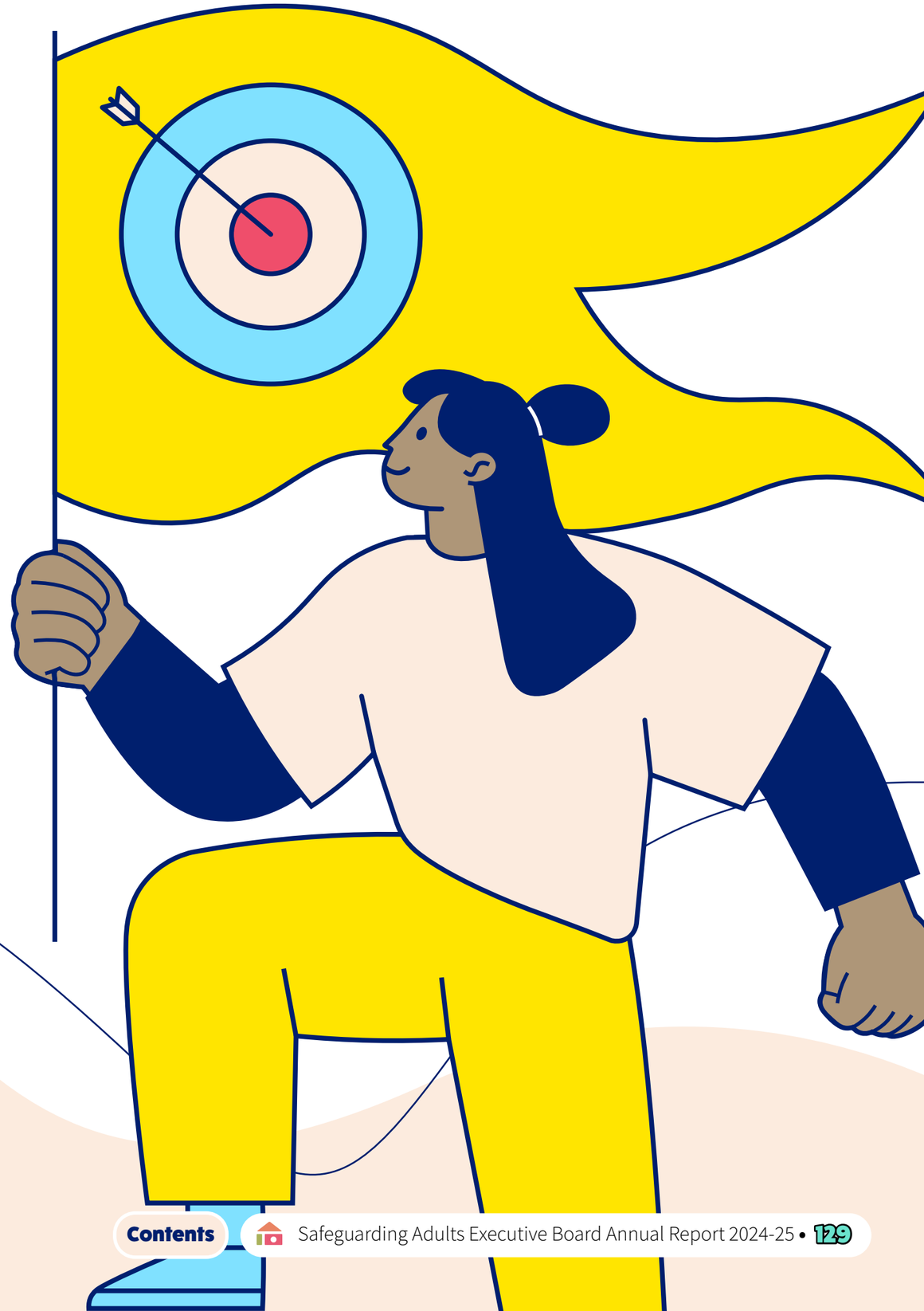
Themes and priorities for improvement

EMERGING THEMES

- Lack of reasonable adjustments. There is a need to improve flagging on systems of people with LDA to ensure reasonable adjustments are made within all health services.
- All lived at home, 60% with family members, two lived alone, one unknown.
- Improvements to carer's assessment offer, some were declined and not followed up. None of the carer's had a carer's assessment.
- Transitioning from child to adult services.
- Poor application of MCA in individual decision making.
- The need to improve on completion of timely reviews of care packages and care reviews - this is particularly relevant to people living in the family home.
- The need to establish consent to treatment. Family members declining vaccinations and screening with no power of attorney.
- Poor engagement with Adult social care, families declined intervention in some cases. Other families requesting support, social care not involved at the point of death.
- Lack of coordinated care and support for family members – there is a need to better equip families to respond to some of the challenges they experience looking after their loved one at home.
- Where LD/A liaison professionals were involved, there were good outcomes and a positive experience for family members.

