Safeguarding Adults Executive Board Annual Report 2025-26

Safer communities, stronger futures



City of Westminster

Safeguarding Adults Executive Board

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Contents

Foreword 4

Welcome to this years Annual Report 6

Business Plan and Priorities 2025/6 8

Safeguarding Ambassador : Jean's Story 10

Section 1 Safeguarding at a Glance 12

- Safeguarding adults activity and outcomes 2025–26 13
- Kensington and Chelsea at a glance 15
- Westminster at a glance 26

Section 2 Key Priority Areas 37

- Theme 1 - Self-neglect and Hoarding 38
- Theme 2 - Partnership responses to system demand 41
- Theme 3 - Domestic Abuse and Safeguarding 45
- Theme 4 - Mental Health, Safeguarding and Complex Risk 48
- Theme 5 - Multi-Exclusion Homelessness 51

Section 3 Leading Listening and Learning 54

- Safeguarding Adults Reviews 55
- Ministerial Action Plan: Rough Sleeping, Homelessness and Safeguarding 62

Section 4 Board Impact and Improvement 64

Commuity Engagement in Safeguarding 66

Looking Ahead 2026/27: Closing Statement 71

Appendix 1 72

Governance and Finance SAEB 2026 73

Appendix 2 75

Learning and Development subgroup end of year report 76

Appendix 3 80

Community Engagement Sub-Group end of year report 81

Appendix 4 90

QA Subgroup End of Year Report 91



Foreword

As Chair of the Safeguarding Adults Executive Board, I am pleased to introduce the Annual Report for 2025–26. This report sets out the progress made across Kensington and Chelsea and Westminster, but it also recognises the pressures facing adults, carers, communities and services. Our role as a Board is to provide leadership, challenge and assurance. We must ask whether adults are safer, whether partners are acting early enough, and whether learning is leading to real change.

A clear message from this year is that prevention starts in communities. Safeguarding works best when people can recognise abuse and neglect, know where to go for help and trust that they will be listened to. The Community Engagement Group, BME Safeguarding Network and Safeguarding Ambassadors have helped the Board hear more clearly from residents, carers and community organisations. Their work has strengthened translated resources, digital safety messages, awareness campaigns and trusted conversations about hidden harm, scams, domestic abuse, elder abuse, self-neglect and caring pressures.

This community work has helped the Board understand why a lack of trust and not knowing what support is available can all stop people asking for help. The message from the BME Safeguarding Network is powerful: safeguarding cannot protect people it does not see. That challenge runs through this report and will continue to shape the Board's work.

There is much to be proud of. The Safeguarding Ambassadors were recognised nationally through the "We See You, We Hear You" Prevention Team Award. This recognition reflects their commitment, courage and lived experience leadership. They have helped make safeguarding messages more human, more accessible and more relevant to the people and communities we serve.

The report also shows a wider shift in the Board's approach. We are moving from describing activity to testing impact. During 2025–26, the Board focused on learning from reviews, self-neglect and hoarding, domestic abuse, mental health and complex risk, rough sleeping, community engagement, equality and stronger assurance. Across this work, four practice themes have become clear: engagement, safe closure of cases, professional curiosity and escalation. These themes will help us test whether learning is changing practice and whether partners are working together earlier and more effectively.

We know there is more to do. Some adults continue to face complex and hidden risks, particularly where trauma, mental ill health, homelessness, substance use, domestic abuse, cognitive impairment, discrimination or isolation are part of their lives. These risks do not sit neatly within one service. They require partners to work together with persistence, curiosity and shared responsibility.

Looking ahead to 2026–27, the Board will focus on turning learning into visible change. We will strengthen community prevention, improve how we use data and evidence, test whether learning is embedded in practice and continue to listen to people with lived experience. We will also respond to the stronger national focus on adult safeguarding and the additional scrutiny that will come through the new National Adult Safeguarding Board.

I would like to thank Board members, subgroup chairs, practitioners, voluntary and community partners, unpaid carers and people with lived experience for their commitment throughout the year. Their contribution is central to making safeguarding everyone's business and to building safer, more connected communities.





Welcome to this year's Annual Report

9th Edition

Who this report is for

This Annual Report is for residents, adults with care and support needs, unpaid carers, community and voluntary organisations, practitioners, partner agencies, elected members and anyone who wants to understand how adult safeguarding is working across Kensington and Chelsea and Westminster. It explains, in clear language, what the Safeguarding Adults Executive Board has focused on during 2025–26, what the partnership has learned, where risks remain, and what difference the work is making for people and communities.

The report is also intended to support accountability. It helps the Board, statutory partners and wider safeguarding partners show how they are working together to prevent abuse and neglect, respond to concerns, learn from safeguarding adult reviews and improve local safeguarding arrangements.



Introduction

Welcome to the 9th Annual Report of the Kensington and Chelsea and Westminster Safeguarding Adults Executive Board. This report describes how partners have worked together during 2025–26 to help keep adults safe, prevent abuse and neglect, and strengthen confidence in safeguarding across our communities.

This year's report marks an important shift in how the Board tells its story. Previous reports have often described a wide range of activity. This report still recognises the work delivered by partners, but it places greater emphasis on the risks that matter most, what we have learned from local evidence, and how the partnership can show impact. In simple terms, the report asks: what are we worried about, what have we done, what has changed, and what still needs attention?

The main report is laid out around four connected themes. It is designed to be readable and focused, giving readers the key messages, risks, learning and evidence of impact without including every supporting detail.

1

Safeguarding at a Glance

Provides a clear picture of safeguarding activity, demand, quality and outcomes.

2

Key Risks

Focuses on the five risks that have shaped Board assurance, including self-neglect and hoarding, workforce pressures, domestic abuse, mental health and complex risk, rough sleeping and multiple exclusion.

3

Leading Listening and Learning

Explains how learning from Safeguarding Adult Reviews and other review activity is being used to improve practice.

4

Impact and Improvement

Looks at impact, improvement particularly with our communities and our central approach to listening and learning from the voice of people with lived experience .

More detailed assurance material, including full performance datasets, and supporting evidence from the Community Engagement, Quality Assurance and Learning and Development workstreams, is included in the appendices.

Three Year Strategy. Year 1 Business Plan 2025/26

Purpose: This section sets out the Board's statutory Business Plan and priorities. It shows how the priorities respond to legal duties, local evidence, learning from reviews and the main safeguarding risks for the year ahead. The three year strategy can be found in Appendix 1

What shapes the Business Plan?	How it shapes Board priorities
 **Statutory duties**	The Board must make sure partners work together to prevent abuse and neglect, learn from reviews, publish priorities and hold the system to account.
 **Local evidence**	Safeguarding data, Care Quality Commission, CQC feedback, self audit findings, audit activity and partner reports show where demand, risk and practice need closer attention.
 **Learning systems**	Learning from Safeguarding Adult Reviews, case discussions, domestic abuse reviews, LeDeR, rough sleeping deaths and community feedback helps the Board focus on what needs to change.
 **System risk**	The Board will focus on risks that cut across agencies, especially where adults may experience hidden harm, multiple disadvantage, poor access to support or fragmented responses.

Business Plan priorities

Priority	Why this matters	What we will do	How we will know it is working
1 **Turn learning into practice**	Reviews and case discussions show recurring challenges to engagement, safe closure, professional curiosity and escalation.	Embed learning through SAR Champions, briefings, workshops, supervision prompts and action-plan follow-up.	Audit evidence, partner examples and Action Plan updates show that learning is changing frontline practice.
2 **Strengthen responses to complex risk**	Adults experiencing homelessness, self-neglect, mental ill health, substance use, domestic abuse or trauma can fall between services.	Improve shared pathways, earlier escalation, safe closure and joint ownership of risk, including work linked to SAR Malcolm and self-neglect and hoarding.	High-risk panel activity, case audits and partner assurance show clearer ownership, earlier action and safer follow-up.

Priority	Why this matters	What we will do	How we will know it is working
3 **Use evidence to drive assurance**	The Board needs a stronger shared picture of demand, risk, outcomes and impact.	Develop the multi-agency safeguarding dashboard and use audit and performance data to identify trends and areas for action.	Board reports show clearer trends, stronger challenge and actions linked to evidence rather than activity alone.
4 **Build community confidence and prevention**	People may not recognise abuse, know where to get help or trust services enough to raise concerns. Community feedback shows that stigma, fear, language barriers, isolation, discrimination and low trust can stop people coming forward.	Work with Safeguarding Ambassadors, carers, voluntary organisations, the BME Safeguarding Network and community partners to improve prevention messages, translated resources, trusted conversations and local training.	Reach, confidence, onward sharing, use of resources, community feedback and voluntary sector insight show that people are more able to recognise concerns and know where to get help.
5 **Make safeguarding inclusive**	Hidden harm can be missed where people face discrimination, language barriers, disability, cultural barriers, isolation or lack of trust.	Strengthen work on unpaid carers, protected characteristics, discriminatory abuse, culturally competent practice and transitional safeguarding.	Assurance reports and community insight show that safeguarding information and support are more accessible, trusted and responsive.

Key risks the Board will watch

Risk	Why it matters	Board assurance question
Increasing complexity	More adults are presenting with overlapping needs and risks that require partners to work together.	Are partners identifying risk early and acting together before harm escalates?
Gaps between services	Adults can fall between services when responsibility is unclear or support does not fit eligibility criteria pathways.	Can partners show clearer ownership, safer closure and earlier escalation?
Learning not fully embedded	Learning has limited value unless it changes practice and improves outcomes.	Can partners evidence what has changed because of review learning, audits and community feedback?

How progress will be reported

The Board will review progress through quarterly updates, subgroup reports, audit findings, the safeguarding dashboard, action-plan monitoring, learning evaluation and feedback from people with lived experience and community partners.

The test for the Business Plan is simple and the outcomes in this report show impact and tangible evidence of success which is clearly linked back the Business plan priority areas.

> "are adults safer, are partners acting earlier together, and can the Board show that learning is improving practice?"
>
> **Aileen Buckton**
> **Independent Chair,**



Safeguarding Ambassador: Jean's Story



The Safeguarding Ambassadors continue to play a vital role in helping the Board understand what safeguarding feels like in real life, what language people understand, what barriers stop people asking for help, and how services can build trust. Their work is not an "add-on" to the report. It runs through the Board's thinking about prevention, communication, community confidence and strategic decision-making.

The Ambassadors help ensure that safeguarding is grounded in people's experiences, not just in policies, meetings or performance data. Their contribution

supports Making Safeguarding Personal by reminding the partnership that safeguarding should be about listening well, respecting choice, improving access, and helping people feel safer and more confident to speak up.

At first, I could not understand why this had happened to me. I felt angry, frightened and disconnected from the world. I wanted to hide away at home and not speak to anyone. But even in that very difficult time, there was a part of me that knew I was still the same person. I was still a mum, still part of my family, and still someone with a voice, views and experiences that mattered.

Over time, with support and adjustments, my world began to open up again. One of my first important connections was with my local disabled people's centre, where I learnt to use a computer with speech software.

Through this, I became involved in different community groups, including disability groups, local resident groups and opportunities to speak with services such as the police.

One experience that stayed with me was meeting a visually impaired woman who felt very sad because she could no longer bake cakes for her friends. We shared our stories, and I told her about the support I had received, which helped me to do things I thought I had lost. Sometime later, she invited me for afternoon tea and proudly offered me a carrot cake she had baked herself. That moment reminded me how powerful it can be when people share experiences, listen to one another and help each other find confidence again.



For me, being a Safeguarding Ambassador is about using my voice and my lived experience to help make services and communities safer, more inclusive and more aware of people's different needs. It is about making sure that people who may feel isolated, unheard or unsure where to turn know that they matter. It is also about helping professionals and organisations understand what life can feel like from the perspective of someone who has faced barriers, loss and change.

Vogt-Koyanagi-Harada (VKH) disease, a rare autoimmune condition left me wanting to hide away, but if I had stayed hidden, I would never have met so many wonderful people or discovered how much I still had to give. Being a Safeguarding Ambassador gives me the opportunity to turn my experiences into something positive: to connect with others, support awareness, and help make sure that people's voices are heard.

Section 1
Safeguarding at a glance



Jargon buster

Safeguarding Concern: A safeguarding concern is when someone is worried that an adult may be experiencing, or may be at risk of, abuse or neglect.

Section 42 Enquiry (Safeguarding Enquiry): is when the local authority decides: "This concern meets the legal test, so we need to formally look into what has happened and what needs to be done to help keep the person safe."

Conversion Rate : The percentage of concerns that get converted in safeguarding enquiries 31 per cent national avg.

Other safeguarding enquiry : This is an approach when the eligibility criteria is not met but the risk and person of concern is regarded as requiring support under the safeguarding framework e.g people with a neurodiversity who are not eligible for a statutory service or a Domestic Abuse Victim Survivor who does not have care and support needs.

Multi Agency Risk Assessment Conference, MARAC: Domestic Abuse partnership forum to discuss high risk DA cases . Generally chaired by the Police

Independent Domestic Violence Advisor, IDVA: Trained specialist professionals who provide safety planning , practical support and advocacy to victims of DA .

Safeguarding adults activity and outcomes 2025–26

What the data tells us about demand, risk and outcomes.

Data helps the Safeguarding Adults Executive Board understand what is happening behind the numbers. The Quality Assurance Group a subgroup of the SAEB helps us identify early key safeguarding insights such as seeing where more people are asking for help, what kinds of abuse or neglect are being reported, where risks may be increasing, and whether people are getting the right response at the right time. Appendix 4 Describes how the SAEB is developing a better partnership Data dashborad a movement away from just relying on local authority data . Used well, data can act like an early warning system. It can show patterns that may not be obvious from individual cases alone, such as rising demand, repeat concerns, delays, gaps in support, or groups of people who may be less visible to services.

This section shows how the Board uses data to understand safeguarding demand, risk and outcomes across Kensington and Chelsea and Westminster. We look at each borough separately, compare local information over a three-year period, and, where available, compare our position with London and national data. This helps the Board understand whether local trends reflect wider safeguarding patterns or whether there are issues that need closer local attention.

The section is organised around four themes. Demand and activity shows how many concerns and enquiries are coming into the safeguarding system and where they are coming from. Nature of risk helps us understand the types of abuse and neglect being reported, where harm is happening and whether some risks may be hidden or under-reported. Quality and outcomes looks at whether safeguarding responses are timely, lawful, person-centred and making a difference for adults. Priority areas brings the information together to identify what senior leaders need to watch most closely and where the partnership may need to act earlier or differently.

By looking at these themes together, the SAEB can ask better questions about risk and assurance. The data does not tell the whole story on its own, but it helps the Board decide where further discussion, audit, partner challenge or community insight is needed. This section is aligned to business plan priority area “Evidence to drive assurance” priority 3.



Kensington and Chelsea at a glance

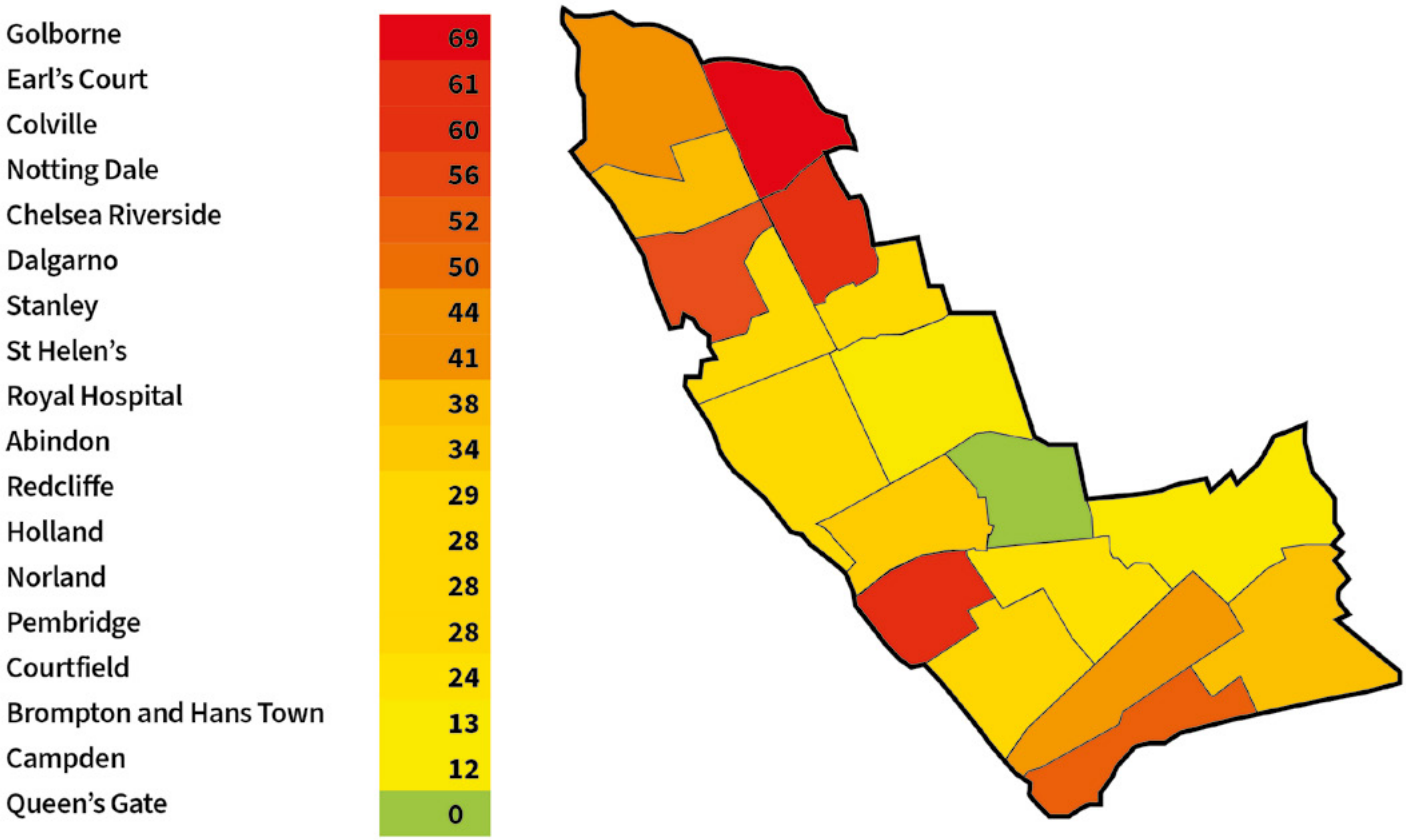
Safeguarding adults activity and outcomes 2025–26

What the data tells us about demand, risk and outcomes in RBKC

This section explains safeguarding adults demand. A safeguarding concern is when someone tells the Council that an adult may be experiencing abuse, neglect or harm. Not every concern needs a formal safeguarding enquiry, but every concern is checked and responded to in the most appropriate way.

Safeguarding Profile across the Safeguarding Partnership

Heat map of Kensington and Chelsea showing safeguarding referrals which in the main sit in the most deprived wards in both boroughs.



Highlight report

953

Safeguarding concerns were received in 2025–26, down from 1,165 the year before.

32%

About one in three concerns went on to a safeguarding enquiry or similar safeguarding pathway. This is called ‘the conversation rate’.

39%

Health partners raised the largest share of concerns that progressed to the safeguarding pathway.

57%

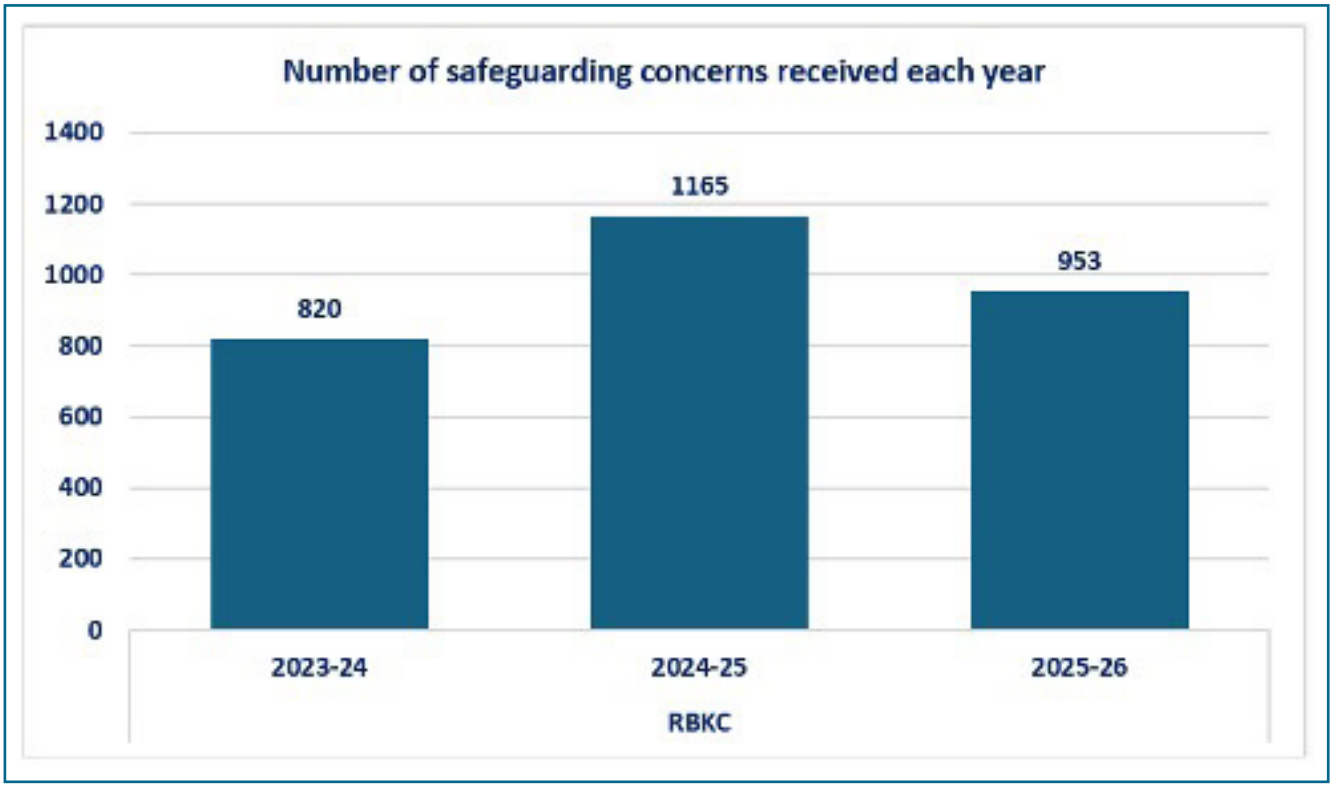
Most safeguarding incidents considered through enquiries happened in the person’s own home.