PRIORITIES FOR THE YEAR AHEAD

- The introduction of annual health checks for autistic people is currently being piloted and due to be rolled out in the future.
- Work with borough teams and people with lived experience to undertake an audit of annual health and health action plans to assess the quality.
- Co-design and deliver webinars to professionals to share good practice and improve the impact on families caring for autistic people living at home. To promote person centred care - Contact, Comprehensiveness, Coordination, Continuity.
- This training should also include information about the need to report deaths of autistic people without LD through LeDeR.
- A dual diagnosis of LD and Autism should be escalated to a focused review.
- Complete an annual audit of autism review to demonstrate improvements in targeted areas.



A new life LDT campaign

- https://www.learningdisabilitytoday.co.uk/ldt-campaign/https://www.learningdisabilitytoday.co.uk/ldt-campaign
- ‘A Nice Life’ LDT campaign.
- The article discusses the urgent issue of premature mortality among people with learning disabilities and autistic individuals, largely due to inequities in healthcare. It introduces the campaign “A NICE Life,” which calls for changes to clinical guidance from NICE (National Institute for Health and Care Excellence).

KEY GOALS OF THE CAMPAIGN

- Addressing health inequalities in clinical guidelines.
- Promote lived experience involvement in shaping healthcare policy.
- Tackle issues such as barriers to access healthcare and legal acts under the Mental Capacity Act.

WHY IT IS IMPORTANT

- People with learning disabilities and autistic individuals face poorer health outcomes.
- The 2022 LeDeR report found that 42% of deaths in this group were avoidable.
- Research highlights chronic health issues and poor-quality care in autistic populations.

IMPROVEMENTS THAT CAN BE MADE (ALL GUIDANCE)

- Add people with lived experience to recommended guidance.
- Mandate inclusion of learning disability and autism and assign named professionals to support transitions from child to adult services.

SMART Action Table

Issue	Specific Action	Measurable	Achievable	Relevant	Time-bound
Lack of reasonable adjustments and poor flagging of LDA	Implementing a flagging system on all health records to identify individuals with LDA	100% of health records updated with LDA flag	Use existing IT systems and staff training. Focus on consistency of Cerner packages.	Ensures relevant reasonable adjustments across services	Within 6 months
Low carer’s assessment uptake	Develop follow-up protocol for declined carer’s assessments	100% follow up calls completed within 1 month of decline	Use existing social care staff for follow-ups	Supports carer wellbeing and legal compliance	Protocol launched in 3 months
Transition from child to adult services	Introduce a named transition coordinator in each borough	Co-ordinator assigned to 100% of young people with LDA	Start with pilot in one borough	Smooth transitions reduce care gaps	Pilot in place within 4 months
Poor mental capacity Act (MCA) application	Deliver MCA refresher training to all frontline staff	95% staff trained and assessed	Online and face to face options	Promotes lawful and person centred decisions	Training rollout complete in 6 months
Delayed or missing care reviews for those living at home	Introduce a care review tracker for people living with family	100% of reviews scheduled and monitored	Integrated with social care planning systems	Ensures timely updates to care plans	Tracker live in 3 months
Consent to treatment not established properly	Develop checklist and guidance for establishing legal consent. (consent form)	Used in 100% of cases where family refuse interventions	Include in staff induction	Ensures lawful consent process for treatment	In use within 2 months
P oor engagement with adult social care	Create early engagement protocol with adult social care at signs of carer strain	Referrals made in 90% of identified cases	Based on existing referral pathways.	Supports crisis prevention and timely support	Protocol operational in 4 months
Lack of coordinated care and family support	Set up monthly multidisciplinary family support meetings	100% of complex cases reviewed monthly	Leverage existing team meetings	Helps families manage home-based care safely	First meeting held within 2 months

Learning related to Homelessness deaths and prevention in Safeguarding Adults

All Safeguarding Boards received a letter from central government following the 2022 government strategy 'Ending Rough Sleeping for Good' which provides recommendations on how Safeguarding Adults Boards (SABs) can support vulnerable adults who are homeless and or rough sleeping.

It underlines the significant risk of abuse, neglect, and health deterioration among rough sleepers and positions SABs as key players in safeguarding this population stating:

- SABs should ensure effective multi-agency partnerships, with clear governance and accountability frameworks to support people rough sleeping who overlap with safeguarding concerns.
- SABs must designate a named board member or advocate specialized in addressing rough sleeping issues at a strategic and operational level. This advocate may come from housing, voluntary sector, or faith organizations but must have deep knowledge of safeguarding rough sleepers.
- SABs are responsible for ensuring appropriate policies, procedures, workforce safeguarding literacy revolving around safeguarding rough sleepers, including understanding legal duties under the Care Act 2014, especially Section 42 and safeguarding adult reviews (SARs).

The SAEB has a successful track record over the past several years in ensuring that it has focused on learning from rough sleeping deaths and service improvements . It has been useful reviewing the SAEB's current board structure and strategic actions to ensure that it is in alignment with central governments recommendations .

What the SAEB has in place

- **Ongoing review of rough sleeping deaths:** A Safeguarding Adult Review (SAR) is underway for the case of MC, focusing on individuals with multiple exclusion homelessness and cognitive impairments, aiming to produce local system recommendations using the Learning Together methodology.
- **Regular mortality reporting:** The SAEB subgroup receives bi-annual updates on mortality reviews related to rough sleeping, with an annual overview presented to the board for discussion a practice established for Westminster since 2018/19.
- **Support for London-wide data sharing:** The board has agreed to adopt a London-wide process for sharing data and learning about adults who die while homeless, including key personal and case details.
- **Governance and accountability:** The SAEB includes senior housing and commissioning representatives who provide updates and ensure appropriate services for rough sleepers, with active involvement in system-wide governance and integration of experience-informed practices.

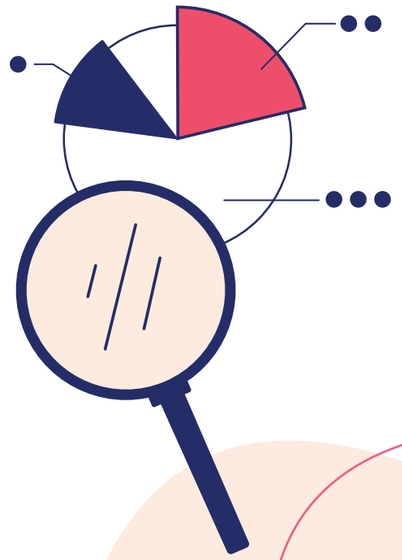
The process in place to review rough sleeping deaths

Westminster and Kensington & Chelsea are 2 very different boroughs in terms of the systems in place to support the safety needs of the roughsleeping population.

This is most starkly highlighted in the number of deaths each borough reports on annually through the Rough Sleeping Fatality Review Reports with Westminster reporting on the highest number of deaths across England and Wales while Kensington & Chelsea report on very low single numbers.

- Westminster has a multi-agency review process since 2019 for every rough sleeper death with safeguarding representation analysing demographics, trends and reviewing specific cases for eligibility for a SAR.
- Since 2024 Kensington & Chelsea have implemented a similar framework which is activated when a death occurs given the very low numbers.

We present an annual overview of deaths in the Rough Sleeping Pathway system for Westminster and Kensington & Chelsea. Westminster presents previous years data 2023-2024. At the time of publication of this report 2024-25 information was not ready for publication.



Deaths in the Westminster Rough Sleeping Pathway April 2023 to March 2024

Data insights

24 deaths in the Rough Sleeping Pathway occurred between 1 April 2023 and 31 March 2024.

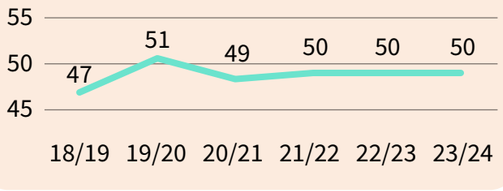
Quarterly multi-agency review meetings, held in line with the Deaths in The Rough Sleeping Pathway Process Map, have taken place virtually throughout. The last analysis of deaths in the Rough Sleeping Pathway took place for the 12 months between April 2022 and March 2023, identifying 21 individuals.

One death was referred for Safeguarding Adult Reviews "Malcolm " as the criteria of multi-agency failure in relation to health pathways and social care interfaces was met.

Overview of trends

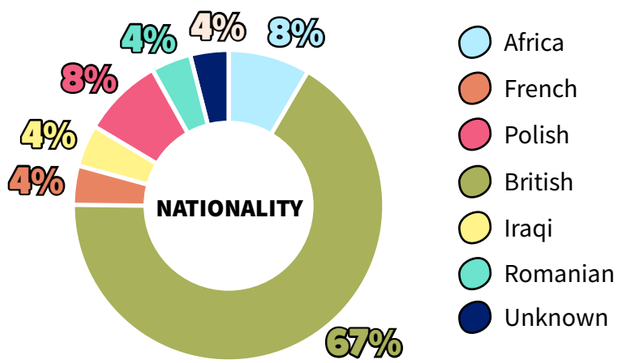
Of the 24 deaths in the Rough Sleeping Pathway between April 2023 and March 2024: 22 were male with only 2 female deaths recorded.
The average age of death the individuals that died was 50 – the same as 21/22 and 22/23.

AVERAGE AGE OF DEATH



Ethnicity

67% were British nationals. The remaining **13%** included the following nationalities: 2 Africans, 1 French, 1 Iraqi, 1 Polish, 1 Romanian and 1 unknown.



WHERE THE DEATH OCCURRED

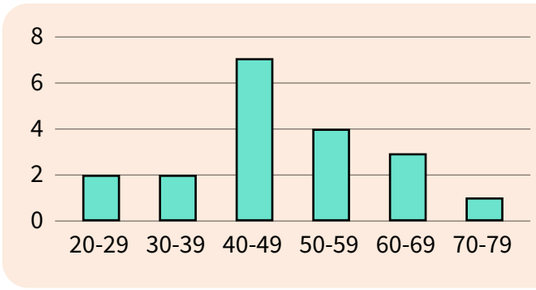
46% died on the street (compared to 24% last year), **21%** died in hospital, **13%** died in a hospice (10% last year), **17%** died in their supported accommodation (33% last year), and **1** (4%) died at Crisis at Christmas.

84% died in Westminster, with 4 passing either in Lambeth, Camden or Devon (in a hospice).