97%

Where a risk was identified, the risk was removed or reduced in the great majority of cases.

Safeguarding demand and activity

In 2025–26 **RBKC received 953 safeguarding concerns**. This was lower than the 1,165 concerns received in 2024–25, but higher than the 820 concerns received in 2022–23. When these totals are compared with the size of the adult population, RBKC's rate remains below the most recently available London rates, which are also below England rates.

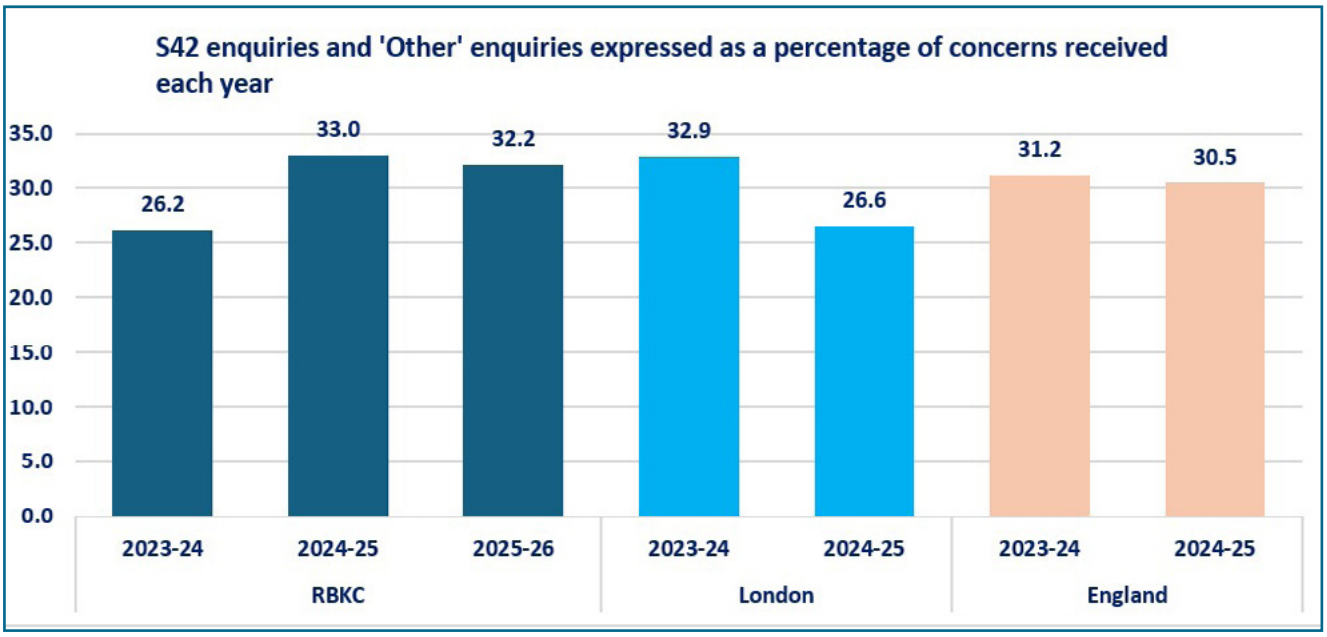


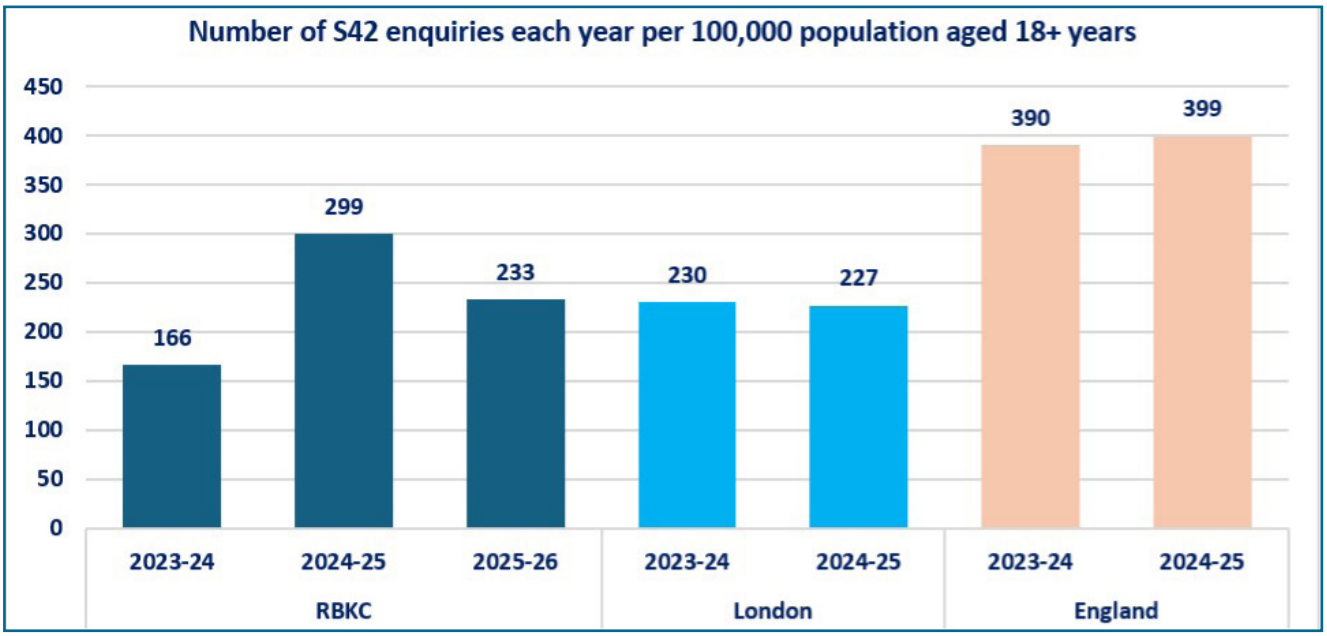
Every concern is checked and risk assessed. Some concerns need a formal safeguarding enquiry, while others are better dealt with through another route, such as care management, provider quality work, housing support or advice and signposting. In 2025–26, 284 concerns met the legal threshold for a Section 42 enquiry. This gives an overall conversion rate of 32 per cent.

Analysis: changing demand, but not all concerns need the same response

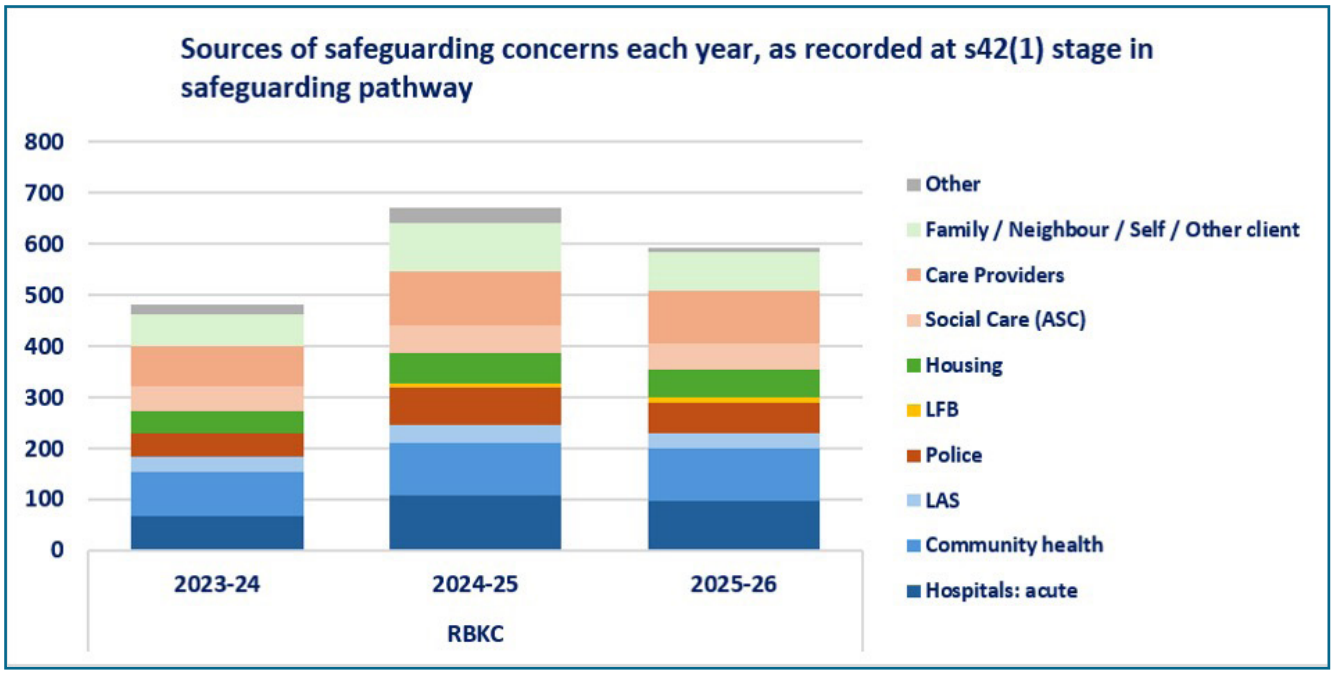
The fall in concerns is important and should be monitored alongside the previous rise in demand. It may reflect changes in local patterns, reporting behaviour or recording practice. The conversion rate shows that the Council is not treating every concern as a formal enquiry, but is checking each concern and directing it to the right response.

When the number of S42 enquiries in RBKC for 2025-26 is expressed as a rate per head of adult population, the rate (233) is very similar to the rates for London for the previous two years which themselves are considerably below the corresponding rates for England as a whole.



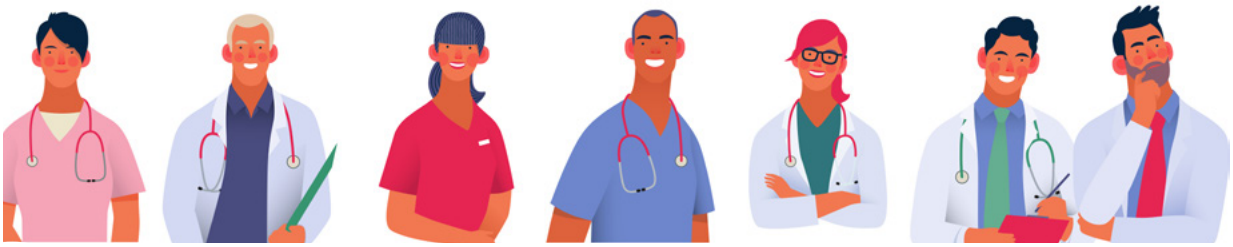


Where safeguarding demand comes from



Safeguarding concerns come from many places. They can be raised by health and care services, the police, housing, the London Fire Brigade, banks, advocates, family members, friends or by the adult themselves. **In 2025–26, health partners raised 39 per cent of concerns that progressed to the safeguarding pathway**. Social care providers accounted for 17 per cent, family members, friends or adults at risk for 13 per cent, and the police and housing each for about 10 per cent.

For most people, this was the first concern raised about them in the previous two years. However, some people had repeated concerns. Repeated concerns are important because they may show that a person's situation is complex, that risks are changing, or that support needs to be strengthened.

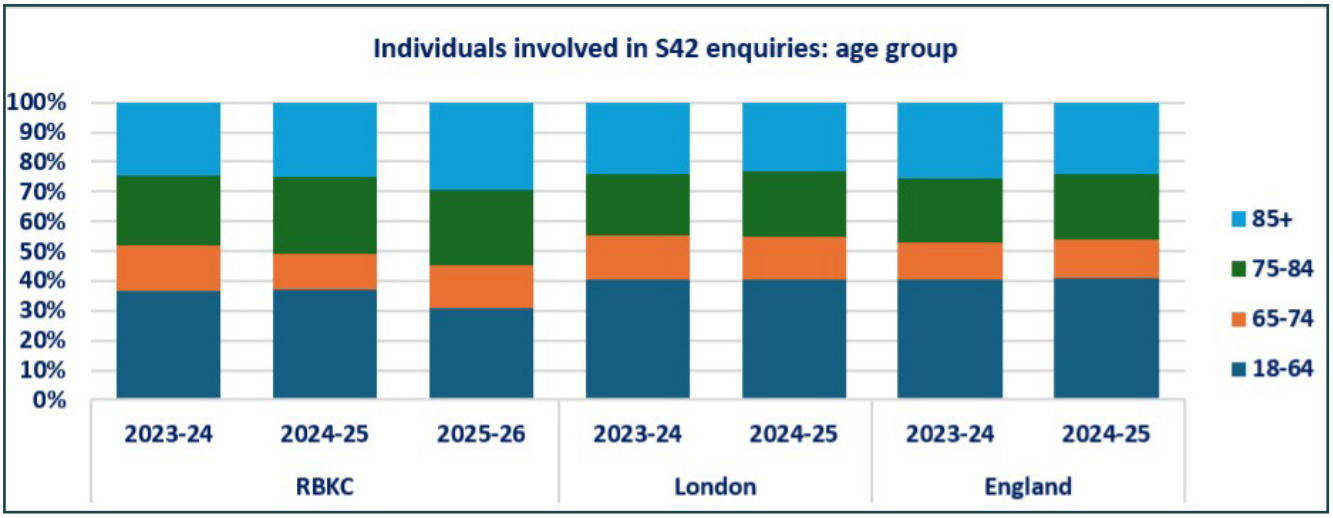


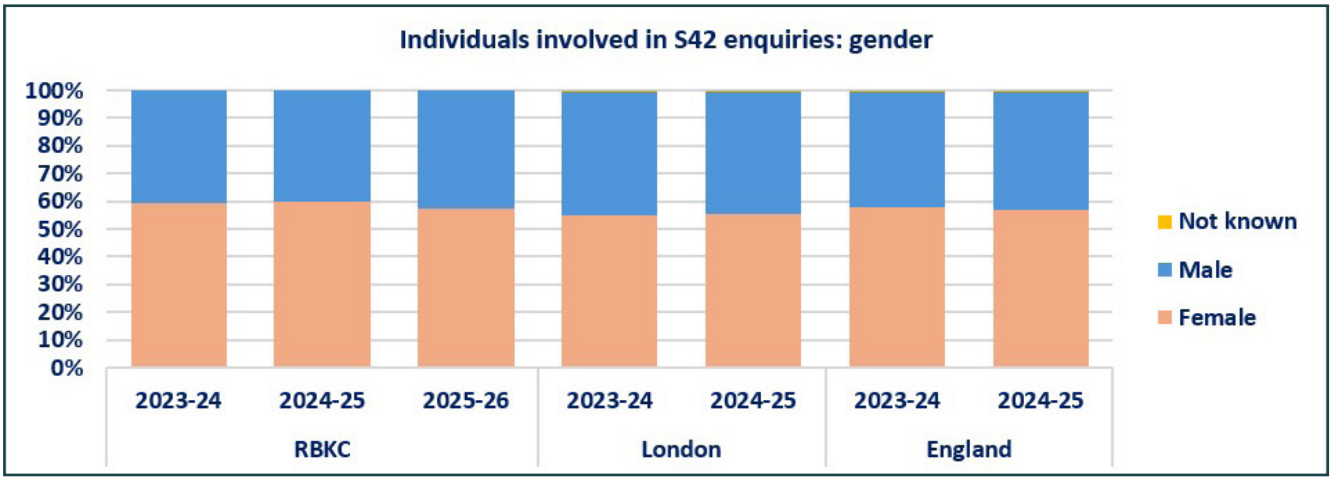
Analysis: repeated concerns need a joined-up response

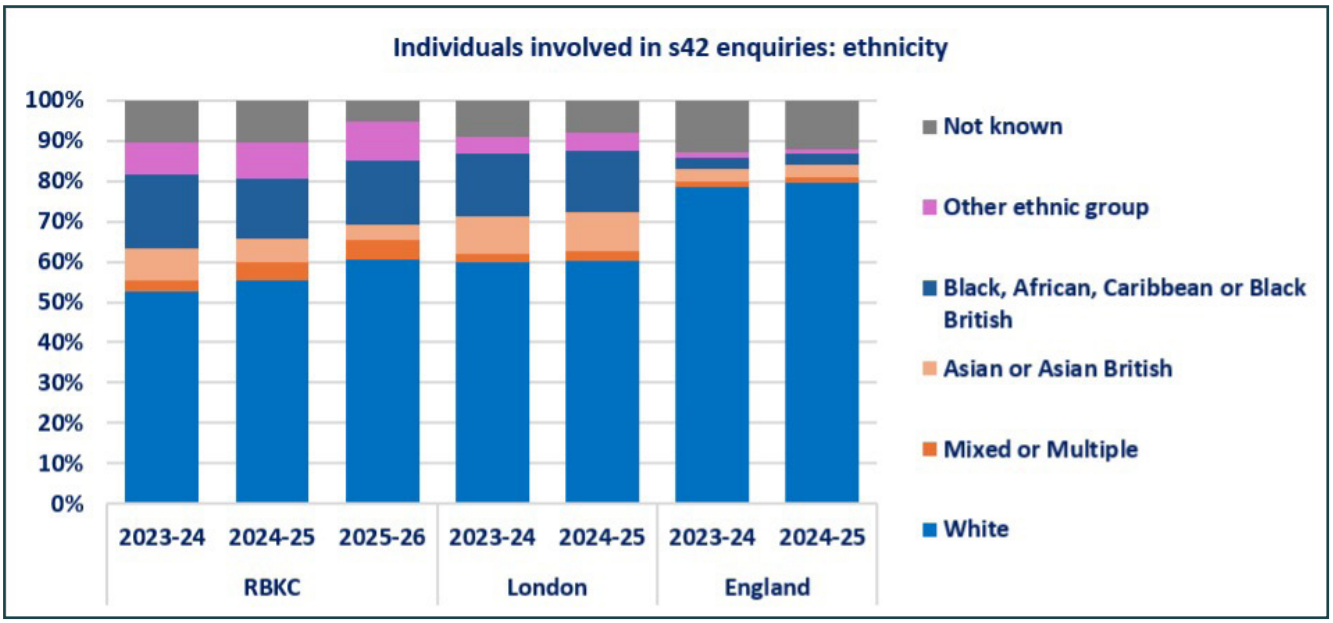
When the same person is the subject of repeated concerns, agencies need to look beyond the single incident and ask what is happening in the person's life. This supports earlier, more coordinated help and can reduce the chance of harm continuing or escalating.

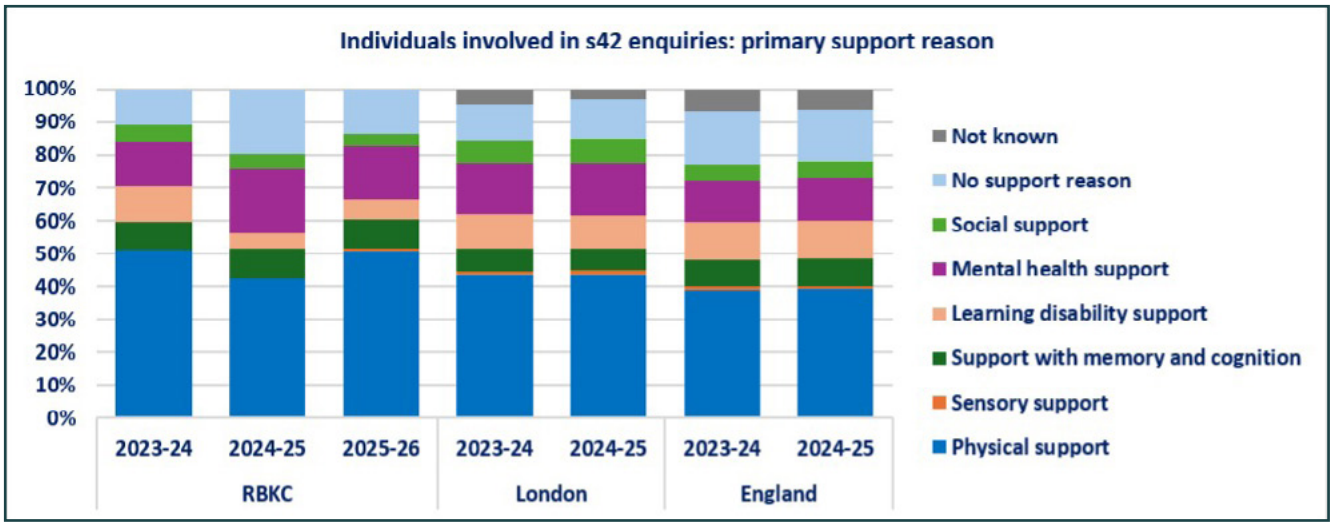
Who was at risk?

The profile of adults involved in safeguarding enquiries broadly reflects RBKC's local population and care and support needs. This includes differences from the national picture, particularly because RBKC is more ethnically diverse than many parts of England.