TYPE OF DEATH

5 deaths were recorded as **end of life**, 1 more than the previous year. 3 of the 5 individuals died in a hospice (compared with 2 last year), and 2 at hospital.

AGE AT DEATH



Type of death

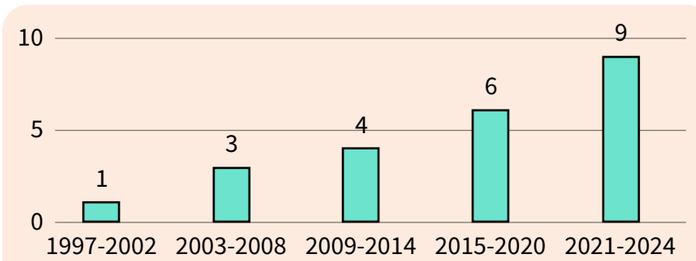
8% died aged 20-29, with 8% aged 30-39, 29% aged 40-49, 17% aged 50-59, 13% 60-69 and 4% aged 70-79. Even though the **average age** at which people died this year is unchanged compared to previous year, more people died at younger and older ages than the previous year.

What is CHAIN?

Combined Homelessness and Information Network, CHAIN, is a multi-agency database recording information about people sleeping rough and the wider street population in London. The system represents the UK's most detailed and comprehensive source of information about rough sleeping.

CHAIN allows users to share information about work done with rough sleepers. Reports from the system are used at an operational level by commissioning bodies to monitor the effectiveness of their services, and at a more strategic level by policy makers to gather intelligence about trends within the rough sleeping population.

CHAIN REGISTRATION



The CHAIN registration table demonstrates that 63% of individuals who have passed on in 2023-24 had their first recorded CHAIN contact in the last 10 years, 30% between 10 and 20 years and 4% (1 individual) beyond that. 1 individual was not listed on CHAIN.

Cause of death

7 individuals, or 30% of the deaths, had substance use recorded as the official cause of death from the coroner. 6 of the deaths were recorded as alcohol related and 1 as drug related.

11 individuals, or 46% of the deaths, had alcohol use recorded on a recent CHAIN recorded risk assessment, compared to 43% the previous year.

9 individuals, or 37% of the deaths, had drug use recorded on a recent CHAIN recorded risk assessment, compared to 43% the previous year.

The increase in funding for substance misuse provision via the Public Heath England Rough Sleeping Drug and Alcohol Treatment Grant, is a welcome addition to address these substance misuse death trends.

Project Work addressing trends from the deaths review process from a health perspective

The Westminster Homeless Health Coordination Project (WHHCP) **delivered by Groundswell, commissioned by WCC, plays a central role responding to learning from deaths, working in collaboration with 22 homeless services across the borough.**

The project exists to improve health access and decrease health inequalities by building focus and capacity by:

- Identifying the health needs of service users and improving awareness amongst statutory health providers around the health needs of the cohort.
- Working with a multitude of services to raise the capacity of supported housing providers to support service users to improve their health outcomes through training, information, accessing health services and facilitating a range of health events.

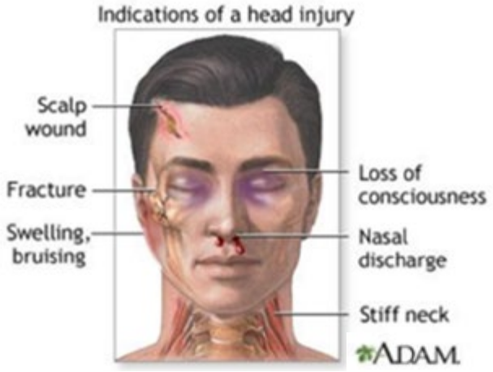
- Creating Toolkits and information sheets and directories Health organisation directories providing up to date best practice and easy access details of services in Westminster

They delivered 110 training sessions, attended by workers across the system including themes relating to self-harm and suicide, mental capacity, safeguarding, common physical health conditions, drug and alcohol support etc.

Proactive project work directly related to the quarterly deaths reviews where the SAR criteria has not been met included:

- Mental capacity awareness – check list circulated and regular training on aspects of capacity to include cognitive impact of brain injury on decision making
- Smoothing communication regarding WCC Public Health funeral arrangements – contact and process details are circulated and additional training on the role of the Court of Protection in palliative cases has been provided .
- Reminder poster has been created about head injuries when it was indicated that an injury involving the head was not communicated to the ambulance crew. Reminder poster created – **"always inform ambulance/A&E of a head injury even if days before".**

Head Injury and Alcohol/Substance Intoxication



YOU CANNOT PROPERLY ASSESS SOMEONE WITH A **HEAD INJURY** IF THEY ARE **UNDER THE INFLUENCE** OF DRUGS OR ALCOHOL

ALWAYS MENTION A POTENTIAL OR KNOWN **HEAD INJURY** TO THE AMBULANCE CREW / 999 EVEN IF HEAD INJURY HAPPENED **WEEKS AGO**

IF SOMEONE WITH A HEAD INJURY AND INTOXICATION IS REFUSING HEALTHCARE, CONSIDER IF THEY HAVE THE **MENTAL CAPACITY** TO DO SO