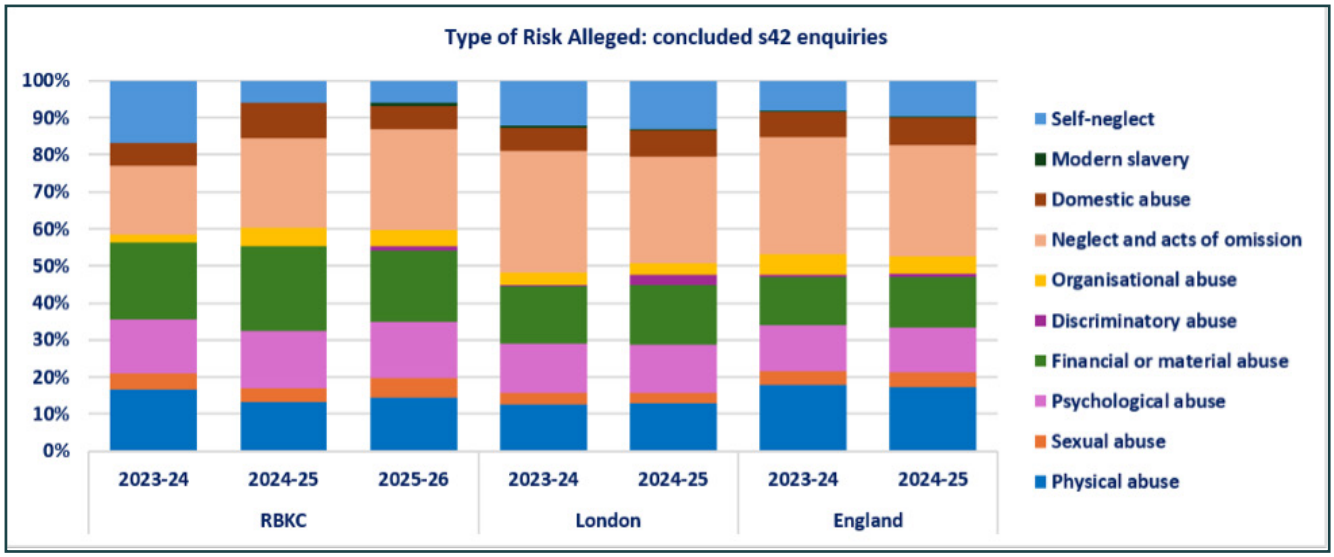


In 2025–26, adults at risk in RBKC were more likely to be aged 75 and over and less likely to be aged 18–64. Women were more likely than men to be involved in safeguarding enquiries, which is also seen across London and England. RBKC also had a higher proportion of adults from "other" ethnic groups, mainly Arab, North African, Middle Eastern and Chinese communities. Physical support was more common as a main support need, while learning disability support was less common than in the wider comparator areas.

Analysis: safeguarding support must reflect RBKC's communities

The data shows the importance of culturally aware safeguarding practice and clear communication with different communities, age groups and support needs. It also highlights the need to make prevention messages accessible and relevant to people who may have different routes into support.

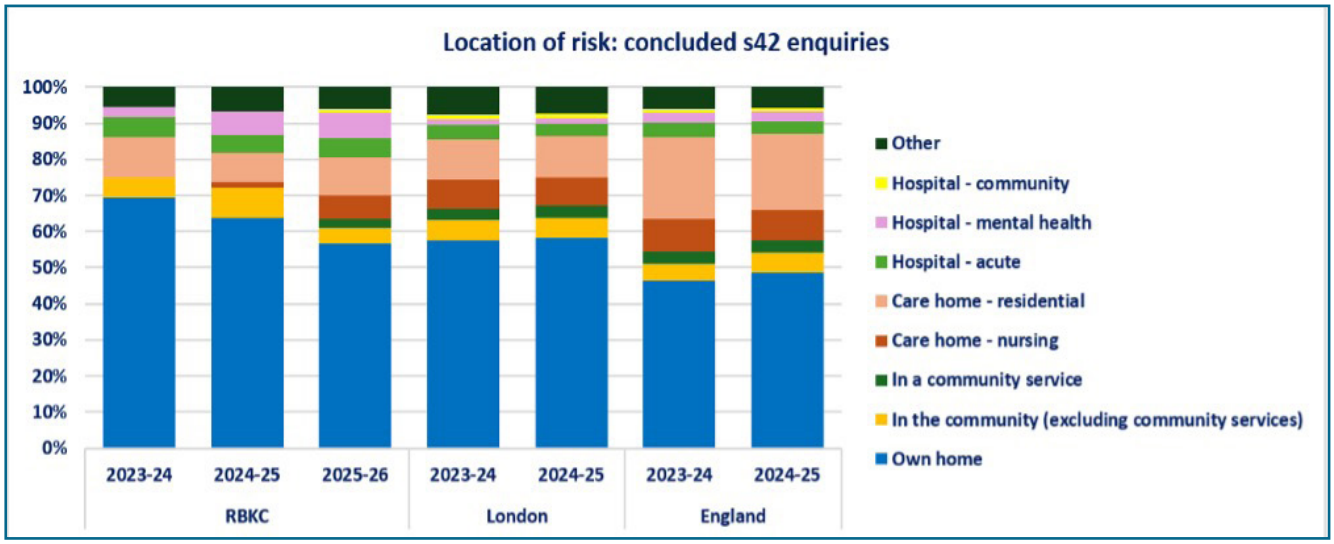
What types of harm were reported?



Safeguarding enquiries may involve different types of abuse or neglect. **RBKC's overall pattern is broadly similar to London and England, but financial abuse stands out locally and neglect or acts of omission has increased over the last two years.** In 2025–26, neglect or acts of omission accounted for 27 per cent of the different risk types alleged, close to the most recent London and England proportions. This could be related to the focus on Hoarding and Self Neglect cases and better recording .

The most common place where harm or abuse was reported was the person's own home. In 2025–26, 57 per cent of incidents considered through concluded enquiries happened at home. This was lower than in previous years, with a higher proportion of incidents occurring in care home settings.

Over the last two years, incidents involved in concluded enquiries in RBKC were also more likely to have occurred in a mental health hospital setting when compared with London and England. This partly reflects the location of St Charles Hospital within the borough.



In most enquiries, the person or organisation linked to the risk was known to the adult. This may include family members, neighbours, other people using services, health workers or care providers. This pattern is similar across London and England.

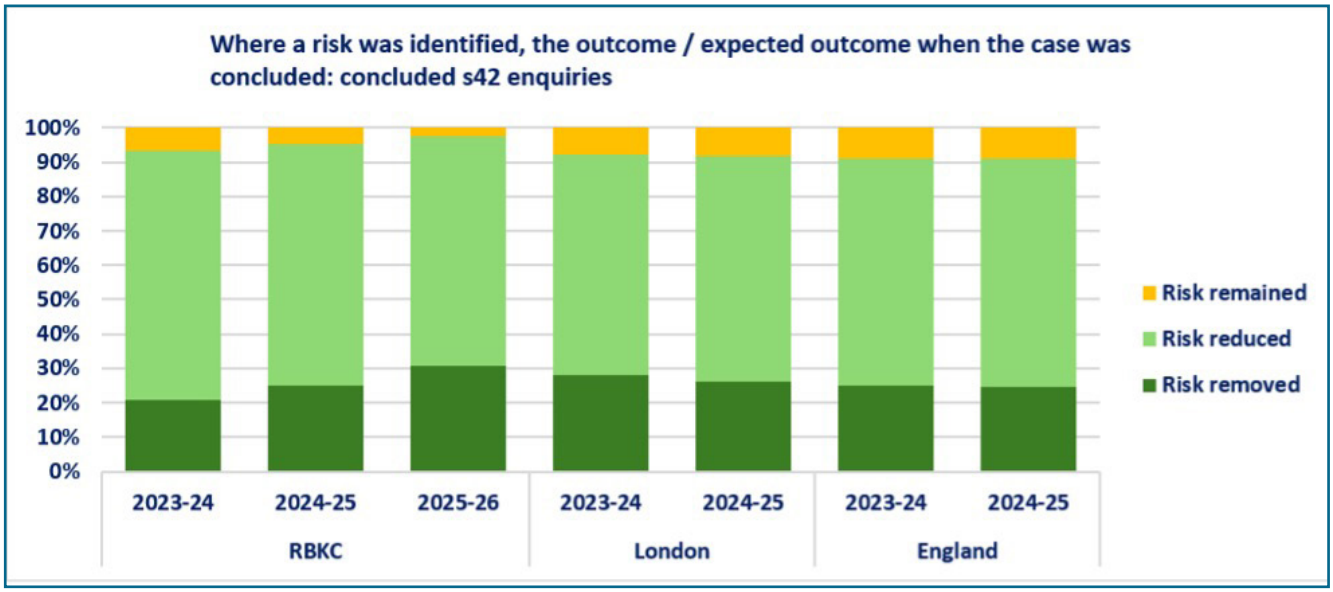
Analysis: prevention work needs to focus on home, money and relationships

The data suggests that safeguarding is not only about regulated care settings. Many risks happen in people's homes and involve people known to them. This means prevention work should include financial safety, emotional harm, family and community networks, and support for people who may be isolated.

Was risk reduced?

The main aim of a safeguarding enquiry is to support the adult in keeping themselves safe and improve their wellbeing. Practitioners look at what has happened, listen to the adult or their representative, and agree together what action is needed to stop or reduce the risk.

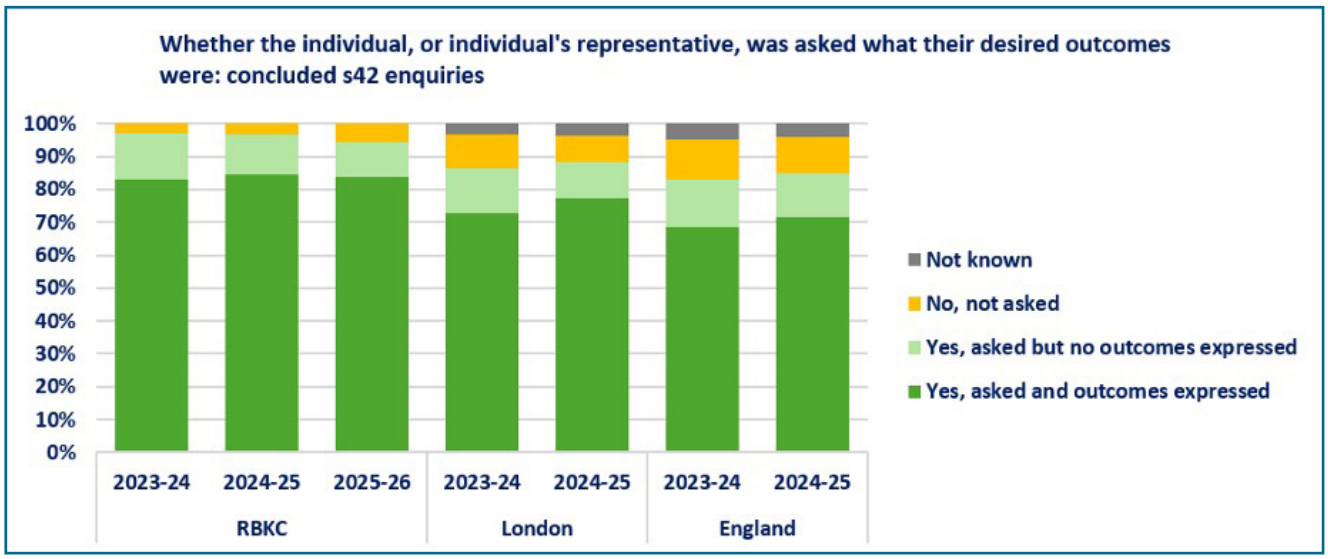
In 2025–26, where a risk was identified, it was removed or reduced in 97 per cent of cases. This is higher than the most recent rates for London and England, which were 92 per cent and 91 per cent respectively. This is a strong outcome because it shows that safeguarding enquiries are usually leading to practical action that improves safety.

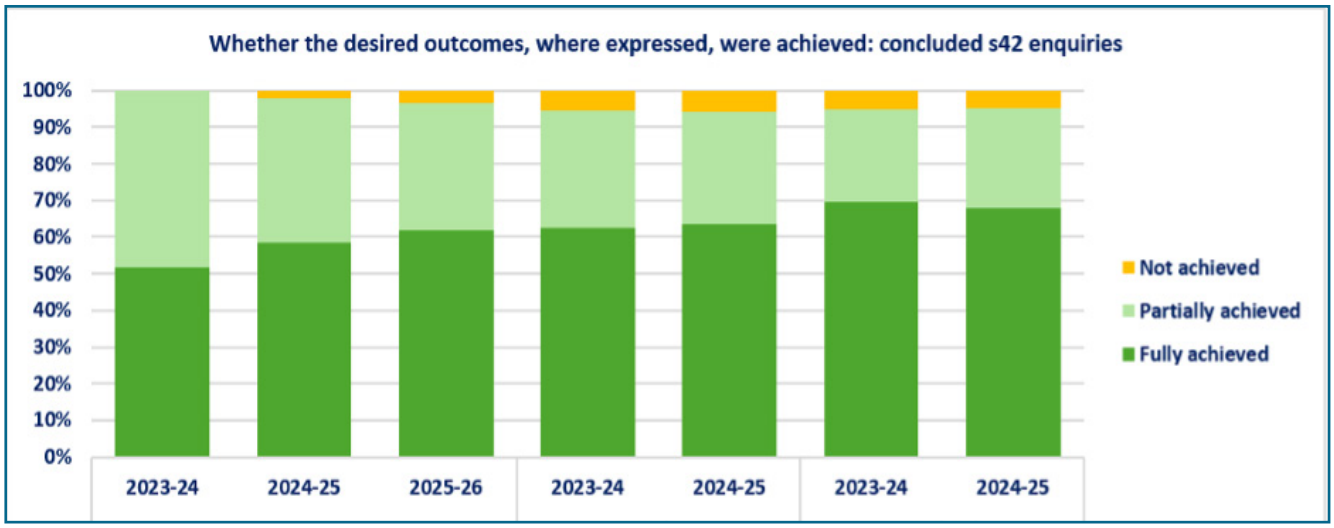


Analysis: the strongest outcome is reducing real risk

The most important measure is not simply how many enquiries take place, but whether people are safer afterwards. The data shows that, when risk is found, RBKC is usually able to reduce or remove it.

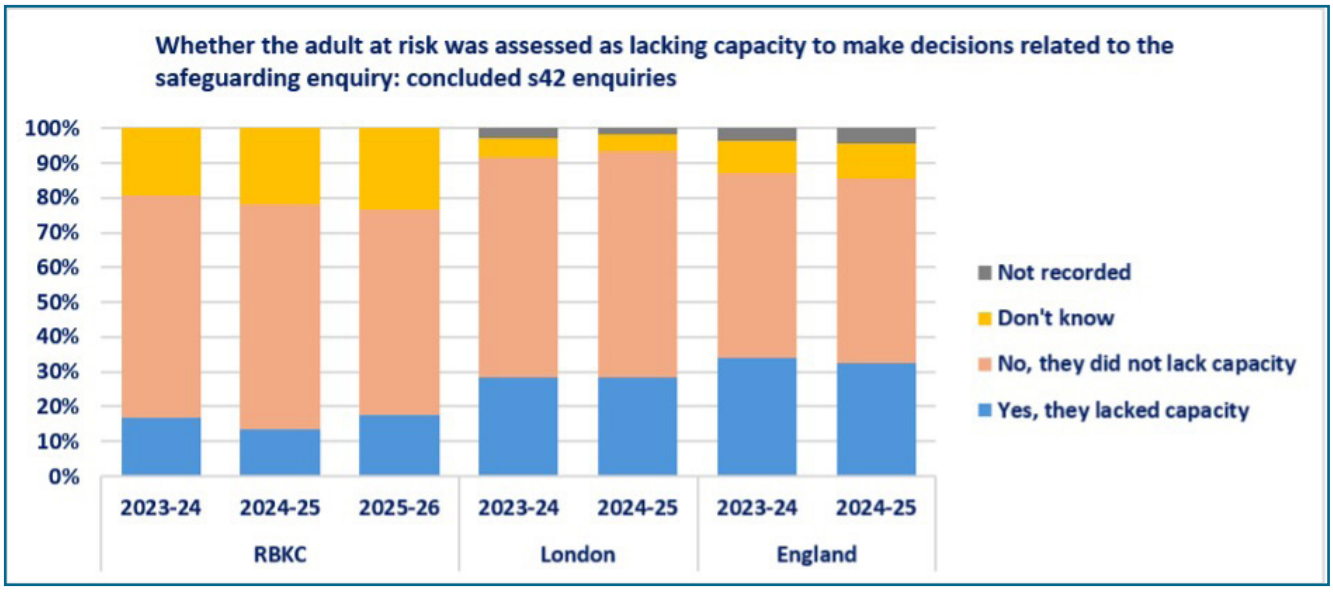
Making safeguarding personal: listening to the person and acting in time

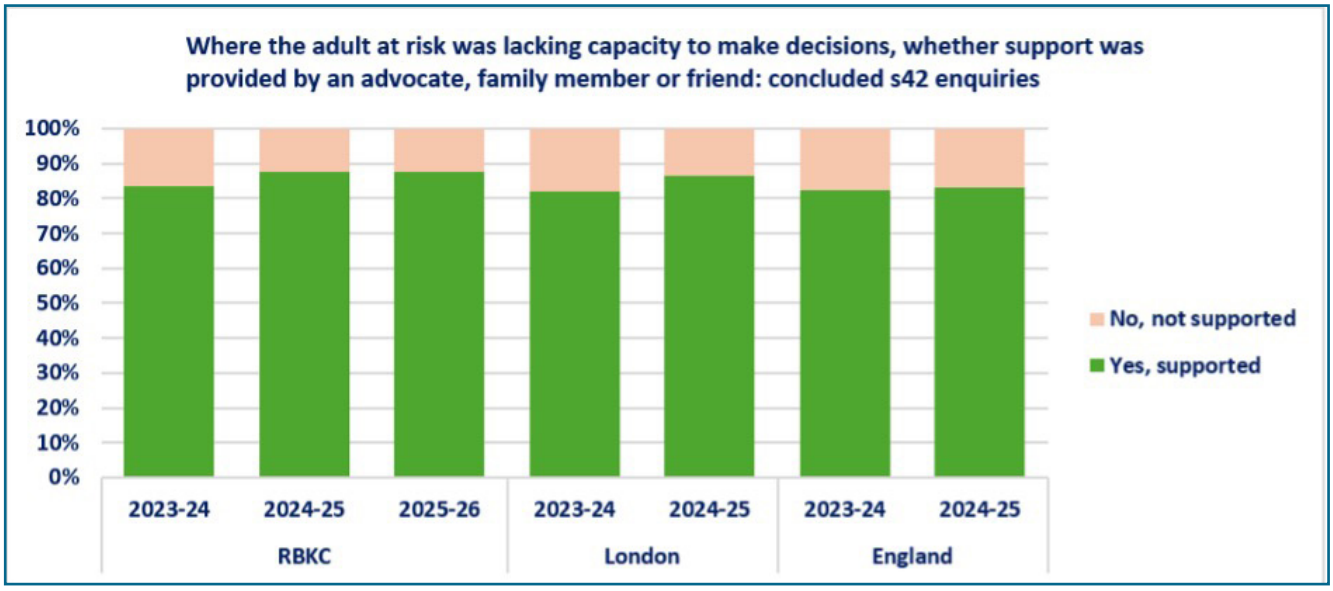




Good safeguarding starts with the adult. Wherever possible, the adult or their representative should be asked what they want to happen and what would help them feel safer.

In RBKC, adults or their representatives were asked about their desired outcomes in 96 per cent or more of concluded Section 42 enquiries over the last three years. This is higher than the most recent London and England figures. Where people expressed outcomes, the great majority were either partly or fully achieved.





Some adults may need support to make decisions about safeguarding. The Mental Capacity Act 2005 protects people who may lack capacity to make a specific decision. It also makes clear that people should be supported to make their own decisions wherever possible.

In RBKC, around 16 per cent of concluded Section 42 enquiries involved an adult assessed as lacking capacity. In around one in five cases, capacity was recorded as “not known”. A local audit was carried out to understand this better. As a result, safeguarding forms have been changed so practitioners record clearer evidence and explanations about capacity.

Where an adult lacks capacity, they should have appropriate support from an independent advocate, family member, friend or carer. In RBKC, this support was recorded in nearly 90 per cent of relevant concluded enquiries, similar to London and above England.

There is no national target for how quickly safeguarding enquiries should be completed, but London guidance suggests completion within three months. **In RBKC in 2025–26, the average time between the concern being raised and the enquiry concluding was 71 days, within the recommended guideline.**

Analysis: strong person-centred practice, with one area to keep improving

The data shows strong practice in asking people what they want to happen and in arranging advocacy where needed. The change to mental capacity recording is a positive improvement and should help provide clearer assurance in future reports.

Overall conclusion

Safeguarding demand in RBKC reduced in 2025–26, but the data shows a balanced response: concerns are checked, the right pathway is used, and risks are usually reduced or removed when they are identified. The main messages for the year are clear: prevention should focus on risks in people's own homes, financial abuse and neglect or acts of omission need continued attention, and support must reflect RBKC's diverse communities and care and support needs.



Westminster at a glance

Safeguarding adults activity and outcomes 2025–26

This section explains safeguarding adults demand . A safeguarding concern is when someone tells the Council that an adult may be experiencing abuse, neglect or harm. Not every concern needs a formal safeguarding enquiry, but every concern is checked and responded to in the most appropriate way.

Highlight report

1,474

Safeguarding concerns were received in 2025–26, up from 1,365 the year before.