MOST PEOPLE WHO HAVE HAD A HEAD INJURY AND ARE INTOXICATED **WILL NEED A CT SCAN** TO RULE OUT A BLEED ON THE BRAIN

HEAD INJURY + ALCOHOL/DRUGS = A&E

Two dedicated reflective multiagency sessions took place for people who died in period of extreme cold weather, for people who declined accommodation. This led to a comprehensive piece of work over 2024/25 to create a suite of materials to encourage people indoors, assess risk and action plan on a multi agency basis, assess capacity and escalate concerns. These materials have been shared across London and are available here:

Escalation-Process-for-SWEP-refusal.pdf

MDT evictions protocol | Groundswell

Palliative care join-up

A number of deaths were noted as palliative care situations, with strong end of life care and join up. Groundswell HHCP created a Palliative Care pathway with the aim of improving outcomes for end of life clients and linking homelessness services and mainstream services including 'hospice at home' and attending to practical measures like storage of pain medication.

Caseload nurses pilot

Over the last three years there have been scenarios relating to people with high health needs and repeat hospital admissions in accommodation services that do not have in reach nursing and GP sessions. This has led to the development of a case load nurse pilot which began in 2023 and is delivering an assertive nursing in-reach service with a relationship oriented, trauma informed focus, based in the Homeless Health Nursing Team. The team is delivering impressive outcomes and an 18 month impact report is now available.

Join up with non specialist GPs

Communication was improved with Grand Union Medical Centre , who had two roughsleeing pathway patients who died. Learning points were around pregabalin prescribing and clearly flagging vulnerable homeless patients (as their patient numbers are c 20,000) and improved communication with Turning Point.

Blue Light Project

Physical health conditions related to dependent drinking is a strong theme across the pathway deaths reviews each year. The Blue Light project is an established initiative to develop alternative approaches and care pathways for drinkers who are not in contact with treatment services, but who have complex needs and this work continued over the year with a range of initiatives and tools created. Blue Light Resources

Deaths in the Kensington & Chelsea Rough Sleeping Pathway April 2024 to March 2025

Three deaths in the Rough Sleeping Pathway occurred between 1 April 2024 and 31 March 2025. Multi agency virtual meetings have been held quarterly.

One individual met the remit of the quarterly death review because they lived in supported housing, however they did not have a history of rough sleeping and therefore had never been verified on CHAIN. As a result, the data below relates to the two rough sleepers who were verified in RBKC. Given the small amount of deaths it is difficult to draw local conclusions so we provide a snap shot of the 2 people concerned. We also provide a case study of when things go right called “Peters Journey”.

Rough sleeper A

- Gender: Male
- Gender the same at birth: yes
- Age at death 44
- British
- First recorded on CHAIN four years prior to his death.
- Support needs recorded on CHAIN-drugs, alcohol and physical health needs.
- Part of the Target Priority Group, formerly known as T1000, as high risk.
- Housed in accommodation at the time of his death.
- Cause of death: multiple organ failure.

Rough sleeper B

- Gender: Male
- Gender the same at birth: yes
- Age at death 51
- British
- First recorded on CHAIN one year prior to his death.
- Support needs recorded on CHAIN- alcohol.
- Long history of involvement with statutory mental health services.
- Engaged with alcohol service
- Part of the Target Priority Group,[1] formerly known as T1000, as high risk.
- Homeless at the time of his death.
- Cause of death: not confirmed

Case Study

Peter’s Journey

Peter had lived for years with mental health challenges and addiction. His past was marked by instability—over a decade spent intermittently sleeping rough, entangled in a cycle of daily drug use, recurrent brushes with the criminal justice system, and feelings of isolation. Despite being diagnosed with anxiety and depression, Peter often went unmedicated and was hesitant to engage with support services, which left him feeling unseen and unsupported.

When the opportunity arose for Peter to move into supported accommodation through the RBKC pathway, something shifted. He made the brave decision to accept help, and that willingness opened new doors. The multi-agency team and Navigator Service rallied around him, offering consistent, person-centred support tailored to his needs. They collaborated and all worked together to build trust, and gradually Peter engaged not just with their mental health needs but also with his substance misuse.

Within a few months Peter chose to relocate outside of London, seeking a fresh start and the chance to reconnect with family—most importantly, with his mother. Peter kept in contact with the RBKC housing staff telling them about his first clean months in years and sending photographs showing the new version of himself. Peter began to take their prescribed medication independently, followed through with long-delayed dental work, and now smiles with renewed confidence. There have been numerous milestones along the way: applying for a new passport, planning their first trip in years, purchasing a wardrobe of new clothes, and delighting in home-cooked meals and walks .

Together with my colleagues in the Navigator Service and across the agencies, we have seen what’s possible when support is truly tailored to the person.

The Target Priority Group is made up of people who have a history of sleeping rough in an area who are furthest from having their rough sleeping resolved, have been in this position for some time, and will remain so without bespoke multi-agency interventions and on-going support. The TPG includes the following.

- people who have been seen sleeping rough in two or more years out of the last three
- people who have been seen sleeping rough in two or more months out of the last 12, or
- those currently in off the street settings who are most likely to return to rough sleeping.

SAEB Learning Programme

Our well received lunch and learn programs and events continue to enhance staff skills in growing their safeguarding knowledge and fulfilling their safeguarding duties.

Additionally, we are raising awareness and increasing our library of safeguarding topics that are crucial for prevention of safeguarding issues across our communities.

Every event we have is evaluated to assess how learning objectives have been met and to ensure learning experience and outcomes are achieved. Impact is key to embedding the work we do and we frequently test this to assure ourselves that learning is understood and can be seen in day to day operational practice to be making a difference where it counts .

This year we have placed a strong emphasis in 3 key areas to test out our learning

- Fire safety (both online and in-person events) which have offered the partnership resources to integrate fire safety into existing training modules. These resources have equipped our workforce with the necessary skills to address the evolving needs during discharge and MCA Executive Function, ensuring comprehensive fire safety preparedness. Additionally, we are raising awareness of key fire safety issues that are crucial for prevention across our communities.
- Mental Health Learning Programme is designed to raise awareness of mental health issues and local services, reduce stigma, and equip staff with the skills needed to promote early intervention. It also provides support and information to our communities, enhancing and promoting resources for better well-being and support for everyone.
- Scams and online safety - raising awareness about scams and online safety is crucial due to scammers continually evolving their tactics, exploiting new technologies and psychological vulnerabilities to steal money and personal information, with devastating consequences beyond financial loss. The increasing sophistication of online threats, including the use of AI to create highly convincing fake content and automated campaigns, means that even careful individuals can be at risk, necessitating continuous vigilance and education for everyone.

Safeguarding Adults Executive Board

October 2024
Fire Safety Focus Group Session (in person event).

November 2024
Fire Competency Training for all SAEB organisations.

November 2024
Fire Safety Training Awareness (London Fire Brigade)

December 2024
Electrical Fire Safety - London Fire Brigade) & Safeguarding Ambassadors

February 2025
Fire Safety Learning Event

February 2025
Romance Fraud and online digital Safety Safeguarding Ambassadors

March 2025
Bite Size Training: MCA and Fire Safety

March 2025
BME Safeguarding Network - Putting Safety Policy into Practice to include protected characteristics and Discriminatory Abuse

MHLP Mental Health Learning Programme

January 2025
Bridging the Gap. Safeguarding together across the partnership.

April 2025
Talking therapies.

Setting our priorities for the next 3 years. "Looking Back, looking forward"

SAEB Strategy and SAPAT Development Day Event March 2025 Reviewing our Governance arrangements. Looking back, looking forward

Our local annual audit of safeguarding partnership arrangements, conducted in March 2025, aimed to gather comprehensive information from key partners, evaluate our achievements, identify barriers, and analyse strengths and challenges across the partnership.

At the event, partners and our communities presented , discussed and agreed priorities and intentions for the next 3 years. The collaboration between our professionals, the voluntary sector, service users, and unpaid carers brought diverse perspectives and expertise to the table.

This multi-agency approach ensures that our agreed priorities lead to a more holistic understanding of how we enhance and expand our efforts in protecting residents from abuse and neglect.

Review of challenges and achievements

Looking back SAEB Key Highlights 2022 – 2025

2022 – 2023

Making Safeguarding Personal

- Glenda's video her story from Service User to Safeguarding Ambassador to becoming a voice to influence safeguarding for London
- Think Fire Campaign Launched

Creating Safe and Healthy Communities

- Staying Safe Project 'Train the Trainer'
- The Cost-of-living Crisis - Sensible precautions and local solutions
- ADASS Safeguarding Adults Board Conference – Ambassadors Led Regional Co-production session

Leading, Listening and Learning

- SAR Joan
- Joan's Legacy Video
- SAR Annie – embedding the purple pathway
- Sponsorship of The Blue Light Project – Ian's story and Video

Quality & Performance

- SAEB Learning Programme
- SAEB Website launch with translation
- SAR Champions Network launched

2023 – 2024

Making Safeguarding Personal

- National Safeguarding Awareness Week – Safeguarding and Domestic Abuse Video
- London ADASS Conference - Co-production session
- Self-Neglect and Hoarding Webinar

Creating Safe and Healthy Communities BME Safeguarding Network Launch

- Fatal Fires Thematic Review
- Learning from Complex Mental Health Cases Learning Event

Leading, Listening and Learning

- Fatal Fires Thematic Review
- Learning from Complex Mental Health Cases Learning Event

Quality & Performance

- SAEB Safeguarding Referrals Practice Guidance

Our Safeguarding Ambassadors who designed our House logo told us:

> Our House Logo symbolises safety and stability.
>
> It has 4 rooms, each representing a pillar of the SAEB Strategic Plan. We would like to encourage the board to retain this logo as it embodies the essential practices that guide our ambitions for safeguarding adults in the Bi-borough. We would also like the board to think of our Group as the roof, keeping 'Making Safeguarding Personal' (MSP) at the forefront of everything achieved and allowing the voice of our residents and those with lived experience to continue to be distributed evenly throughout the structure.