29.5%

About one in four concerns went on to a safeguarding enquiry or similar safeguarding pathway. The conversion rate

42%

Health partners raised the largest share of concerns that progressed to the safeguarding pathway

68%

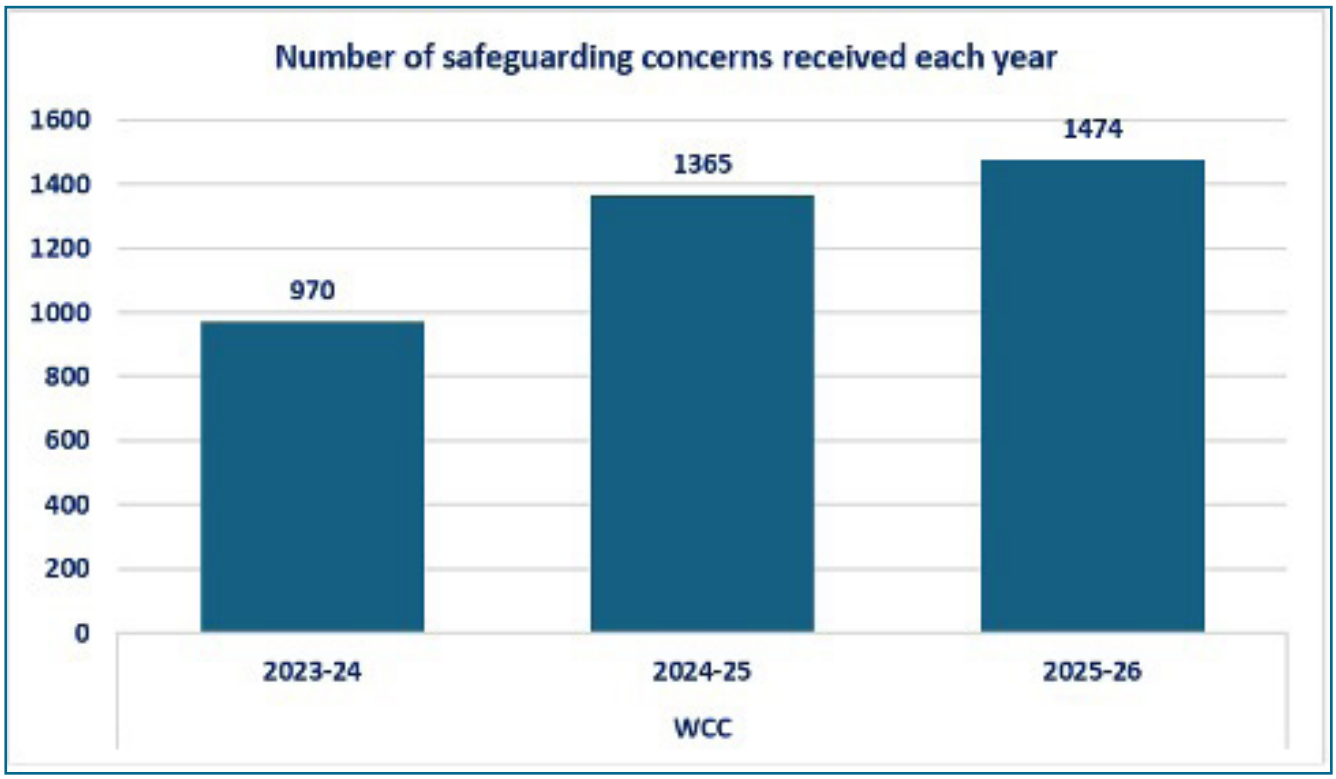
Most safeguarding incidents considered through enquiries happened in the person's own home.

71 days

The average time taken to conclude an enquiry was within the London guideline. There is no national target but guidance suggests 90 days for completion.

Safeguarding demand and activity

In 2025–26 Westminster received 1,474 safeguarding concerns. This is higher than the 1,365 concerns received in 2024–25 and the 970 concerns received in 2022–23. This shows a continuing rise in the number of people and organisations raising worries about adults who may be at risk of abuse, neglect or harm. However, when the figures are adjusted for the size of the adult population, Westminster remains below the most recently available London and England rates.

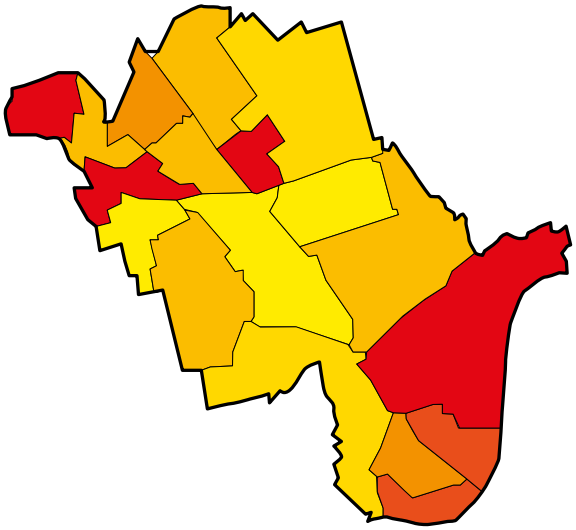


Every concern is checked and risk assessed. Some concerns need a formal safeguarding enquiry, while others are better dealt with through another route, such as care management, provider quality work, housing support or advice and signposting. In 2025–26, 348 concerns met the legal threshold for a safeguarding enquiry.

Safeguarding profile across the safeguarding partnership

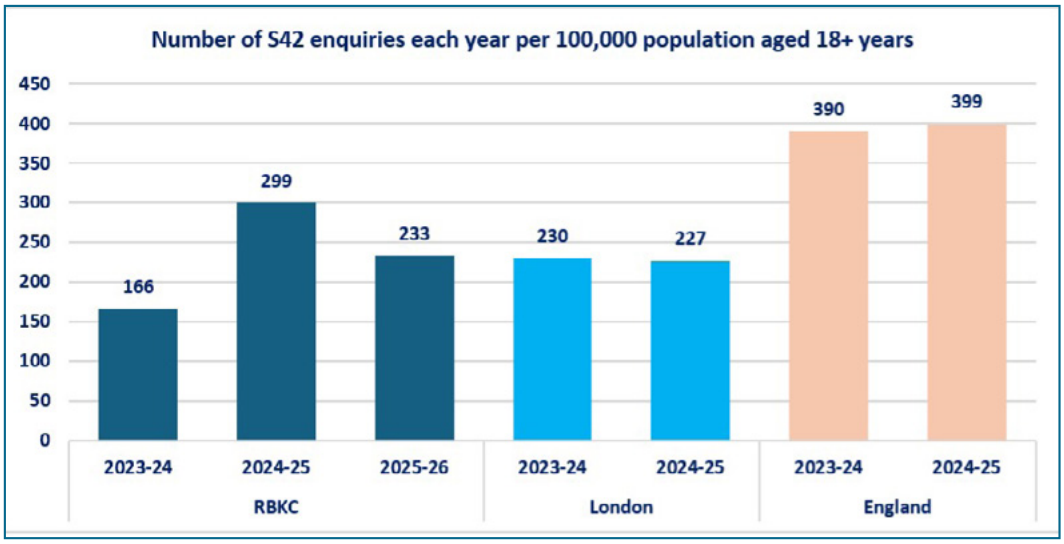
Heat map of Westminster showing safeguarding referrals which in the main sit in the most deprived wards in both boroughs.

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



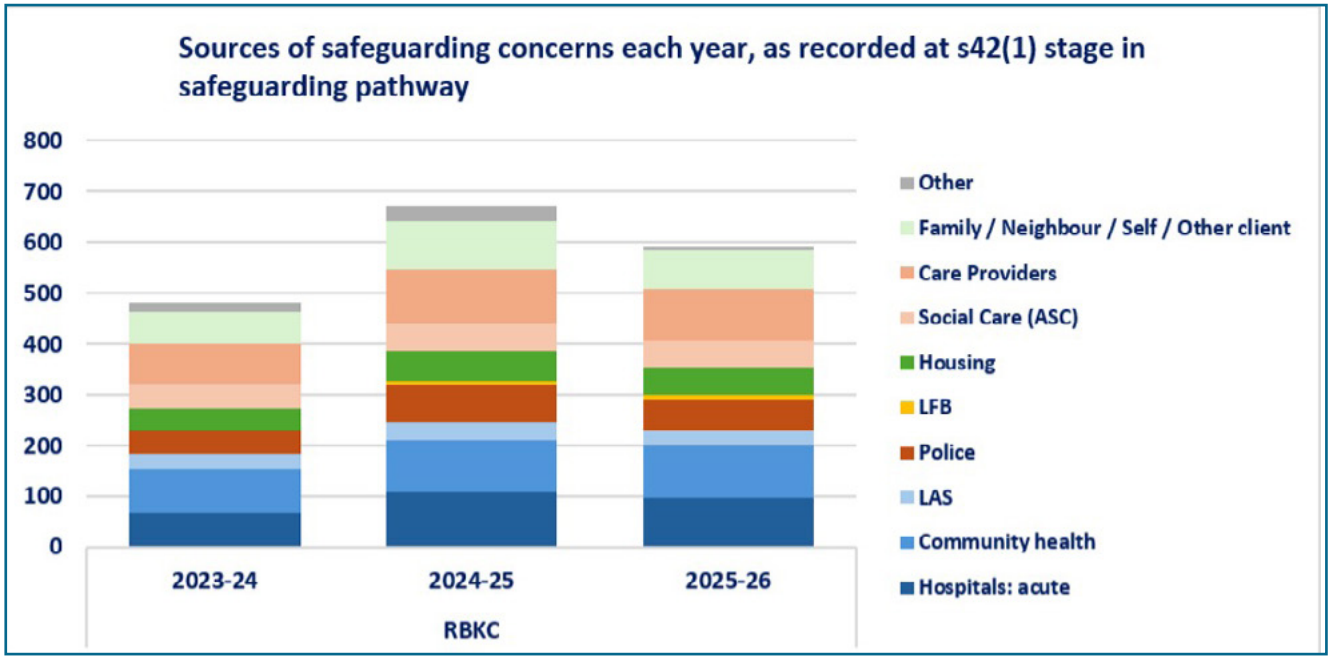
Analysis: rising demand, but not all concerns need the same response

The rise in concerns is important and should be monitored. It may reflect greater pressure in the community, better awareness of safeguarding, or both. It also reflects the year on year increase in referrals for Care Act Assessments .The conversion rate shows that the Council is not treating every concern as a formal enquiry, but is checking each concern and directing it to the right response.



When safeguarding enquiries are compared with the size of the adult population, Westminster's rate remains below the most recently available London and England rates. This suggests that, although local demand is rising, Westminster is not an outlier when compared with wider patterns.

Where safeguarding demand comes from



Safeguarding concerns come from many places. They can be raised by health and care services, the police, housing, the London Fire Brigade, banks, advocates, family members, friends or by the adult themselves. **In 2025–26, health partners raised 42 per cent of concerns that progressed to the safeguarding pathway.** The police raised 15 per cent, social care providers 14 per cent, family members, friends or adults at risk 10 per cent, and housing 8 per cent.

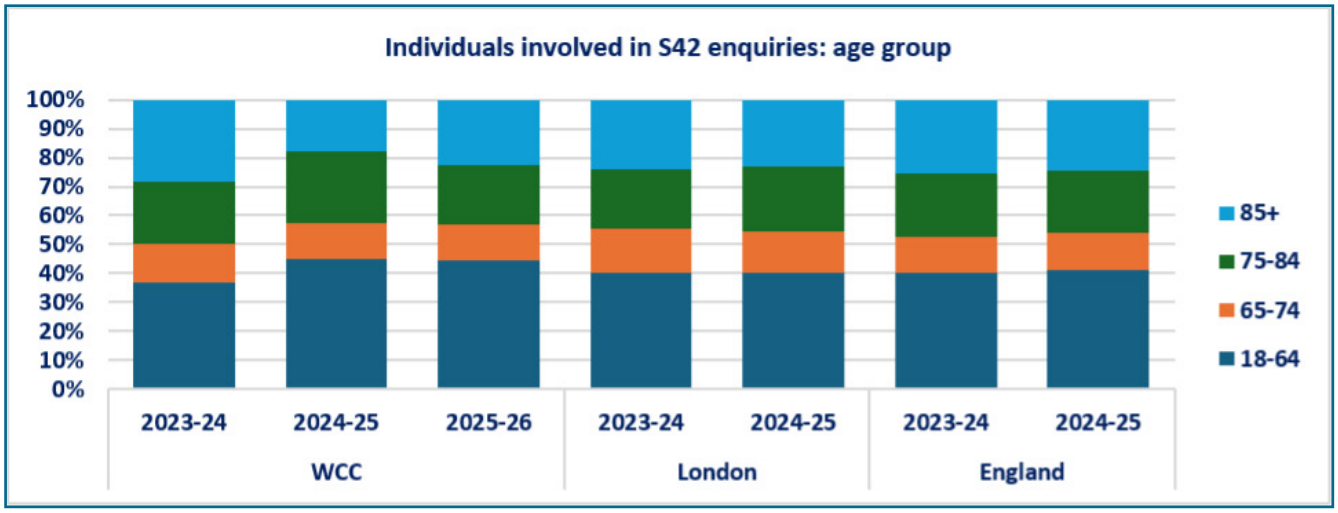
For most people, this was the first concern raised about them in the previous two years. However, some people had repeated concerns. In 2025–26, 41 people had three or more concerns raised in the previous two years, slightly fewer than 47 in 2024–25. Repeated concerns are important because they may show that a person's situation is complex, that risks are changing, or that support needs to be strengthened.

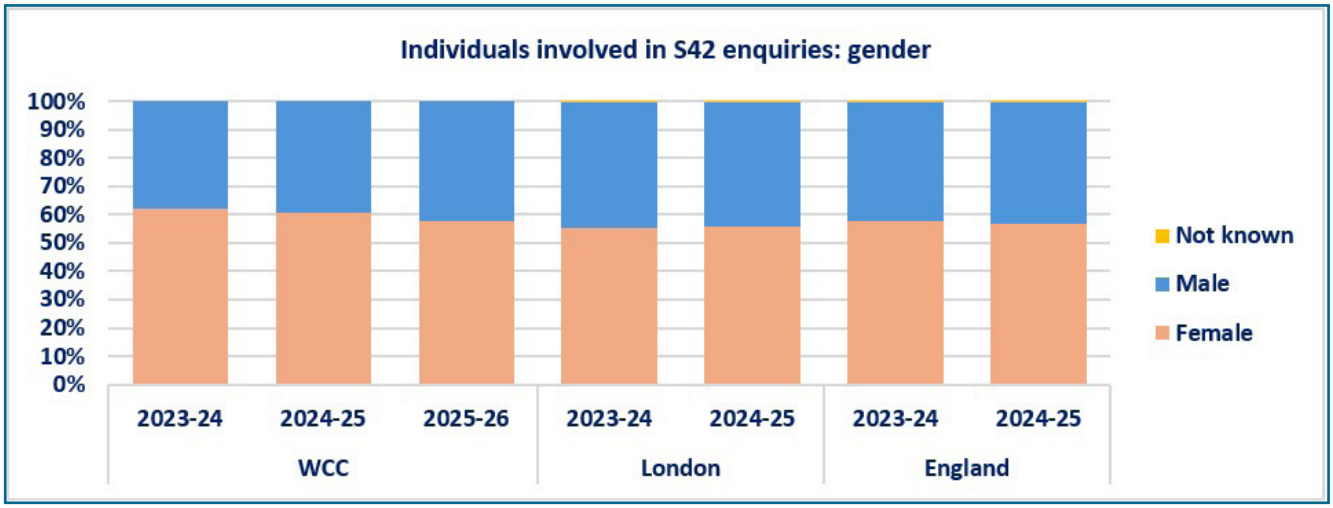
Analysis: repeated concerns need a joined-up response

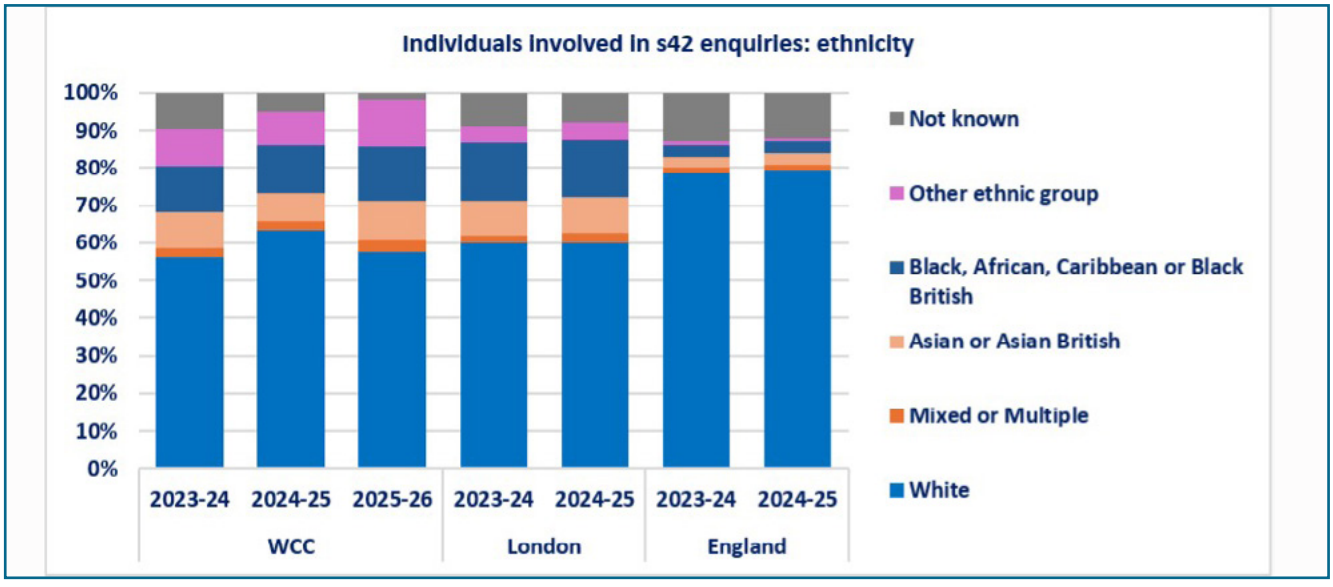
When the same person is the subject of repeated concerns, agencies need to look beyond the single incident and ask what is happening in the person's life. This supports earlier, more coordinated help and can reduce the chance of harm continuing or escalating.

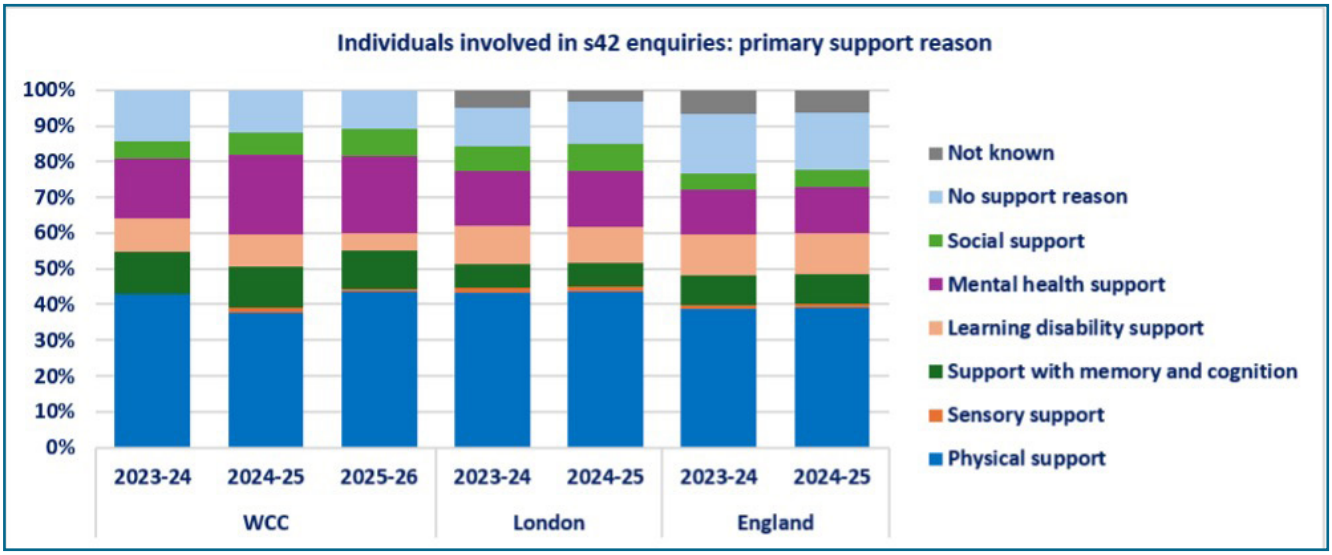
Who was at risk?

The profile of adults involved in safeguarding enquiries broadly reflects Westminster's local population and care and support needs. This includes differences from the national picture, particularly because Westminster is more ethnically diverse than many parts of England.









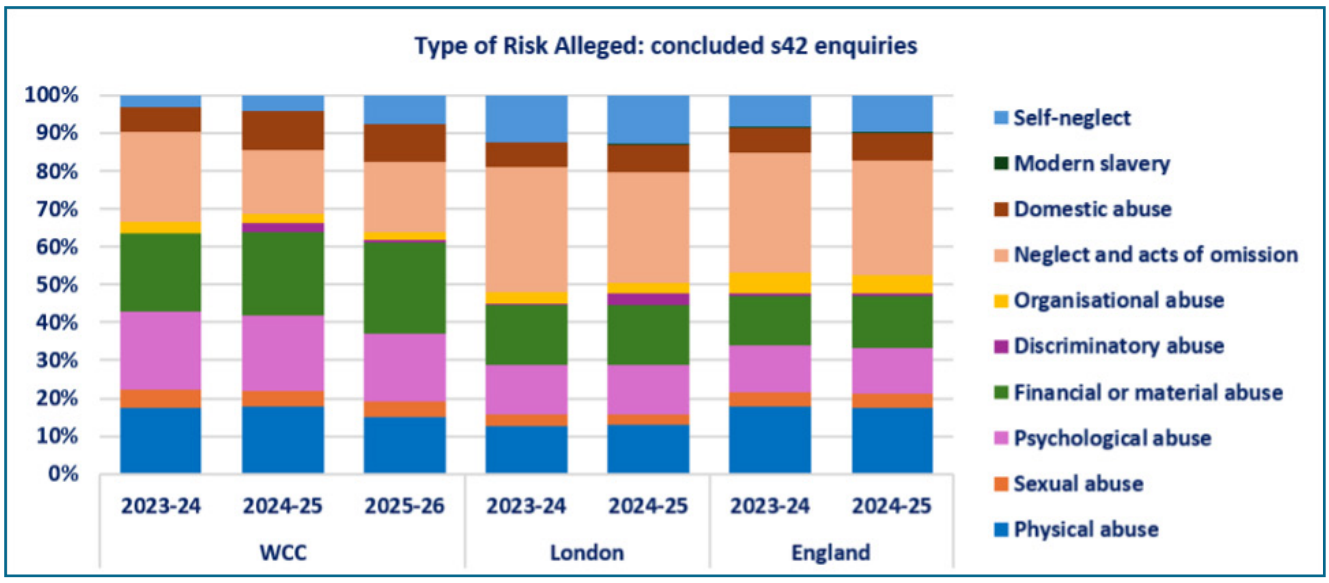
In 2025–26, adults at risk in Westminster were more likely to be aged 75 and over and less likely to be aged 18–64. Women were more likely than men to be involved in safeguarding enquiries, which is also seen across London and England. Westminster also had a higher proportion of adults from "other" ethnic groups, mainly Arab, North African, Middle Eastern and Chinese communities. Physical support was more common as a main support need, while learning disability support was less common than in the wider comparator areas

Analysis: safeguarding support must reflect Westminster communities

The data shows the importance of culturally aware safeguarding practice and clear communication with different communities, age groups and support needs. It also highlights the need to make prevention messages accessible and relevant to people who may have different routes into support.