The Safeguarding Adults Executive Board Strategy 2025 – 2028

Our 3-year strategy for 2025 – 2028

Our 3-year strategy for 2025 – 2028 sets out our aims and objectives and a framework within which to achieve them.

Our Strategic Priorities are built on the foundation of our vision and values and are grouped under the following pillars below which set out how the Board will work towards achieving its ambitions for safeguarding adults in the Bi-borough. It focuses on four key priorities to ensure that safeguarding responsibilities are delivered in a way that fosters safeguarding prosperity within our communities and continues to have 'Making Safeguarding Personal' (MSP) at the core of everything we do.

1 Making Safeguarding Personal – Listening to voices of lived experience

At the heart of our safeguarding approach is a deep commitment to Making Safeguarding Personal—ensuring that every individual's voice is not only heard, but shapes the response to new and emerging themes arising from safeguarding referrals.

We recognise that safeguarding cannot be addressed with a one-size-fits-all mentality, especially as we confront complex issues like domestic abuse and the nuances of cultural identity. Instead, we adapt our practices to reflect the lived experiences of those we support, listening intently to understand their perspectives, their hopes, and their unique circumstances. By fostering an environment where cultural awareness and personal experience guide our action, we are better equipped to respond to the realities of people's lives and ensure that safeguarding is both meaningful and effective.

Making safeguarding everybody's business

1. Continue to Improve awareness of safeguarding across all communities.
2. Culturally competent safeguarding and support is embedded into the partnership.
3. Closer working with the voluntary sector.
4. Listening and collaborating with service users by experience.

2 Empowering Communities to Prevent Abuse and Neglect

Aim: To create an inclusive and diverse safeguarding culture, which is informed by what is most important to specific community groups.

Prevent harm and abuse: Work together with our communities to prevent harm and abuse, improving awareness of safeguarding to ensure they are informed, confident, and supported in raising safeguarding concerns.

Inclusive and diverse safeguarding culture: Continue to create an inclusive and diverse safeguarding culture that learns by listening and providing tailored learning programmes and support.

Empower communities: Empower our communities to raise awareness about adult safeguarding among residents by ensuring language used and pathways are known and understood and accessible

Promote equality, diversity, and inclusion: Continue our Community Engagement Group Prevention Agenda of engagement activities to promote safeguarding awareness across diverse community groups.

Communication, Prevention and Early Intervention.

1. Shared safeguarding goals and wellbeing responsibilities that create a safe space to seek assurance.
2. Understanding what the new prevalent trends are in safeguarding and not conforming to old abuse types when trying to do something about it.
3. Making sure safeguarding arrangements for unpaid carers and adults with care and support needs work effectively and we have people by experience working alongside us informing our learning.

3 Better Outcomes for People – Evaluating Progress and Performance

Aim: To ensure that safeguarding arrangements for adults at risk work effectively through quality assurance mechanisms and multi-agency safeguarding data, equipping practitioners across the partnership to support adults appropriately where abuse, neglect, and exploitation are suspected or have taken place. Promote, encourage, and disseminate information about best practices related to referrals, making safeguarding personal (MSP), and all frontline work. Ensure that best practices are embedded across all agencies involved in safeguarding adults.

Making sure safeguarding arrangements for adults at risk work effectively and support organisations to continually improve practice.

Ensuring our safeguarding systems are improving and we are learning and getting better through use of digital technology to get our messages across.

Learning through Development of best practice and using data better to help inform partnership responses to safeguarding referrals.

Communication, Prevention and Early Intervention.

1. **Robust multi-agency data** is presented in an informed way so it can shape priorities and effect change where required
2. **Collaborative projects** are agreed to enhance our safeguarding knowledge across the partnership
3. **Addressing abuse types:** We focus on understanding and addressing the most common types of abuse. Keeping ahead of the game on anticipating trends and placing focus where it is needed
4. **Consistent coordinated and evaluated multi-agency training:** The SAEB Learning Programme promotes competency-based learning, development opportunities, and best practices. Our programme fosters an open and transparent safeguarding culture, ensuring that our partnership, including provider services and the voluntary and community sector, is well-equipped to support adults appropriately where abuse, neglect, or exploitation is suspected or has occurred.

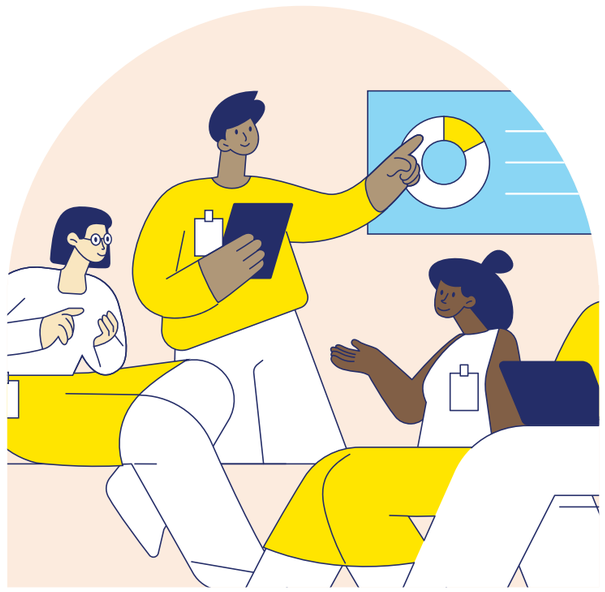
4 Leading, Listening and Learning – Enhancing Safeguarding Practices through learning from Safeguarding Adult Reviews

Aim: To promote a culture of continuous learning across our Safeguarding partnership, recognising and supporting the challenges to learning, particularly within our Safeguarding Adult Review process. Ensure that we commission SAR's with efficiency and effectiveness in mind and a focus on targeted learning .This includes implementing the findings from Safeguarding Adult Reviews and other key areas of practice improvement.