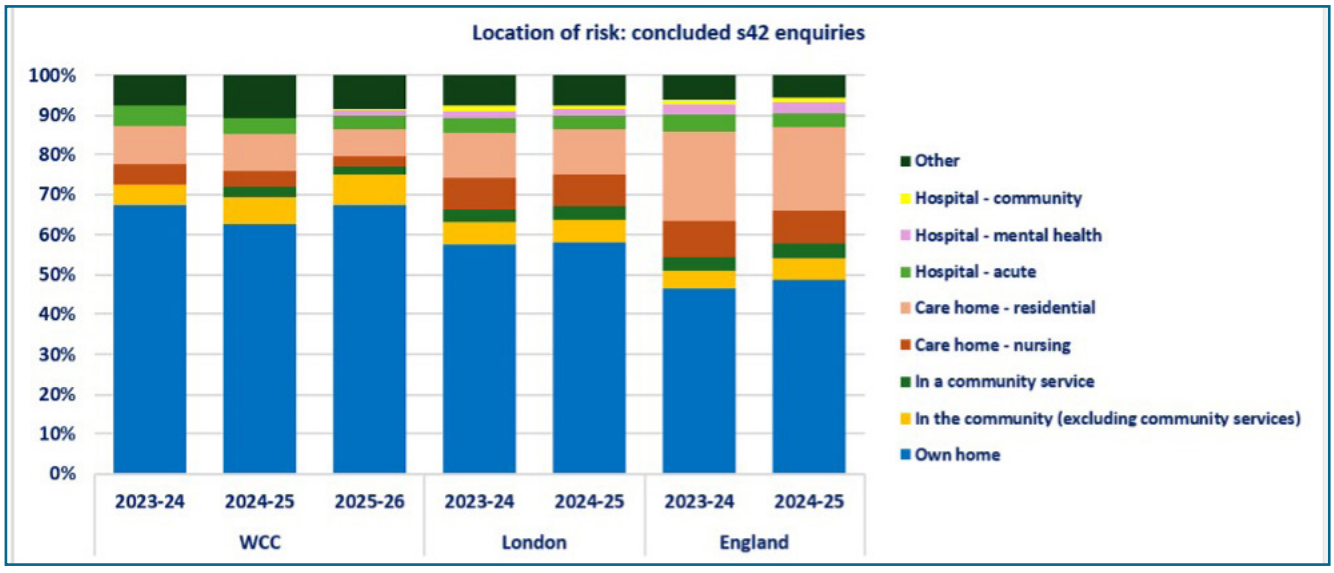
What types of harm were reported?



Safeguarding enquiries may involve different types of abuse or neglect. Westminster's overall pattern is broadly similar to London and England, but financial abuse and psychological abuse stand out locally. In 2025–26, these two types of harm made up 42 per cent of the risks considered in concluded enquiries, compared with 29 per cent in London and 26 per cent in England using the most recent comparator data.

The most common place where harm or abuse was reported was the person's own home. In 2025–26, 68 per cent of incidents considered through concluded enquiries happened at home. This was slightly higher than the previous year. The proportion of incidents in care homes fell from 13 per cent to 10 per cent.

In most enquiries, the person or organisation linked to the risk was known to the adult. This may include family members, neighbours, other people using services, health workers or care providers. Over the last three years, the proportion of concluded enquiries where the source of risk was an adult social care provider fell from 31 per cent in 2023–24 to 16 per cent in 2025–26.



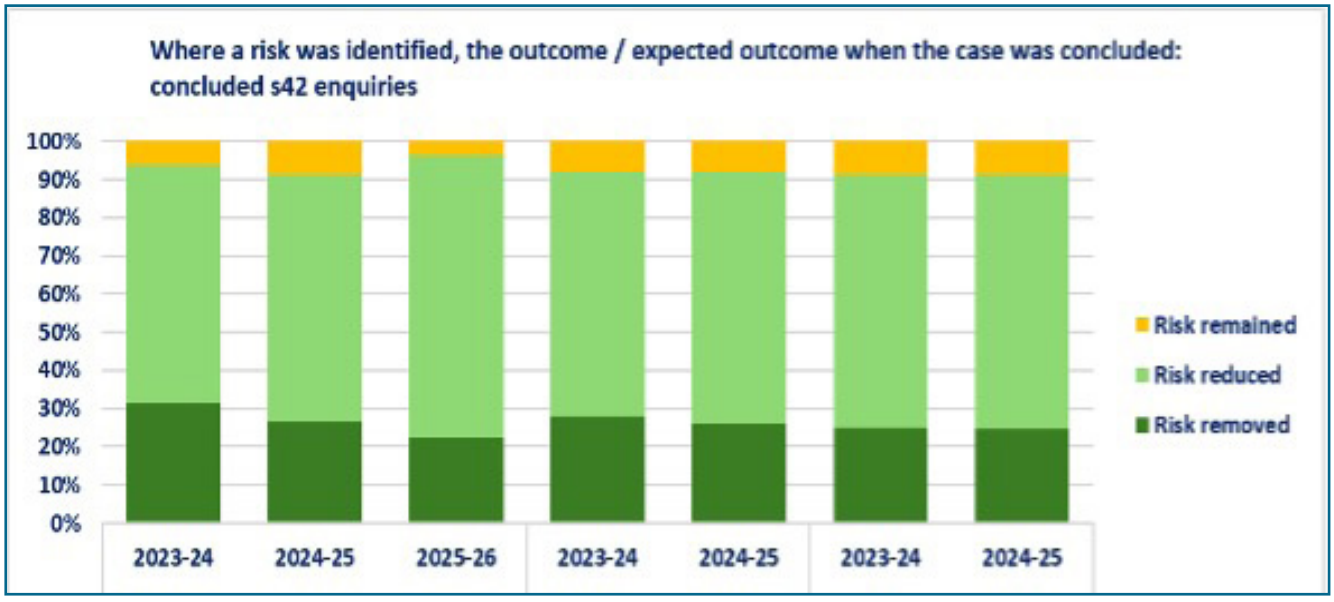
Analysis: prevention work needs to focus on home, money and relationships

The data suggests that safeguarding is not only about regulated care settings. Many risks happen in people's homes and involve people known to them. This means prevention work should include financial safety, emotional harm, family and community networks, and support for people who may be isolated.

Was risk reduced?

The main aim of a safeguarding enquiry is to support the adult in keeping themselves safe and improve their wellbeing. Practitioners look at what has happened, listen to the adult or their representative, and agree together what action is needed to stop or reduce the risk.

In 2025–26, where a risk was identified, it was removed or reduced in 96 per cent of cases. This is higher than the most recent rates for London and England, which were 92 per cent and 91 per cent respectively. This is a strong outcome because it shows that safeguarding enquiries are usually leading to practical action that improves safety.



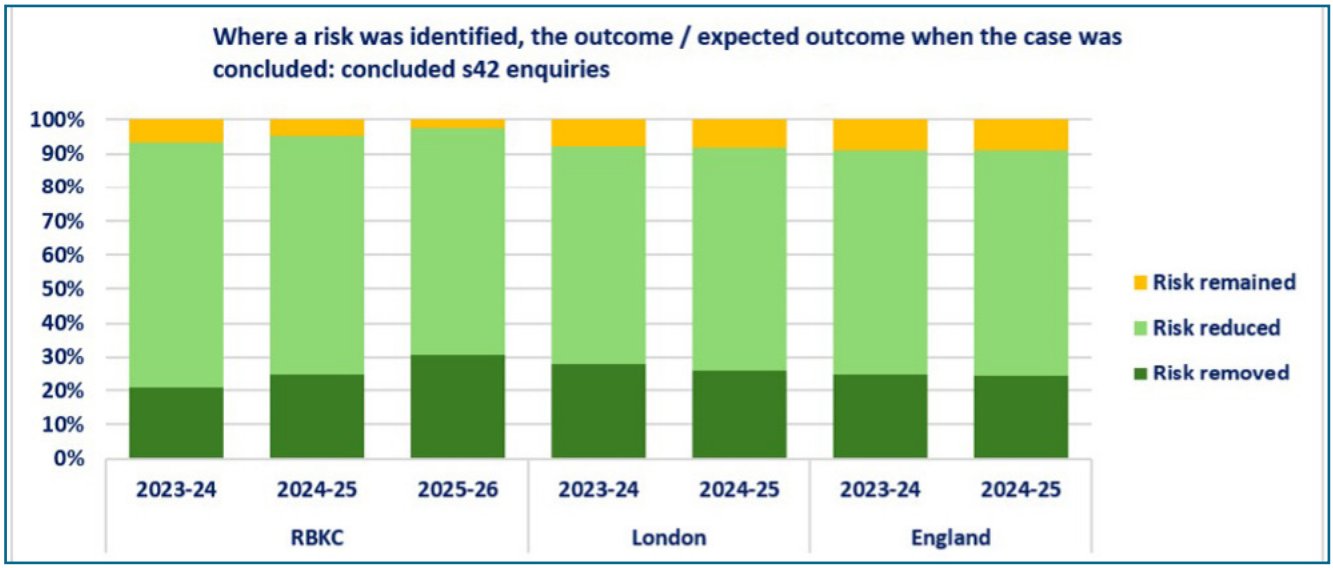
Analysis: the strongest outcome is reducing real risk

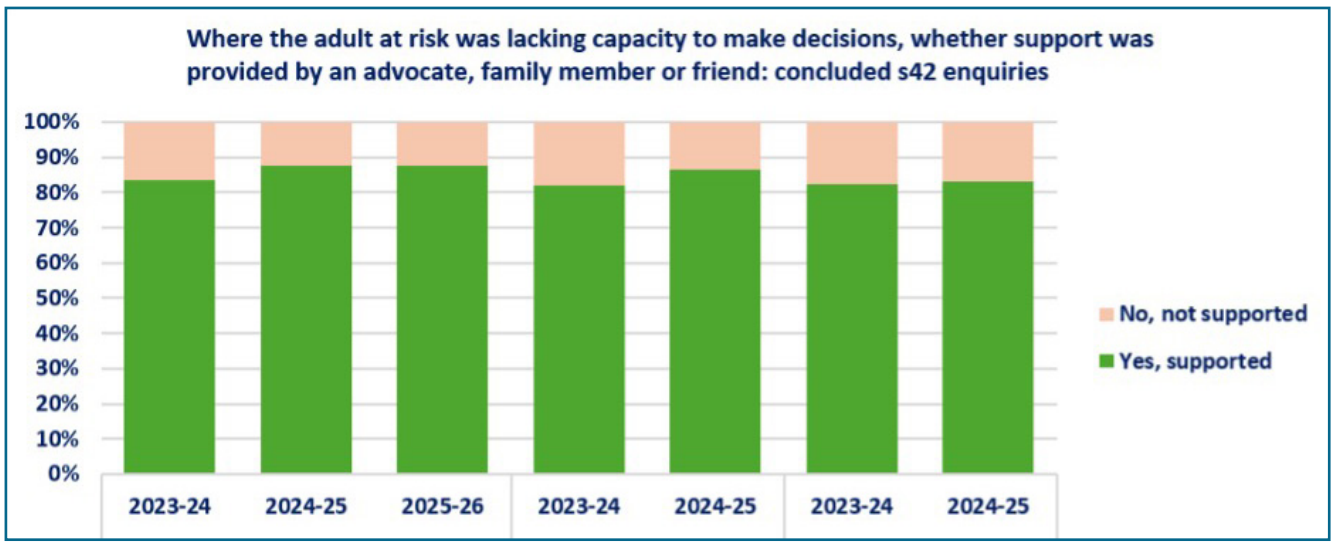
The most important measure is not simply how many enquiries take place, but whether people are safer afterwards. The data shows that, when risk is found, WCC is usually able to reduce or remove it.

Making safeguarding personal: listening to the person and acting in time

Good safeguarding starts with the adult. Wherever possible, the adult or their representative should be asked what they want to happen and what would help them feel safer.

In Westminster, adults or their representatives were asked about their desired outcomes in 96 per cent or more of concluded Section 42 enquiries over the last three years. This is higher than the most recent London and England figures. Where people expressed outcomes, the great majority were either partly or fully achieved.

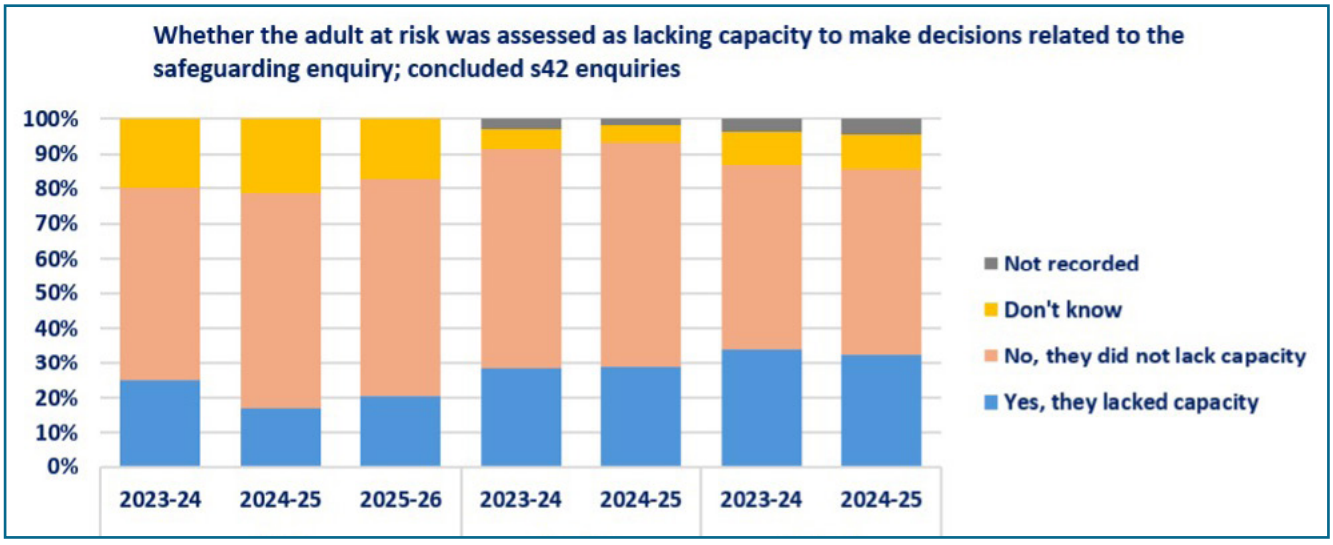




Some adults may need support to make decisions about safeguarding. The Mental Capacity Act 2005 protects people who may lack capacity to make a specific decision. It also makes clear that people should be supported to make their own decisions wherever possible.

In Westminster, around one in five concluded enquiries involved an adult assessed as lacking capacity. In around one in five cases, capacity was recorded as "not known". A local audit was carried out to understand this better. As a result, safeguarding forms have been changed so practitioners record clearer evidence and explanations about capacity.

Where an adult lacks capacity, they should have appropriate support from an independent advocate, family member, friend or carer. In Westminster, this support was recorded in about 90 per cent of relevant concluded enquiries, above the most recent London and England figures.



Analysis: strong person-centred practice, with one area to keep improving

The data shows strong practice in asking people what they want to happen and in arranging advocacy where needed. The change to mental capacity recording is a positive improvement and should help provide clearer assurance in future reports.

Overall conclusion

Safeguarding demand in Westminster continues to rise, but the data shows a balanced response: concerns are checked, the right pathway is used, and risks are usually reduced or removed when they are identified. The main messages for the year are clear: prevention should focus on risks in people's own homes, financial and psychological abuse need continued attention, and support must reflect Westminster's diverse communities and mental health need

What we have learnt from the data for RBKC & WCC

3 strengths

- Safeguarding concerns are more visible, with more adults being brought to attention.
- Over 95 per cent of identified risks were reduced or removed through enquiry activity.
- Person-centred practice remained strong, with desired outcomes discussed in at least 95% of enquiries.

2 concerns

- Financial and psychological abuse featured more strongly than in London and England comparisons.
- Mental capacity recording needs further improvement where capacity is recorded as not known.

1 partnership priority

Strengthen early recognition and follow-up for adults experiencing hidden harm at home, repeat concerns, financial or psychological abuse, domestic abuse, mental health needs, isolation or barriers to seeking help.

Section 2
Key Priority Areas
Strengthening responses to Risk. Priority 2



Jargon buster

Alcohol related brain damage ARBD. A long term brain disorder caused by heavy drinking over many years. Key conditions and effects include Wernicke-Korsakoff Syndrome, coordination, thinking, planning and memory. ARBD can stop getting worse and often improves if drinking stops and treatment begins.

Multi-Exclusion Homelessness. A severe form of housing loss combined with multi-layered social exclusion such as substance misuse, institutional care such as in a mental health hospital or a prison, early years trauma .

Clutter Image Rating. The 9 levels of hoarding refer to the Clutter Image rating scale, a visual assessment tool with distinct photographic stages. Hoarding behaviours are measured in severity related to the physical volume of clutter in the room.

Executive dysfunction. A disruption of the brain's management system causing trouble with planning task initiation and emotional regulation

Second Safeguarding Adult Review Analysis. Examined 652 statutory reviews completed across England between 2019-2023. It identified core national practice, trends , prominent types of abuse and key sector-led improvement priorities

Domestic Abuse Related Death Reviews, DARDR. Are carried out where a person has died as a result of abuse, violence or neglect by a relative, intimate partner or member of the same household

Theme 1

Self-neglect and hoarding





Theme contributor

Clinton Alder: WCC Hoarding & Self-Neglect Lead, Housing and Commercial Partnerships

Levi Burke: RBKC Head of Neighbourhood Management

Further thanks to the partnership for their insights into this article

Self-neglect and hoarding remained a significant area of strategic safeguarding risk for the SAEB during 2025–26. The Board's focus was not only on producing guidance, but on strengthening assurance that partners understand the risk, share responsibility for managing it, and can evidence a consistent, proportionate and person-centred response across the Bi-Borough.

What is the risk?

Self-neglect and hoarding present complex and often hidden safeguarding risks. They can involve poor self-care, unsafe or cluttered living environments, deteriorating physical or mental health, fire risk, environmental health concerns, social isolation, trauma, addiction, cognitive impairment and difficulties engaging with services. In many cases, adults may have mental capacity to make decisions that others consider unwise, while still experiencing escalating risk. This creates a difficult balance for practitioners: respecting autonomy and Making Safeguarding Personal, while ensuring that agencies do not close down concern too early or work in silos when risk is increasing.

In RBKC and WCC concluded S42 enquiries have been less likely to include allegations of self-neglect but this difference may be due in part to the fact that there is a separate pathway for responding to concerns about self-neglect and hoarding.

The strategic risk for the Board is that inconsistent thresholds, weak multi-agency coordination, limited legal literacy or insufficient management oversight could result in missed opportunities for early intervention, poor risk assessment, ineffective escalation and avoidable harm. This is why self-neglect and hoarding require sustained senior oversight, clear routes for escalation, robust use of the Mental Capacity Act, and assurance that learning from Safeguarding Adult Reviews is being embedded in frontline practice.



What did we see this year?

During 2025–26, the SAEB moved self-neglect and hoarding from an identified area of concern into a clearer strategic improvement programme. The Bi-Borough Self-Neglect and Hoarding Strategy and Pathway, together with the accompanying Hoarding Toolkit, was published in September 2025 and formally launched through a multi-agency event in February 2026. The launch brought together Adult Social Care, Housing, Environmental Health, London Fire Brigade, specialist support services and other partners to explore the national and local context, lived experience, roles and responsibilities, and the practical challenges of working with adults where risk is complex and engagement may be difficult.

The Board saw strong evidence of learning and communications activity to support embedding. This included the Understanding Hoarding webinar in March 2026, wider Mental Capacity Act and self-neglect learning resources, and a strategic hoarding bulletin in May 2026 to reinforce key messages and extend practitioner awareness. Questions raised through the launch event showed that practitioners are actively grappling with difficult operational issues, including the interface between safeguarding, mental health, housing, environmental health, fire safety, legal routes, capacity and refusal of support.

What changed?

The most important change was the creation of a shared partnership framework. The Strategy and Pathway clarified definitions, the interface with Section 42 safeguarding duties, the role of the Self-Neglect and Hoarding pathway, expectations for effective engagement, risk assessment, mental capacity consideration, information sharing, fire safety and legal remedies. The Hoarding Toolkit gave practitioners practical tools, including engagement prompts, assessment questions, risk assessment guidance, Clutter Image Rating guidance and resources to support proportionate action at different levels of risk.

This work strengthened the Board's assurance position by moving the partnership away from reliance on individual agency responses and towards a clearer multi-agency model. It reinforced that self-neglect and hoarding are not the responsibility of one service alone; they require coordinated assessment, shared risk ownership, clear lead agency

CLOUDS END

We believe in people not problems

As part of National Hoarding Awareness Week, sponsored by Clouds End there are a range of free online webinars, which aim to raise awareness, break stigma and open up conversations that are all too often avoided, while continuing the discussion around the urgent need for national support guidelines to help ensure people affected receive the understanding and support they deserve.

arrangements and escalation routes where risk remains unresolved. The work also strengthened the prevention and early intervention offer by giving partners a common language and practical resources before risk reaches crisis point.

What remains fragile?

The Board recognises that this remains a fragile area of practice. Self-neglect and hoarding cases often require sustained relationship-based work over time, and outcomes may not be linear. Adults may disengage, re-hoard, decline support or move between thresholds. There can also be continuing uncertainty about lead agency responsibility, information sharing, legal options, the point at which risk should escalate, and how best to respond when an adult has capacity but the risks to themselves or others remain significant.

The next phase is therefore focused on impact and evaluation. During 2026–27, the SAEB will need to test whether the Strategy and Toolkit are consistently embedded in practice, whether operational high-risk panels are effective, whether partners are using the pathway as intended, and whether audit findings, evaluation feedback and case examples demonstrate improved practice. Senior officers will need to remain sighted on whether multi-agency risk management is sufficiently timely, whether escalation routes are working, and whether the partnership can evidence impact for adults, carers and communities.

Case study



When professionals first met the Hartley family (a pseudonym used for anonymity), it was clear things had been getting harder for some time. Mr and Mrs Hartley were older and coping with reduced mobility and memory difficulties. Their adult son was struggling with his mental health and found it difficult to engage with services. As hospital admissions became more frequent, the home environment became increasingly cluttered and unhygienic and everyday risks began to stack up.

The turning point was a patient, therapeutic approach: a small core group of consistent workers stayed involved, focused on building trust, and worked at the family's pace. Together, they agreed a simple, shared plan, starting with what mattered most to the family, not what services wanted to remove. Over time the home became safer and more manageable, with practical changes (storage, shelving and clear pathways) that the family could sustain. The case remains open for light-touch monitoring, recognising that progress can be gradual and needs ongoing support.

Assurance position: The Board is assured that the partnership has made significant progress in establishing a shared framework, practical tools and learning activity for self-neglect and hoarding. However, assurance is not yet complete. The priority for the next year is to demonstrate consistent implementation, measurable practice impact and sustained senior oversight of the most complex and high-risk cases.

Theme 2

Partnership responses to system demand



Theme contributor

Louise Butler: Head of Safeguarding Adults, Quality Assurance and Workforce Development.

With thanks to the partnership for their insights into this article

The Safeguarding Adults Executive Board held its Safeguarding Adults Partnership Audit Tool (SAPAT) event on Wednesday 4 March 2026 to bring partners together to reflect on safeguarding achievements during 2025–26, agree key items for the SAEB Annual Report, and shape priorities and workstreams for 2026–27. The event combined Safeguarding Adults Partnership Audit Tool (SAPAT) audit findings, subgroup updates, national and local safeguarding context, and facilitated group discussions focused on what is working well, what remains challenging, and how the partnership can measure progress and impact.

Partners described a shifting landscape shaped by pressures on eligibility identification to include increasing digital harm complexity, workforce pressures, organisational change and rising levels of risk among adults experiencing multiple disadvantage, self-neglect, homelessness, domestic abuse, mental ill health, substance use and social isolation.

Despite these pressures, the audit showed evidence of a committed and maturing partnership. Agencies reported stronger safeguarding governance, improved training take up , increased awareness of Mental Capacity Act practice, better fire safety awareness, wider dissemination

In July 2025 the Safeguarding Ambassadors worked with the Police and Digital Safety Team and shared the results of short digital safety survey undertaken by our diverse communities to support sharing knowledge with the K&C Digital Inclusion Partnership - "No-one Left Behind". The Ambassadors highlighted: 100per cent of survey respondents had received scam texts or emails, emphasising the prevalence of the issue. The survey showed a significant portion of our communities and voluntary sector staff do not feel safe online, highlighting the ongoing need for awareness and safety measures. Especially where English was not a first language or if late onset sensory impairments had impacted upon vision. Resources, including the Ambassador video with top 10 tips for online safety, and our popular webinars encouraging community groups to use these

of Safeguarding Adult Review learning and more established routes for multi-agency discussion. The challenge for the coming year is to protect and build on this progress while recognising the fragility of the wider system in which safeguarding work is taking place.

What is the risk?

The primary risk is that increasing system demand will outpace the partnership's collective capacity to respond effectively, consistently and in a person-centred way. Partners described high-risk safeguarding work becoming more complex, particularly where adults are experiencing overlapping needs and increasing complexity as already described .

Several partners highlighted that statutory and operational services are stretched, with concerns about capacity to attend multiple boards, respond to complex cases, embed learning and maintain consistent safeguarding oversight.



What did we see this year?

This year, the partnership saw strong evidence of commitment, adaptation and learning. Partners reported better use of learning resources, increased engagement with webinars and 7-minute briefings, and a continued focus on embedding learning from local and national Safeguarding Adult Reviews. The SAEB learning programme was repeatedly described as a significant area of impact, particularly in relation to Mental Capacity Act practice, fire safety, self-neglect, hoarding and complex case work.

At the same time, the discussions showed that demand is increasingly concentrated around adults with complex and intersecting needs. Rough sleeping, multiple exclusion homelessness, domestic abuse among older people, financial abuse, executive function, mental capacity and non-engagement all emerged as areas requiring continued attention locally.

What changed?

The audit suggests that the partnership has moved from identifying recurring safeguarding themes to developing more structured responses. Fire safety is a clear example: partners reported greater awareness, training, assessment prompts, referral pathways and practical resources following learning from fatal fire reviews. Mental Capacity Act practice has also become more visible through audit work, training, supervision, task and finish activity, and increased attention to executive function and best interests decision-making .

There has also been stronger recognition of the need for trauma-informed and

relationship-based approaches. Group discussions emphasised the importance of engagement rather than simple referral, particularly where adults are reluctant to accept support or where services need to persist in creative and proportionate ways.

Phayza's experience of Peer support in reporting a scam.

Phayza a SAEB Safeguarding Ambassador, almost became the victim of a scam involving people pretending to be from a well known mobile company . The callers offered un-limited data, free international calls, a free iPad and a lower monthly bill. They sounded professional and convincing. They also knew personal details, including her address and how long she had been a customer, which made the call feel more believable.

The warning signs became clearer when the callers asked for bank details, sent the wrong device and then arranged for it to be collected, promising that the "right" item would follow.

Phayza later spoke about her experience at a Safeguarding Ambassador meeting. The group asked whether she had reported the incident to Report Fraud and whether she had checked her bank account to make sure no direct debit had been set up. They encour-aged and supported her to take action.

Phayza acted quickly. She contacted the mobile company, reported the incident to Action Fraud, alerted her bank, cancelled her card and continued to monitor her account. Her experience shows the importance of trust-ed networks, peer support and immediate action when something does not feel right.

What remains fragile?

Despite clear progress, the system requires continued improvement in several important areas.

1. Workforce capacity Partners referred to overstretched teams, financial pressures, staff turnover, organisational restructuring and competing demands from multiple Safeguarding Adults Boards.

2. Pathways for complex and high-risk adults Partners identified continuing support for high risk panels and escalation processes, feedback following safeguarding referrals, and the management of complex cases that sit across several agencies.

3. Although **learning from SARs** is being disseminated through many routes, partners noted that it can still be difficult to demonstrate impact at the frontline and to ensure learning reaches operational practitioners quickly enough.

Early recommendations emerging from Baroness Casey's Adult Social Care Reform work include action on adult safeguarding, highlighting that serious safeguarding failures were too often treated as isolated local problems rather than being used to drive national scrutiny, learning and accountability.

Her recommendations included creating a new National Adult Safeguarding Board, chaired by the Chief Social Worker and reporting to the Minister for Social Care, and reviewing adult safeguarding statutory duties and powers to test whether the current framework is strong enough in high-risk situations.



One You Be Tobacco Free (KCW) supporting residents to quit smoking

We interviewed the One You Be Tobacco Free Team to share practical tips, referral route and how community partners can get involved.

At a glance

Who it's for: Age 12+ living in Kensington & Chelsea or Westminster

How support works: 1:1 or group, in person / online / phone, up to 12 weeks

What's included: Quit plan, cravings support, free aids (NRT/vapes), and help accessing medication where appropriate

Extra support: Pregnancy and shisha

Referrals: Self-refer online, call, or professional/pharmacy referral (no GP needed)

Phone: 0808 175 6385

This national development is important for the SAEB because it reflects many of the issues seen locally: complex risk, pressure on services, adults who fall between pathways, the need for clearer escalation, and the need to show that learning from reviews leads to real change. The creation of the National Adult Safeguarding Board provides a stronger route for national oversight of adult safeguarding risks, Safeguarding Adult Review learning and themes that require action beyond individual local areas.

For the local partnership, the next phase of work should focus on protecting capacity, strengthening complex case pathways, improving assurance about impact, and ensuring that adults with the greatest levels of risk and exclusion remain visible within safeguarding decision-making.

Assurance position:
The SAPAT audit and group discussions show a partnership that is committed, reflective and increasingly mature in its response to system demand. There is strong evidence of progress in beginning to use a preventative approach to safeguarding particularly within fire safety.

Theme 3
Domestic abuse and safeguarding

Theme contributor

Hugh Constant, Bi-B Safeguarding Operational Service Manager.

Manju Lukhman , Bi-Borough Violence against Women and Girls Strategic Lead.

With thanks to the partnership for their insights into this article.

Domestic abuse remained a significant safeguarding risk during 2025–26, particularly where older people were at risk of hidden harm and familial abuse was complex or not easily recognised through traditional safeguarding routes. The Board's focus was on strengthening professional curiosity, improving joint working with Violence Against Women and Girls specialist services, and ensuring that domestic abuse risks are understood within adult safeguarding practice, including where adults may have care and support needs, experience homelessness, be older, or face multiple and intersecting vulnerabilities.



What is the risk?

There are several safeguarding risks linked to domestic abuse. One that stands out locally is the continued underestimation of risk where domestic abuse is carried out by adult children against their parents who have care and support needs . Parents may feel less able than almost any other group to take steps to end abusive relationships, often because of love, loyalty, dependency or fear of the consequences for their adult child. This can mean that people tolerate very risky situations for long periods before concerns become visible to services.

Another significant risk area is domestic abuse affecting rough sleepers, most often women, where partners may also be experiencing very difficult circumstances. In these situations, risks can be multiple and enmeshed across homelessness, trauma, substance use, mental ill health, poverty and coercive control. This can sometimes blur professional focus, when the safeguarding response needs to remain clear about domestic abuse and domestic violence risks alongside other forms of need.

Domestic abuse can also be harder to identify and report where harmful practices, discrimination, language

barriers, race and cultural identity, disability, immigration worries, fear of community judgement, or lack of trust in services create additional barriers to asking for help. The Board therefore needs to keep equality, diversity and inclusion at the centre of domestic abuse safeguarding, so that people are not missed because services do not recognise how abuse may be hidden, minimised or experienced differently across communities.

The Board also recognises that risk can remain high when older people separate from a partner or long-term relationship. Separation should not be assumed to mean that risk has reduced: coercive control, stalking, financial abuse, emotional pressure, housing insecurity, loneliness and fear can continue or escalate after separation. Professionals therefore need to remain alert to partner and ex-partner abuse in later life, as well as abuse by adult children or carers.

What did we see this year?

The number of domestic abuse cases continued to rise in small numbers particularly in the adult child category. This is reflected in the pressure seen through Multi-Agency Risk Assessment Conference0 ,MARAC, meetings, where both boroughs reported increasing demands . This increasing demand provides an important indicator of the scale and complexity of domestic abuse risk within the safeguarding system for people with care and support needs .

MARAC activity also demonstrated a wider strength: good joint working across agencies. This was often spearheaded by Violence Against Women and Girls specialist staff and agencies making up the Angelou Partnership, whose expertise helped maintain a clear focus on risk, safety planning and coordinated responses where cases involved complex relationships, repeated harm or multiple vulnerabilities.

What changed?

The Bi-Borough is currently working on a number of Domestic Abuse-Related Death Reviews. While these reviews inevitably arise from devastating losses, they provide important opportunities for learning, improvement and system challenge. Clear action plans have been developed from the reviews, and the learning is shaping training across organisations and supporting new ways of working.

A key change has been the stronger emphasis on professional curiosity about the nature of people's family relationships and the hidden risks they may be facing. This includes encouraging practitioners to ask more direct and thoughtful questions about the family support network , recognise coercion and control, understand relationship dynamics beyond formal labels.

What remains fragile?

The stories behind the Domestic Abuse-Related Death Reviews are a clear reminder that the system must continue to improve for older people . There is a need to get better at identifying when people are in relationships and the interface with a caring role , recognising the risks for older people within those relationships, and viewing harm through a domestic abuse lens where appropriate. This includes maintaining attention to domestic abuse in later life, abuse by adult

children, domestic abuse among rough sleepers and the relationship between domestic abuse and suicide risk.

A further fragile area is the gap between domestic abuse support and adult safeguarding thresholds. Being a victim of domestic abuse does not automatically mean that an adult will meet the legal threshold for a Section 42 safeguarding enquiry. However, this should not leave people without help. The partnership needs to be clear about how domestic abuse services, housing, health, voluntary sector support, advocacy and safeguarding pathways work together so that adults receive the right support, advice and risk management even when the statutory safeguarding threshold is not met.

Assurance position: The Board is assured that there is strong multi-agency commitment to responding to domestic abuse risk, supported by specialist VAWG expertise, MARAC activity and learning from Domestic Abuse-Related Death Reviews. However, assurance remains developing. The priority for 2026–27 is to strengthen recognition of hidden and familial complex domestic abuse, embed learning from reviews, maintain clear links between domestic abuse and adult safeguarding pathways, and ensure that adults facing the highest levels of risk remain visible across the partnership.



Theme 4

Mental health, safeguarding and complex risk

Theme contributor

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With thanks to the partnership for their insights into this article

Mental health, safeguarding and complex risk remained a central assurance theme for the Board during 2025–26. Local learning shows that the greatest risk is not mental health need alone, but the way risk can become fragmented when agencies focus on one presenting issue rather than the whole person. This theme therefore focuses on professional curiosity, information sharing, escalation, policy compliance and multi-agency ownership of risk.

What is the risk?

Stronger "Think Family" practice is needed where mental health, substance misuse, domestic abuse, historical trauma, family or carer context and safeguarding risk intersect. Without this wider view, agencies may miss the cumulative impact of trauma, isolation, coercion, neurodiversity, homelessness, physical health and fluctuating engagement.

A second risk is failure to follow agreed policies and processes. This can include limited involvement of families and carers where appropriate, poor information sharing, lack of escalation, and missed opportunities to convene professional meetings to share risk and agree a coordinated action plan. Domestic Abuse-Related Death Reviews now include cases where a victim completed suicide, and locally there are increasing referrals that require practitioners to understand the relationship between domestic abuse, mental health, suicide risk and adult safeguarding.

What did we see locally this year?

Local case review activity showed many dedicated professionals working persistently with adults experiencing complex mental health, trauma, homelessness, substance use, neurodiversity, cognitive impairment or difficulty trusting services. However, the



wider system did not always support timely resolution of barriers. Learning from the "Malcolm" Safeguarding Adult Review highlighted challenges around mental health diagnosis and clear Alcohol Related Brain Disease , ARBD, pathways within the homeless population, professional curiosity and escalation. Wider case review learning also highlighted how trauma, neurodiversity, distrust of professionals and difficulty engaging can contribute to premature case closure where risk has not been fully understood or held collectively.

What changed, improved or developed during the year?

The Second National SAR Analysis was discussed and local areas of focus were agreed, including greater monitoring and scrutiny around unpaid carers and safeguarding and safeguarding for people with protected characteristics. These themes have helped the Board connect mental health-related safeguarding with wider priorities around trauma-informed practice, cultural competence, safe closure and multi-agency ownership of risk.

The Mental Health Learning Programme now in its second year has supported practitioners to learn at a partnership level to understand many areas of safeguarding within the context of mental health e.g patient on patient abuse hoarding and self-neglect and hoarding . The programme also strengthened knowledge of talking therapies and signposting routes so that practitioners could better connect adults to appropriate mental health support.

The Malcolm SAR action planning has supported work on the ARBD pathway, including how to strengthen the partnership approach to trauma-informed care . The partnership has also joined the National Engagement Project to look at tools to support practitioners in how to understand better the challenges for some people to engage with services .

What remains fragile?

Some improvement work remains across mental health services in relationship to pathways for adults with complex needs. The High Risk Panel is still becoming embedded, and the Board will need to maintain oversight of how it supports earlier escalation, shared ownership and coordinated action where standard pathways are not resolving risk.

Learning from drug and alcohol deaths also requires continued attention. These deaths often sit at the intersection of mental health, trauma, homelessness, domestic abuse, exploitation, physical ill health and social exclusion. The Board will need to continue testing whether learning is being shared across the right forums and whether agencies are using it to strengthen prevention, escalation and multi-agency case coordination.

Assurance position: The Board is assured that the partnership has strengthened its understanding of mental health, trauma and complex safeguarding risk through learning, case review discussion, SAR action planning and multi-agency reflection. Assurance remains developing because complex mental health pathways, ARBD, high-risk escalation, safe closure and learning from drug and alcohol deaths is a developing area of sustained need and will require SAEB oversight during 2026–27.

Case study

Supporting People in Mental Health Crisis: Section 136 and the Health-Based Place of Safety

During 2025/26, the Safeguarding Adults Board continued to oversee the Section 136 pathway for people experiencing a mental health crisis in Westminster and Kensington & Chelsea. The Board's focus has been on ensuring people receive timely, safe and dignified care, while supporting partners to identify and address delays within the system.

A positive development during the year has been improved timeliness within the pathway. Average Approved Mental Health Professional (AMHP) response times reduced to 3.5 hours, supporting faster assessment and decision-making for people in crisis. This reflects continued collaboration between health, social care and partner agencies to improve access to appropriate support

There have also been improvements in the time people spend within the Health-Based Place of Safety at St Charles Hospital. The proportion of people staying longer than 72 hours reduced significantly, falling from an average of 28 per cent to 14 per cent in March 2026. This indicates improved patient flow and more timely progression to assessment, treatment and onward care.

During the year, partners also introduced the Thalamos dashboard, providing improved oversight of pathway activity, waiting times and outcomes. This has strengthened multi-agency understanding of demand and system pressures, supporting a more informed approach to service improvement.

While challenges remain, particularly around access to mental health beds and timely assessment, these improvements provide encouraging evidence that partners are working together to reduce delays and improve the experience of people detained under Section 136. The Board will continue to monitor performance and seek assurance that learning is translated into practical improvements during 2026/27.

Response from Superintendent Lisa Parker, Lead Responsible Officer for Mental Health, Adult Safeguarding & Suicide Prevention

The MPS recognises the positive progress made by partners in improving the Section 136 pathway during 2025/26. Local data indicates increased use of Health-Based Places of Safety and reductions in time spent at incidents, reflecting the benefits of strong multi-agency collaboration and a shared commitment to ensuring people experiencing mental health crisis receive the right care from the right service at the right time. The enhanced Thalamos dashboard has strengthened system oversight by providing improved visibility of pathway activity, waiting times and outcomes, enabling partners to better understand demand, identify pressures and drive continuous improvement across the pathway.

Theme 5
Multi-exclusion homelessness

With thanks to the partnership for their insights into this article



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Multiple exclusion Homelessness remains a priority area for the SAEB. The Board's scrutiny during 2025–26 linked SAR learning, rough sleeping death review processes, domestic abuse learning, health inequality, housing pathways and multi-agency escalation.

What is the key safeguarding risk in relation to rough sleeping?

People experiencing multiple exclusion homelessness are extremely vulnerable to abuse and neglect, including severe self-neglect, criminal exploitation and sexual exploitation. These risks often sit within complex systems that can create barriers to holistic, wrap-around support, particularly where homelessness, trauma, mental ill health, substance use, cognitive impairment, exploitation and difficulties engaging with services intersect.

What did we see locally this year?

The need for greater flexibility within diagnostic inclusion criteria where someone presents with suspected alcohol-related brain damage but is too young to be assessed by Older Adults Mental Health Services. Partners also identified challenges in providing wrap-around support, or a team around the person, where temporary accommodation has to be sourced out of borough. The lack of appropriate specialist accommodation in borough for people with highly complex needs is an on-going challenge. Despite involvement from dedicated and persistent professionals, cases continued to show the difficulty of providing care and support services to homeless people who have eligible needs under the Care Act. Learning also highlighted the importance of working effectively with probation services for people with complex needs, including mental ill health and substance misuse, and ensuring that a safe release plan from prison is in place.

Cases reinforced the importance of understanding the impact of a person's trauma history on their presentation, engagement and ability to accept support. There was also learning about executive capacity in the context of homelessness, where a person may be able to articulate understanding of risk but may not be able to act physically or practically to protect themselves.

Case study: managing complex risk where alcohol-related brain damage is suspected

A man in his late 50s lives in hostel accommodation for more than five years. He is alcohol dependent, physically frail and living with serious health conditions, and a long history of falls. He also had recently been admitted to intensive care after being found collapsed with hypothermia.

Professionals were increasingly concerned about alcohol-related brain damage and the impact this was having on his ability to keep himself safe. His cognitive assessment worsened significantly over time, to a score indicating severe impairment. This affected his ability to learn new information, plan tasks and follow through with decisions, even when he said he wanted help.

Key risks included: repeated falls, frailty and the risk of sudden death, worsening memory, decision-making and executive functioning linked to continued alcohol use.

He was found asleep outside during cold weather and was reported missing after returning from detox. Repeated safeguarding concerns, antisocial behaviour and contact with the criminal justice system. Limited availability of accommodation able to meet the needs of people with alcohol-related brain damage.

How partners responded

Adult Social Care assessed his needs and provided a care package to support meals and domestic tasks. A multi-disciplinary team worked together to share and manage risk, including considering detox, a short stay in specialist support, falls prevention equipment and options such as location technology. Some measures raised ethical and practical challenges in a hostel setting, particularly around consent, privacy and how any equipment would be used safely.

What this tells us

These types of case highlight the difficulty of supporting people who want help but whose cognitive impairment makes it hard to engage consistently. It shows the importance of shared risk management, clear safeguarding oversight and specialist accommodation pathways for people with alcohol-related brain damage, where the risks of serious harm, deterioration and sudden death are high.



What changed, improved or developed during the year?

The Malcolm SAR Task and Finish Group was established to drive forward improvement actions from SAR Malcolm. With leadership and co-chairing by Directors in Housing and the Integrated Care Board, ICB, progress has been made across several key areas.