The SAEB Learning Programme and SAR Champions Network is extended across the wider partnership, including housing and voluntary sectors, to support, share, and embed learning.

Sharing learning to prevent harm and abuse.

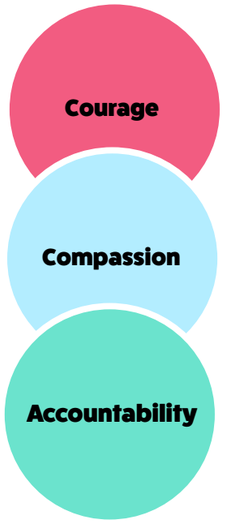
1. A partnership which is open to new ideas and a willingness to learn from mistakes
2. A partnership which wants to get better at preventing abuse and neglect.
3. A partnership which is transparent and accountable to each other and to its residents
4. A partnership that listens and hears what it is being told by users and families.



Values and Behaviours

We have stood by our values and behaviours for the last 8 years and still believe these best describe how we as a Board would wish for our partnership to act .

We believe that adult safeguarding takes **COURAGE** to acknowledge that abuse or neglect is occurring and to overcome our natural reluctance to face the consequences for all concerned by shining a light on it. The Board promotes **COMPASSION** in our dealings with one another, especially when we make mistakes. The Board promotes a culture of learning rather than blame. At the same time, as members of the Board, we are clear that we are **ACCOUNTABLE** to each other, and to the people we serve in the Bi-borough of Kensington & Chelsea and Westminster.



Our Vision

Our Board Vision is based on the rights of people to live a life free from harm where communities:

Have a culture that does not tolerate abuse.

Work together to prevent abuse.

Know what to do if and when abuse happens

To achieve this vision, the Board will:

- Foster a culture of collaboration and commitment.
- Develop and implement proactive prevention strategies.
- listen to the voices of our communities to deliver positive outcomes.

The SAEB is dedicated to the principles of Making Safeguarding Personal, which means listening to the goals of adults or their representatives and providing the most appropriate support to enhance involvement, choice, and control. This approach aims to improve quality of life, wellbeing, and safety. The SAEB's key role is to hold all agencies and members accountable if this vision is not achieved.

The SAEB's key role is to hold all agencies and members accountable if this vision is not achieved.

SAEB Business plan for 2025-2026 Key priorities

1	2	3	4
Making Safeguarding Personal	Empowering Communities	Better Outcomes for People	Leading, Listening and Learning
↓	↓	↓	↓
Listening to the voice of users by experience	Greater awareness of modern slavery, what local issues look like and how to raise a concern	To support the development of a SAEB dash board of partnership data	To implement recommendations from SAR "Malcolm"
↓	↓	↓	↓
Reinforcing ethos of MSP within a cultural framework	Raising profile of SAEB through National Safeguarding Adults Week	Embedding Ministerial letter about homelessness into day-to-day workings of the SAEB	Self neglect and Hoarding pathway and tool kit evaluation
			↓
			MCA workshops Merton and Sutton collaboration

Appendix 1: Membership of the SAEB

There are senior representatives on the board, from the following organisations:

- Adult Social Care and Health
- BME Health Forum
- Carers Network
- Central and North West London NHS Foundation Trust (CNWL)
- Central London Community Healthcare Trust (CLCH)
- Chelsea and Westminster Hospital Foundation NHS Trust
- Children's Services (Local Authority)
- Community Rehabilitation Company (CRC)
- Community Safety (Local Authority)
- Department of Work & Pensions
- Guy's & St. Thomas NHS Foundation Trust
- Healthwatch Central West London
- Housing (Local Authority)
- Imperial College Healthcare NHS Trust
- Local Account Group
- London Fire Brigade
- Metropolitan Police
- National London Probation Service
- North West London Collaboration Integrated Care System (NWL ICS)
- Public Health
- Royal Borough of Kensington & Chelsea
- SAEB Safeguarding Ambassadors
- The Royal Marsden NHS Foundation Trust
- Trading Standards
- Westminster City Council

mistreated?
bullied?
hit?
neglected?
hurt?
exploited?
silenced?

Don't ignore it. Report it.

Kensington & Chelsea
T: 020 7361 3013
E: socialservices@rbkc.gov.uk

Westminster
T: 020 7641 2176
E: adultsocialcare@westminster.gov.uk

Safeguarding Adults Executive Board
W: saeb.org.uk