- A multi-agency data set supports better understanding of the number of people experiencing alcohol-related brain damage in the Bi-Borough, including those who may not have a formal diagnosis and can inform new commissioning arrangements
- Current pathways and arrangements across agencies has been mapped, alongside learning from national best practice examples, to identify gaps and barriers to inform commissioning intentions.
- A pilot is being scoped to test a revised alcohol-related brain damage pathway led on by the local Mental Health Trust.
- The homecare transformation programme has extended homecare support to people living in hostel accommodation in the Bi-Borough. It also includes a Complex by Exception panel, where people with highly complex needs can receive care delivered in partnership across specialist teams.

The Ministerial letter and action plan have strengthened the Board's focus on rough sleeping, homelessness and safeguarding, including the need for clearer oversight of risk, learning from deaths, cross-borough continuity and partnership accountability. Six-monthly updates on rough sleeping are provided to the SAEB by housing colleagues across both boroughs, supporting shared learning from death reviews . See section for further information

What remains fragile or requires continued oversight?

Multiple exclusion homelessness involves a complex interplay between skilled professionals across agencies, the need for meaningful and effective engagement, the impact of trauma history, and system challenges relating to the suitability of care and support services, housing provision and diagnostic pathways. This can create continuing practice challenges around information sharing, communication, escalation, timely formal diagnosis and the management of complex self-neglect. There is also a need to improve awareness of referral pathways for high-risk panel meetings and to embed these more consistently into practice.

Section 3

Leading listening and learning

Turning learning into practice. Priority 1

Jargon buster

SAR Champions: Responsible people from across the Partnership who ensure that SAR learning is embedded into front line practice and who can demonstrate that this has impact

Safeguarding Adults Reviews, SAR's: Is a formal process used when an adult has died or suffered serious harm and there are concerns about how organisations worked together to keep them safe. The review looks at what happened, what can be learned, and how services can improve to better protect people in the future. It is about learning and improvement, not blaming individuals.

LeDeR stands for Learning from Lives and Deaths – People with a Learning Disability and Autistic People: Is a structured learning process that helps health and social care organisations understand what worked well and what could have been done differently when a person with a learning disability or an autistic person dies, so that services can improve and future harm can be prevented."

The Prisons and Probation Ombudsman (PPO): is an independent body that investigates deaths in prison custody, approved premises, immigration detention, and deaths that occur within 14 days of release from prison. Its investigations identify what happened, highlight learning for agencies, and help improve the safety of people in custody and under community supervision.

Child Safeguarding Practice Review Panel: When a child suffers serious harm and abuse or neglect is suspected, a notification is made to the national Panel. A multi-agency Rapid Review is then held within 15 working days to consider what agencies knew, identify learning, and decide whether a Local or National Child Safeguarding Practice Review is needed.

Coroner Section 28: A Regulation 28 report is the coroner's formal mechanism for saying: "I've seen something during this death investigation that could lead to other people dying in similar circumstances. These organisations need to take action and tell me what they are going to do about it."

Safeguarding adults reviews



Theme contributors

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During 2025–26, the Safeguarding Adults Case Review Group continued to meet on a six-weekly basis maintaining oversight of Safeguarding Adults Review activity, monitoring progress against existing SAR action plans and considered whether new referrals met the statutory threshold for a review. The group looked carefully at each referral, made a fair decision about whether a full Safeguarding Adult Review was needed, wrote down the reasons clearly, and pulled out useful learning even when a full review was not required.

SAR referrals at a glance: 2025–26

Published reviews and current position

One review was published during this reporting year: SAR Malcolm. The detailed findings have been reported previously, so this year the Board has focused on what the learning means for current practice and how the partnership is using it to improve responses for live cases where adults are facing similar risks. This has been written up in the Emerging Risks section of this report , Theme 5 Multi-Exclusion Homelessness.

Referrals received

Measure	2025–26 activity	What this tells us
SAR referrals received	**3**	Referrals continued to be considered through the SAEB SAR Protocol and Guidance, with proportionate triage used to support timely decision-making.
Referrals not meeting SAR criteria	**3**	Where referrals did not meet the statutory threshold, learning was still identified through either single-agency review or other non-statutory investigation routes such as LeDeR .

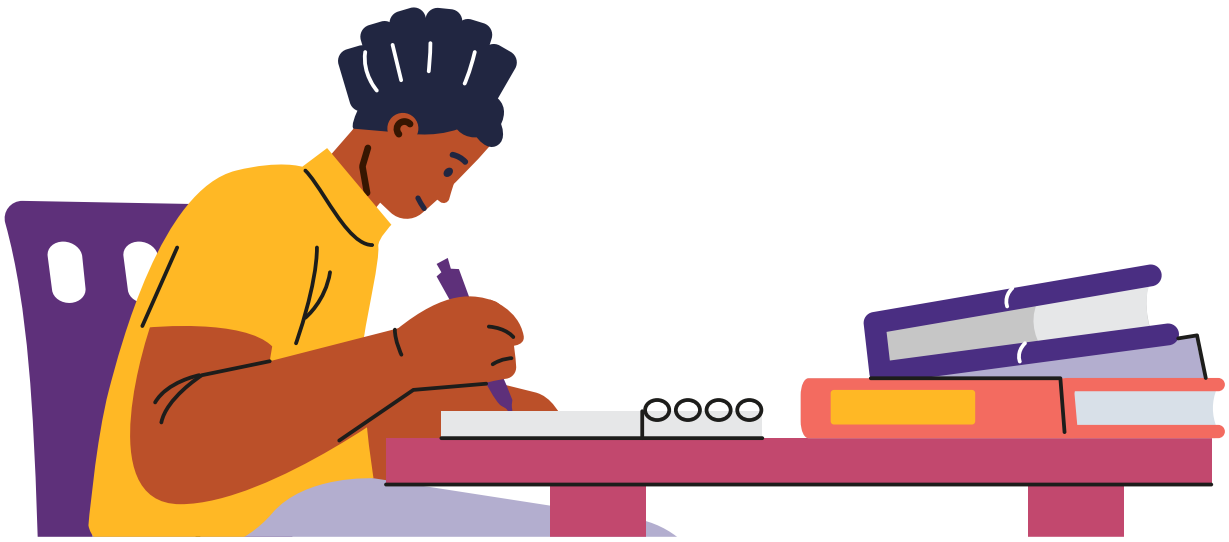
Emerging themes from SAR reviews and case review activity which have not reached the criteria for a SAR.

The Board identified four consistent areas of practice that need continued attention across the partnership. This marks a shift in thinking from simply asking, "What happened in this case?" to asking, "What patterns are we seeing across cases, what do they tell us about the system, and how will we know whether practice is changing?" This approach explores cross-cutting themes and focuses on the areas most likely to prevent harm and acknowledges learning from cases which do not meet the SAR criteria .

The table below identifies what we have learnt:

Practice theme	What we are learning	What we will do next	How we will measure impact
Engagement	Many adults in the cases discussed had experienced trauma, exclusion, poor mental health, homelessness, substance use, disability, neurodiversity or distrust of services. Standard appointments or letters were often not enough to build trust or understand risk.	We will promote relationship-based, trauma-informed and flexible practice. This means encouraging practitioners to keep trying different ways to connect, work with trusted people where appropriate, and avoid describing adults as "not engaging" without first asking what might be getting in the way.	We will look for evidence through case audits, supervision records, SAR Champions feedback, learning evaluations and examples from partners showing that engagement plans are more personalised and persistent.
Safe closure of cases	Reviews and case discussions showed that risk can remain when services step back too early, especially where harm is cumulative, the adult is likely to re-present in crisis, or no one agency has a full view of the situation.	We will strengthen expectations for safe closure. Cases should not be closed simply because an adult declines support or a single service has reached the end of its pathway. Closure decisions should show what risk remains, who has been involved, what follow-up is needed and how concerns can be escalated again.	We will test this through audit of closure decisions, repeat referral data, feedback from high-risk panels, partner assurance reports and case examples that show whether risk is being managed safely after services step back.

Practice theme	What we are learning	What we will do next	How we will measure impact
Professional curiosity	Cases highlighted the importance of seeing the whole person, not only the presenting issue. This includes understanding family or carer relationships, culture, identity, trauma, housing, mental health, substance use, cognitive impairment, domestic abuse and hidden harm.	We will continue to build confidence to ask thoughtful questions, test assumptions such as eligibility criteria for care and support needs and bring together information from different agencies. Learning will be embedded through briefings, workshops, the SAR Champions Network, supervision prompts and links to the Learning and Development programme.	We will measure progress through audit evidence, practitioner feedback, learning evaluation, quality assurance activity and partner examples showing that hidden or cumulative risks are being identified earlier.
Escalation of cases	Some cases showed that agencies recognised risk but did not always escalate early enough when usual pathways were not resolving concerns. Complex risk can drift when ownership is unclear or when barriers sit across several services.	We will promote earlier multi-agency discussion, clearer ownership of risk and use of escalation routes when concerns are persistent, serious or unresolved. This includes links to high-risk panels, safeguarding meetings, management oversight and Board-level assurance where themes keep repeating.	We will monitor use of escalation routes, high-risk panel activity, action-plan progress, partner assurance updates and examples where earlier escalation has improved coordination or reduced risk.



How learning is embedded into practice

The Board continues to use a range of practical routes which have demonstrated success in embedding learning. These include the SAR Action Planning Task and Finish Groups, the SAR Champions Network, practitioner resource packs, case discussion learning, LeDeR and coronial learning, domestic abuse review learning, criminal justice and rough sleeping learning, supervision prompts, themed workshops and the SAEB Learning Programme.

The SAR Champions Network is central to this approach and is made up of senior practioners from across the partnership. Partners are asked not only to receive learning, but to take it back into their organisations, discuss it with teams, test what it means for practice and return with evidence of what has changed. This helps the Board move from sharing learning to checking whether learning is being used.

Impact is measured through a combination of evidence. This includes action-plan progress, audit findings, repeat themes from case discussions, feedback from practitioners and people with lived experience, learning evaluation, high-risk panel activity, partner assurance reports and examples of changed practice. The Board will pay particular attention to whether the same themes keep recurring, whether they are reducing over time, and whether partners can show that adults are receiving earlier, more joined-up and more personalised responses.

This approach supports a stronger line of sight from review learning to real practice change. It also helps the Board understand cross-cutting themes across different types of reviews and cases, so that learning is not held in separate workstreams but used to improve the safeguarding system as a whole.

Parallel learning from other review and investigation models

Overview: The Board's learning this year has not been drawn from SARs alone. The Case Review Group has also considered parallel learning from Children's Rapid Reviews ,domestic abuse-related death reviews, coronial and Prevention of Future Deaths learning, LeDeR, rough sleeping and housing presentations, and probation-related discussion on deaths under supervision. Across these sources, the group repeatedly returned to the same system questions: how well information is brought together, whether thresholds are helping or obstructing the right response, when escalation is warranted, and how agencies stay focused on adults whose risks are chronic, complex or not easily evidenced through conventional service pathways.

- **Domestic abuse-related death reviews**: Learning presented through VAWG colleagues reinforced the importance of making pathways visible not only to professionals, but also to friends, family members and communities who may recognise risk before services do. Group discussion highlighted the need for stronger domestic abuse training, better public awareness of routes to support, and more consistent sharing of review learning so that opportunities for prevention are not missed. Members linked this strongly to wider SAR themes about professional curiosity, recognising cumulative harm earlier, and understanding the barriers that prevent adults from seeking help or sustaining contact with services.

- **Coronial learning and Prevention of Future Deaths reports (S.28):** Prevention of Future Deaths report are directed to national bodies rather than one organisation . CNWL, the Mental Health Trust undertook its own review of a Regulation 28 which it was not involved in to identify practical improvements locally and presented key learning and action to the case review group. The case reinforced the importance of timely, coordinated and person-centred responses, particularly when several organisations share responsibility for someone's care.

Overview of a Regulation 28 Coroners Case

The person was known to a Mental Health Trust with a diagnosis of paranoid schizophrenia and was on the Care Programme Approach. Her mental state deteriorated, with clear signs of relapse and increasing disinhibition. Her mother raised concerns and brought her to the CMHT seeking urgent help. She was assessed by CMHT staff and referred to First Responders, but there were delays, and she left before an assessment took place.

Later that day, she seriously assaulted her mother, was arrested for attempted murder, and taken to A&E. There were prolonged complications between health services, police and AMHPs about the Mental Health Act assessment pathway and setting.

She was subsequently remanded to Prison and died in prison a few days later.



- **LeDeR:** Learning from LeDeR has been particularly valuable in highlighting issues that resonate strongly with local SAR themes. Case discussion in November 2025 considered a death involving a man with a moderate learning disability, diabetes, seizure-related collapse and recent imprisonment. Group reflection focused on information sharing, missed health appointments, specialist placement, reasonable adjustments and support across justice and community settings. The discussion also emphasised the importance of looking beyond diagnostic labels to understand lived experience, family context and changing risks.

- **Probation-related learning:** Between May – July 2025, HMIP inspected six Probation Delivery Units across six regions in the country. A report on findings and recommendations was presented to the board for discussion The focus of the inspection was on the effectiveness of probation policies and practice and the effectiveness of multi-agency arrangements in relation to safeguarding people on probation. The discussion highlighted the importance of hearing the voice of adults whose needs may be poorly understood across systems, improving referral pathways into safeguarding, strengthening joint training, and considering whether higher-risk multi-agency panels or dedicated referral tracking arrangements are needed. As a result greater emphasis will be paid by the board to the interface with the criminal justice system and safeguarding adults and learning from related reviews .

- **Learning Together across Children's and Adults' Services – Rapid Review for Baby S:** Kensington and Chelsea's Local Safeguarding Children's Partnership completed a Rapid Review in 2025 following the sad death of a newborn baby, referred to as Baby S, in north Kensington. The review did not lead to a full Child Safeguarding Practice Review, but it did identify important learning for both children's and adults' services.

  The SAEB worked with the LSCP on the actions relevant to adults with care and support needs. This included strengthening the "Think Family" approach, encouraging staff to ask thoughtful questions, and making sure women of childbearing age are offered support in their own right. Learning also highlighted the need to be alert to possible pregnancy where someone avoids health checks or finds it difficult to access contraception.
  The learning has been included in LSCP training. This reinforces the importance of prevention, trauma-informed practice and flexible support for adults facing multiple difficulties, even where they may not fit neatly into usual service criteria.

Ministerial action plan: rough sleeping, homelessness and safeguarding





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During 2025/26, the Board has further strengthened its oversight of rough sleeping and homelessness in response to national Ministerial recommendations for Safeguarding Adults Boards. Updates from Westminster and RBKC Rough-sleeping teams showed the continued complexity that the rough sleeping systems encounter. The Board's focus has brought this work into mainstream safeguarding assurance and strengthened the link between housing-led activity, death review learning, SAR considerations and partnership action planning.



Relevant data snapshot

Relevant Data Snapshot: Rough Sleeping, Homelessness and Safeguarding

Key data signals show why homelessness, supported housing and rough sleeping remain significant safeguarding assurance issues for the Board.

16 deaths	Westminster annual trend data identified 16 deaths connected to the rough sleeping pathway: 13 men and three women. **Why this matters:** continued high-risk profile requiring ongoing Board oversight.
Average age 49	Four people died in their 30s. **Why this matters:**severe health inequality and need for earlier coordinated intervention.
Domestic abuse in all 3 women's deaths	Domestic abuse was a feature in all three women's deaths reported by Westminster. **Why this matters:** homelessness, domestic abuse, MARAC and safeguarding pathways must connect.
Street deaths reduced	One death occurred on the street, compared with eight in the previous year. **Why this matters:** suggests improvement in preventing street deaths while maintaining vigilance
Nearly half long-term rough sleepers	Nearly half of people sleeping rough in RBKC between July 2025 and January 2026 were considered long-term rough sleepers. **Why this matters:** a smaller but highly complex cohort requires sustained, relationship-based multi-agency support.
Supported housing deaths	RBKC reported four deaths in supported housing pathways in 2025 and two deaths between July 2025 and January 2026, both male. **Why this matters:** risk extends beyond street homelessness into supported accommodation, discharge and move-on pathways.

What changed because of Board scrutiny:

The Board's focus has helped ensure rough sleeping, homelessness and supported housing risk are considered alongside SAR activity, death review processes, domestic abuse learning, coronial learning and housing-led discussions. This has sharpened attention on cumulative risk, cross-borough continuity of care, proactive use of Care Act, Mental Capacity Act and safeguarding powers, and relational, trauma-informed and legally literate practice for adults at clear risk of serious harm or death.

Actions being taken forward

Westminster is using its quarterly multi-agency death review process to support real-time learning and action, including work on chemical /sex and HIV pathway awareness, detox and rehabilitation options for people with no recourse to public funds, relapse contingency planning, end of life care training, and stronger links with inclusion health, sexual health and substance use services.

RBKC is developing its Homelessness and Rough Sleeping Strategy 2026–2029 and aligned action plan, supported by two fixed-term outreach posts focused on preventing rough sleeping and improving move-on from supported pathways.

Further work includes strengthening the Enhanced Vulnerability Forum, involving Adult Social Care, remodelling the Homelessness Forum and improving hospital discharge pathways.

Impact and assurance for the Board:

This work has given the Board a clearer line of sight on adults who move between rough sleeping, temporary accommodation, supported housing, hospital, prison and borough services. It has also highlighted where the system remains fragile, including premature mortality, relapse risk, domestic abuse and coercive control, out-of-borough placements, hospital discharge, provider confidence and fragmented ownership. In 2026/27, the Board will continue to seek assurance that local action plans evidence prevention, early escalation, effective information sharing and coordinated support for people experiencing multiple disadvantage, with particular focus on recognising cumulative risk earlier and strengthening cross-borough continuity of care.

Section 4
SAEB Impact and Improvement



Purpose of this section

This section brings together the main evidence the Board uses to understand impact and improvement , including CQC findings, Safeguarding Adults Partnership Audit Tool findings, Safeguarding Adult Review learning, quality assurance activity, community engagement, and learning and development evidence.

This marks an important shift. The Board is moving beyond describing activity and is now asking whether learning is changing practice, whether risks are being identified earlier, and whether adults, carers and communities are experiencing more joined-up and inclusive safeguarding responses.

Independent assurance: What the Care Quality Commission, CQC, assessment told us about how we engage with our communities .

One of the most significant developments to Safeguarding Adults at a National Level remains the introduction of CQC assurance of local authority adult social care services. Early findings from assessments across England show that safeguarding is one of the strongest predictors of overall performance, but also one of the areas where councils are most vulnerable to criticism.

The CQC assessment in Kensington and Chelsea and Westminster provided important independent assurance about adult social care arrangements. It recognised strong safeguarding practice, visible leadership, effective governance, timely access to support, prevention and early help, and work with diverse communities and voluntary sector partners.

For the Board, the key message is that strong local arrangements are in place, but assurance must continue to focus on impact. The Board will keep testing whether good practice is reaching adults who may experience hidden harm, inequality, discrimination, trauma, isolation or barriers to asking for help.

CQC identified community prevention and lived experience through the model of co-production has been having a significant impact on communities and is one of the best examples nationally of work in this area . The Community Engagement Group, BME Safeguarding Network and Safeguarding Ambassadors helped make safeguarding messages more visible, trusted and accessible. Their work shows that prevention is not just about sharing information. It is about building confidence, listening to communities and helping people recognise harm earlier. The section below provides further information in this area of our partnership work. This remains a key focus for the Board: to keep listening carefully to what communities tell us about risk, barriers and trust, and to use that insight to shape how safeguarding support is delivered. By working together with residents, carers, voluntary organisations and people with lived experience, we can continue to build confidence, strengthen relationships and make safeguarding feel safer and more relevant for everyone.



Adult safeguarding works best when it is shaped with the people and communities it is there to support. Building community confidence and prevention is priority 4 of the SAEB business plan. Over the past year, the Safeguarding Adults Executive Board has continued to strengthen its approach to community engagement and co-production, moving beyond awareness-raising towards shared ownership of local safeguarding priorities.

This means listening carefully to people with lived experience, community representatives, voluntary organisations and service user groups. It means recognising that communities often understand local risks, barriers and fears long before services do. It also means being prepared to change our language, our processes and our pace so that safeguarding feels relevant, trusted and accessible.



Community engagement partners and safeguarding colleagues coming together to share learning and strengthen local prevention work.

From consultation to shared ownership

The Board's approach has developed over many years, starting with service user representation and growing into a wider model of community engagement, co-production and prevention. The foundations were built through the Safeguarding Adults Reference Group, the Community Engagement Group and the involvement of voluntary sector partners, local charities, provider services and residents with lived experience.

That journey has helped shift the conversation from asking communities to comment on safeguarding after decisions have been made, to inviting them to help define the risks, shape the priorities and co-design the response. This reflects the principle of Making Safeguarding Personal: working with people, not doing safeguarding to them.



Hassina Safeguarding Ambassador 2025\6
Winners of the " We See You ,We Hear You " National Excellence Award.

Building trust before expecting disclosure

Trust is at the heart of effective safeguarding. Many people will not raise concerns with statutory services unless they first feel safe, listened to and respected. For some communities, safeguarding language can feel technical or distant; for others, fear of authority, stigma, family expectation or previous experience of services can make disclosure even harder.

The Community Engagement subgroup, Safeguarding Ambassadors and BME Safeguarding Network provide the Board with a stronger route into these experiences. They help us hear what people are worried about, what prevents them from seeking help, and what would make support feel safer. These relationships are not one-off conversations. They are built through regular meetings, development days, awareness events, webinars, campaigns and community-led discussion.

The Staying Safe project: safeguarding in a cultural context

The Staying Safe project has been a practical example of co-production in action. It began by engaging with diverse communities who may not usually choose to engage with adult safeguarding services. Rather than starting with a fixed offer, the work began with listening: understanding what people knew about safeguarding, what felt confusing or frightening, and what would help them feel more confident to recognise and report abuse or neglect.



Community leaders and bilingual partners then helped co-design training and resources in ways that made sense within their own cultural and language contexts. This included train-the-trainer workshops, resource packs and awareness materials that could be shared by trusted community members. Hearing safeguarding messages from familiar leaders, in familiar words, has helped make the subject more understandable and less intimidating.

Community-led translation: more than changing words

One of the strongest lessons we have learnt this year is that translation is about meaning, not just words. Making safeguarding inclusive is Priority 5 of the SAEB Business plan. Safeguarding terms do not always translate easily. Concepts such as abuse, neglect, risk, consent and support can carry different meanings depending on language,

Trust is noted through behaviours before we see formal outcomes

- Good attendance at network meetings
- Engagement through discussion and decision making
- Respect for each others cultural perspective and " Safe place" to challenge
- Ownership of agenda items

culture, faith, family expectations and previous experiences of authority.

Through the BME Safeguarding Network, the Board has finalised the work with community partners to translate the Say No to Abuse booklets into seven languages agreed by the network: Kurdish, French, Somali, Tigrigna, Arabic, Bengali and Farsi.

As one community partner reflected, community-led translation can build confidence, add value and show that language does not need to be a barrier to safety. Another noted that, for such a sensitive subject, familiar words in a person's own language can make a difficult conversation feel more possible.

What human stories are teaching us

The stories shared through this work have challenged the Board to think differently. We have heard that safeguarding can feel like "social services jargon"; that fear of shame, judgement or statutory intervention can stop people asking for help; and that people may worry about being questioned or excluded by their own community if they raise a concern.



Click this link to view the video

Introducing Our Translated 'Say No to Abuse Leaflets

These experiences underline why cultural sensitivity, trust and shared power matter. They also show why safeguarding systems must continue to improve how they record and understand ethnicity, language, culture and inequality, so that prevention work is better targeted and more accountable.

The challenge ahead

Co-production is not always quick or simple. It asks services to slow down, listen properly and share control. But it is the route that makes safeguarding real. The Board's next challenge is to keep turning community insight into shared action: changing language where it creates distance, adapting processes where they create fear, and strengthening partnerships where people already feel trust.

How we will measure impact

The strongest improvement is the Board's move from sharing learning to checking whether learning is being used. Policy implementation, cultural competence, protected characteristics, legal literacy, community engagement and lived experience are now more clearly connected to safeguarding assurance rather than treated as separate workstreams.

The key test will be whether partners can show that adults receive earlier, more personalised and more joined-up responses, particularly where risk is hidden.

Overall assurance

The Board is assured that there has been meaningful progress in strengthening safeguarding practice, learning and community-facing prevention during 2025–26. The strongest evidence relates to independent CQC assurance, improved learning activity, clearer policy and pathway work, stronger community engagement and greater focus on inclusion and lived experience.

Assurance is not complete. During 2026–27, the Board will continue to test whether this improvement is consistently embedded in frontline practice, whether impact can be demonstrated across the partnership, and whether adults with protected characteristics, hidden harm or complex risks are being identified and supported earlier.

Looking Ahead 2026/27: Closing Statement

The Board enters 2026/27 with a clear focus: to show that learning is making a difference in practice and that adults are safer because partners are acting earlier, working together and listening more closely to people and communities.

This report shows progress, but it also shows where the system remains under pressure. The year ahead will be about turning learning into visible change, especially for adults whose risks are hidden, long term or shared across several services.

Prevention will remain central to this work. Next year, the Board wants residents, carers, community groups and voluntary organisations to feel more confident recognising abuse, sharing concerns and knowing where to go for help. The Board will use community feedback, lived experience, translated resources, train the trainer models and examples of onward sharing to understand whether prevention activity is making a real difference.

This work will take place in a changing national context. A new National Adult Safeguarding Board, chaired by the Chief Social Worker and reporting to the Minister for Social Care, has been established to strengthen national oversight, learning and accountability in adult safeguarding. This marks a significant shift for local Boards. There will be clearer expectations to show how learning from serious cases is understood, acted on and used to improve practice. There will also be closer accountability for Boards to demonstrate .

The SAEB is well placed to meet these challenges because it has already begun to strengthen its use of evidence, focus on impact and bring learning, assurance and community voice together.

What should feel different next year

What we want to see	What this should mean in practice
Learning leads to change	Partners can show what has changed because of reviews, audits, case discussions and community feedback.
Risk is identified earlier	Adults facing hidden harm, self-neglect, homelessness, domestic abuse, mental ill health or multiple disadvantage are recognised sooner and supported more consistently.
Responses are more joined up	Partners are clearer about who is leading, what risk remains and when concerns need to be escalated.
People and communities have more influence	Safeguarding messages are clearer, more accessible and shaped by people with lived experience, carers and community partners. The Board can also show whether community activity is improving confidence, knowledge and routes into help.

What the Board will watch closely

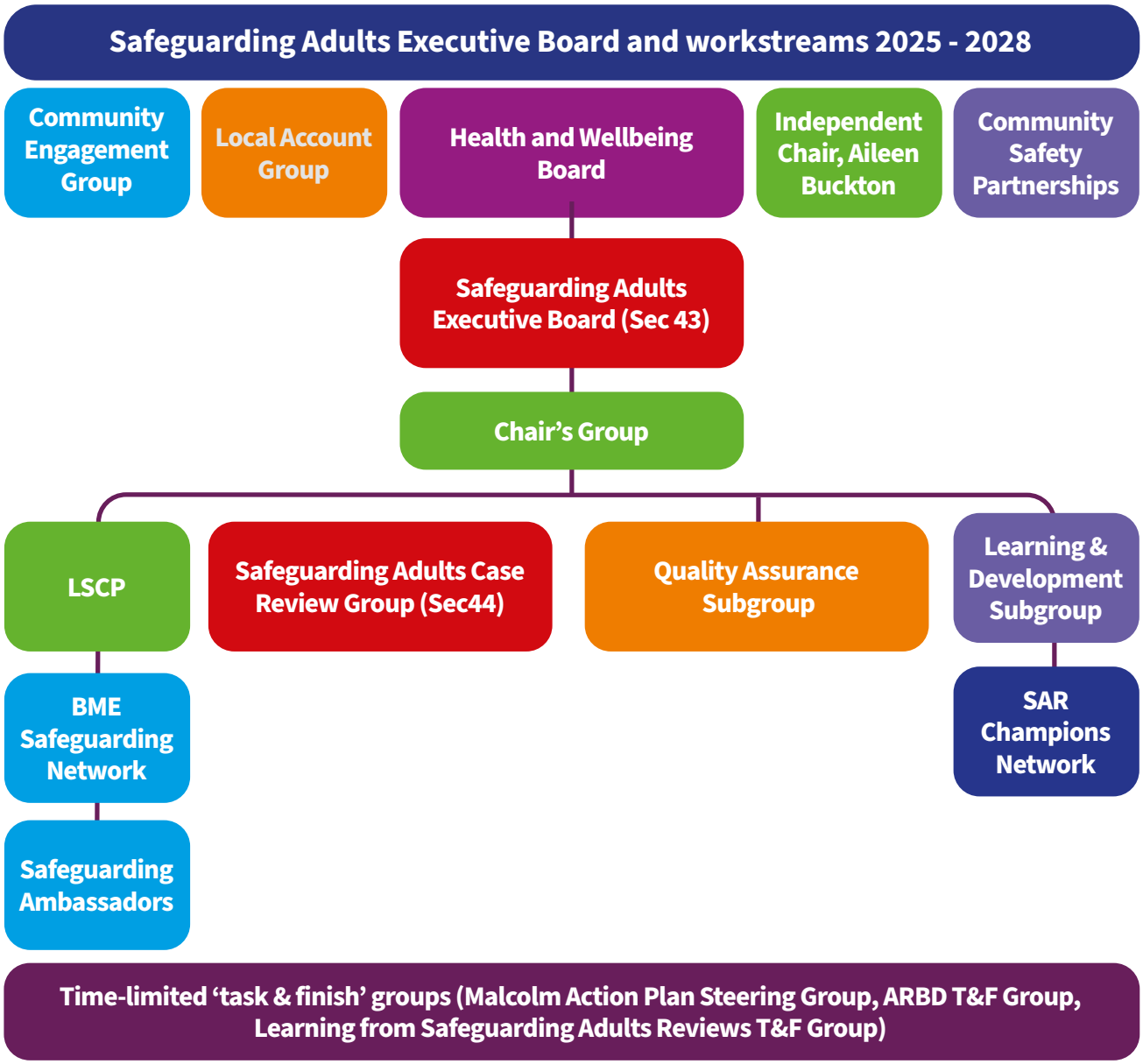
Area of concern	Why this needs attention
Complex and hidden risk	Some adults remain at risk because their needs do not fit neatly into one service or pathway and current legislation has not kept up with changing nature of adult safeguarding
System pressure	Workforce pressure, rising demand and limited capacity can affect how quickly partners respond and follow through.
Safe closure and escalation	The Board will keep testing whether cases are closed safely and whether concerns are escalated when risk remains.
Evidence of impact	The Board needs to continue to build on collecting clearer evidence that learning, training and action plans are improving practice and outcomes.

Appendix 1
Governance and finance SAEB 2026

Governance, accountability and financial oversight

Purpose: To explain how the Board is structured, how it holds partners to account, and how independent scrutiny and assurance are maintained.

The Board's governance arrangements provide the structure through which statutory partners hold one another to account, test assurance and oversee delivery of the **Three Year Strategy 2025 to 2028**. In 2026–27, the Board will continue to strengthen the connection between subgroup activity, quality assurance, learning, community insight and senior decision-making so that governance remains active, purposeful and evidence-led.



Governance feature	Assurance purpose
Board membership and statutory representation	Ensures senior accountability across local authority, health, police, housing, care, community safety and wider safeguarding partners.
Independent scrutiny	Provides challenge, transparency and confidence that the Board is testing impact rather than simply recording activity.
Attendance and engagement oversight	Supports quoracy, continuity, shared ownership and timely follow-through on partnership actions.
Assurance mechanisms	Draws together audit, Safeguarding Adults Partnership Audit Tool (SAPAT), performance reporting, case review learning, subgroup assurance, community insight and thematic deep dives.

Financial Overview and Resources

The Safeguarding Adults Executive Board is funded through annual partner contributions. These resources support the Board's statutory functions, including independent scrutiny, Safeguarding Adult Reviews, learning and development, quality assurance, community engagement, communications and partnership assurance. In 2025–26, the agreed annual partner contribution budget was £52,231, split equally across Westminster and Kensington and Chelsea.

Partner	Annual contribution	Contribution per borough	Purpose
NHS North West London Integrated Care System	£42,231	£21,115.50	Supports the Board's statutory assurance, learning, review and improvement functions.
Mayor's Office for Policing and Crime	£10,000	£5,000	Supports partnership safeguarding priorities, assurance and statutory Board activity.
Total	**£52,231**	**£26,115.50**	**Shared partnership investment in safeguarding governance and improvement.**

Resource assurance: These shared resources enabled the Board to maintain its statutory functions, commission independent review activity, support learning from Safeguarding Adult Reviews, strengthen practice development and maintain partnership assurance arrangements. The Board will continue to monitor whether available resources remain sufficient to support increasing complexity, review activity, learning, community engagement and evidence of impact during 2026–27.

Appendix 2

Learning and development subgroup End of Year Report 2025 - 2026

SAEB Learning Programme

A year of high-impact, practice-focused learning across the partnership



Co-Chairs – Learning & Development Subgroup

Frank Butau
Lead for Safeguarding Adults & Learning Disabilities, Royal Brompton & Harefield, Guy & St Thomas NHS Foundation Trust

Trish Stewart
Associate Director of Safeguarding and Children's Public Health Nursing, Central London Community Healthcare NHS Trust

The SAEB Learning Programme 2025/26 has continued to strengthen multi-agency safeguarding practice across Kensington, Chelsea and Westminster, with a clear focus on practical learning, confidence-building, impact and operational application. Reflecting the breadth and consistency of delivery across the year, the programme was highlighted as a top achievement across Safeguarding Adults Partnership Audit Tool responses for 2025/26.

Learning programme at a glance – reach and engagement

Across 2025/26, the SAEB Learning Programme delivered:

11 webinars delivered	**1,221** attendees	**202** new distribution list members
71% Multi-Agency staff audience	**553** bulletin views	**481** co-produced video views

These results demonstrate sustained demand for **accessible, multi-agency learning**, and continued growth in how the partnership connects with professionals and community-facing organisations.

Programme highlights – key learning events delivered

The programme delivered a varied schedule of practice-focused webinars across the year, covering mental health, falls prevention, MCA practice, bariatric care, SAR learning, domestic and economic abuse, self-neglect and hoarding, and complex safeguarding themes. This report brings the available learning and engagement evidence together to show both the breadth of delivery and the areas where the partnership is continuing to deepen its understanding of impact.

Improving impact and take-up: The Learning and Development Subgroup is drawing together evidence from webinars, videos and bulletins to strengthen engagement, improve assurance and better understand how learning is being accessed, applied and shared across the partnership. The group is moving beyond attendance as the main measure of success by focusing on how learning is accessed, applied and shared across partner organisations. Planned improvements include building feedback time into live sessions and shorter surveys to increase evaluation completion, piloting live polling to capture agency mix, confidence and intended actions in real time, and asking subgroup members to act as Safeguarding Learning Champions within their own organisations. The subgroup is also exploring more accessible formats, including short key-message summaries, highlight clips, podcasts, trailers and written reference materials, so that learning can be revisited and shared more easily. This approach is intended to improve take-up, broaden multi-agency feedback, strengthen under-represented partner engagement and create a clearer impact loop showing how feedback shapes future delivery.

Quality and impact – what participants told us

Evaluation feedback across the programme shows consistently high satisfaction, with participants valuing **well-planned sessions, engaging delivery**, and clear “takeaways” that support practice.

Webinar evaluations – at a glance

Webinar / learning event	Evaluation results	What participants valued / learning impact
Talking Therapies	46 per cent rated 5/5; 54 per cent rated 4/5	Attendees described the session as very well presented, well planned and offering lots to take away to include information on pathways
Safeguarding Ambassadors – Falls Prevention	78 per cent rated 5/5	Participants valued increased awareness of preventative support available through CLCH and Open Age.
Peer Supported Open Dialogue (POD)	83 per cent rated 5/5	Participants described the session as very engaging and helpful in validating practice.
Bariatric Care: Professionals Guidance Launch	84 per cent rated 5 stars; 16 per cent rated 4 stars	Feedback highlighted that the guidance would support professional practice.
Learning Together – Safeguarding Adults Reviews	82 per cent rated 5 stars; 11 per cent rated 4 stars;	Participants valued the focus on executive capacity and self-neglect.
National Safeguarding Adults Week – Domestic & Economic Abuse	87 per cent rated 5 stars; 13 per cent 4 stars	Feedback showed strong satisfaction with the session.
Self-Neglect & Hoarding Strategy + Hoarding Toolkit Launch Event	88 per cent rated 5 stars 12 rated 4 starts	Participants valued the toolkit's relevance to live casework, supervision and partnership working.
SAR Malcolm learning session	90per cent rated 5 stars	The session strengthened understanding of SAR purpose, safeguarding thresholds, referral decisions and multi-agency escalation.
Understanding Hoarding webinar	Positive overall, with ratings ranging from 75 per cent 5 stars	Participants valued the focus on hoarding drivers, trauma-informed practice and lived experience. One response suggested some content needed more time.
Executive Capacity & Self-Neglect	88 per cent 5 stars	The session strengthened understanding of executive capacity using practical MCA insights and case examples. Challenges remain in this complex area of work

What the evaluation tells us – key strengths of the programme

Across the SAEB Learning Programme webinars, evaluation findings consistently demonstrate:

- High participant satisfaction
- Marked increases in practitioner confidence
- Strong appreciation for practical, real world learning
- Better awareness of services and resources
- Clear intentions to apply learning within teams

These themes provide strong evidence that the programme is well received, but also supports practice improvement by helping professionals and partners translate learning into action.

What the group will focus on in 2026 – 27

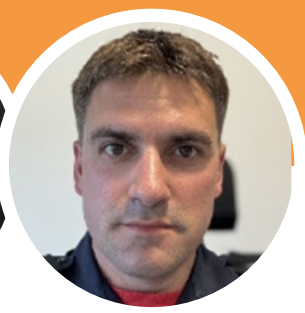
- Introduce a consistent post-event reporting template capturing sign-ups, live attendance, attendance conversion, evaluation returns, rating summary, partner reach and key learning themes.
- Strengthen evaluation prompts so respondents provide examples of intended or actual practice change, not only satisfaction ratings.
- Continue targeted follow-up reminders after webinars, particularly where evaluation return rates are low.
- Use the Learning and Development Subgroup to review attendance trends, gaps in partner feedback and future priority topics.
- Develop shorter learning outputs from longer webinars, such as key-message briefings, short videos or practice checklists, to improve on-demand engagement.

Appendix 3
Community Engagement Group end of year report 2025 - 26

Community Engagement Group

A year of high-impact, practice-focused learning across the partnership





Co-Chairs – Commumity Engagement Subgroup

Brian Jones
Chief Executive, Carers Network

Ben King
Borough Commander - Royal Borough of Kensington & Chelsea London Fire Brigade

The Community Engagement Group has continued to play a central role in supporting the Safeguarding Adults Executive Board's prevention, engagement and lived experience agenda. This year has shown that safeguarding is strongest when communities are informed, trusted, visible and actively involved in shaping the messages and resources intended to support them.

As Co-Chairs, we are grateful to members for their commitment, honesty and energy. The work described in this report demonstrates a clear direction of travel: from awareness-raising towards stronger community capacity, clearer evidence of impact and deeper partnership with residents, carers and community organisations.

Executive Summary

This report brings together the work of the Community Engagement Group, the BME Safeguarding Network and the SAEB Safeguarding Ambassadors into one integrated account of community-facing safeguarding activity during 2025–2026. It shows how the partnership has strengthened prevention through trusted conversations, accessible information, lived experience, cultural insight, awareness campaigns and practical resources. The strongest message from 2025–2026 is that community engagement is not simply a communication function. It is a route into understanding hidden harm, barriers to reporting, discrimination, hidden risks, carer pressure, isolation and the confidence of residents and community organisations to recognise and raise safeguarding concerns. The next phase is to strengthen evaluation so the Board can evidence not only activity and impact, but changes in confidence, knowledge, referral pathways and practice.

How Community Engagement Works

The Community Engagement Group provides the strategic route through which community insight, voluntary sector contributions and lived experience are reported into the Safeguarding Adults Executive Board.

The BME Safeguarding Network strengthens cultural insight, trusted conversations and inclusive safeguarding practice.

The SAEB Safeguarding Ambassadors bring lived experience leadership, co-production, prevention messages and accessible resources. Together, these three routes create a stronger bridge between the Board and local communities.

This appendix reports on all three activity areas of our Community Engagement work .

Community Engagement 2025–2026 priorities

1

Communities keeping themselves safe

Aim: Create an inclusive and diverse safeguarding culture, informed by community needs, and empower residents to raise safeguarding concerns.

2

Cost of living crisis

Aim: The cost-of-living crisis (local support services for food, financial, energy, and wellbeing needs).

3

Strategic priority: events, campaigns, and bulletins

Aim: Empower Safeguarding Ambassadors to raise awareness of abuse and neglect through campaigns and resource development.

How we met these priorities

In-Person Community Engagement Event
(June 2024): Delivered digital safety and scam awareness sessions.

Follow up Digital Evaluation Survey
outcomes shared with Met Police and the Councils Digital Teams

Advocacy Project Broadband Session:
Supported older residents through the BT digital switchover, with practical guidance and presentations from BT and digital teams.

Events
Safeguarding Ambassadors Falls Prevention Training and local services - May 2025
World Elder Abuse Awareness Day Tea and Talk June 2025 (promotion of Key messaging on Professional Curiosity)

National Safeguarding Adults Week- Nov 2025 Webinar - Domestic and economic abuse and the Cost-of- Living Crisis. prevention.

Bulletins / Campaigns
SAEB Learning Programme Library of Safeguarding resources by topic - June 2025 Stop the Pressure week & 7 Preventative Top Tips - Nov 2025
Safeguarding and Ageism 7- point briefing-Nov 2025

BME Safeguarding Network
Launch of "Say No to Abuse' Translated Leaflets into 7 Languages and MPS delivery of SCAM's and online Safety for specific heritage groups

BME Safeguarding Network report





Co-Chairs – of the BME Safeguarding Network

Maureen Brewster
User Involvement Coordinator, The Advocacy Project

Mercyline Ndeti
Organisation Development Manager, BME Health Forum

This year, the Network has created space for honest conversations about rights, abuse, harmful practices, discrimination, online safety, scams, language barriers, stigma, trust and the fears that may stop people from coming forward. The launch of translated safeguarding booklets and the Network's second anniversary event have shown how important it is that communities are not simply consulted, but actively involved as co-designers, trainers, educators and leaders.

Our message is clear: safeguarding cannot protect people it does not see. Prevention requires trust, accessible information, culturally sensitive support and safe routes into help.

BME Network 2025 – 26 - Activities and Learning

Know Your Rights: The Network began the reporting year with a practical session delivered with Healthwatch on NHS rights under the NHS Constitution. The session helped members and community partners understand rights and entitlements, including for migrants and carers, the right to choose a healthcare provider, and what people can do when something goes wrong.

Translated safeguarding information: In September 2025, the Network launched translated "Say No to Abuse" safeguarding booklets in seven languages. This was a significant achievement because safeguarding information only makes a difference when people can understand it, trust it and use it. The booklets support recognition of abuse, reporting routes and access to help through trusted community settings. The event also included a dedicated session on scams and online safety for specific heritage communities.

Voices of lived Experience: Harmful practices and protected characteristics. This session explored how culture, identity, discrimination, stigma, fear and lack of trust can affect risk, disclosure and access to support. They reinforced the importance of culturally competent safeguarding practice and the need to ask better questions before making assumptions.

Survey findings and lived experience discussions identified under-reporting linked to stigma, fear, cultural pressures, language barriers, lack of awareness and low trust. Community safeguarding concerns included isolation, mental health and wellbeing, digital risks, online abuse, financial abuse and scams, domestic abuse, self-neglect and hoarding, dependency-related exploitation and carer burnout.

The strongest message from the Network is that prevention requires trust. Safeguarding services and partner organisations need to be accessible, culturally competent and community-informed. The Network also reinforced that discriminatory abuse must be recognised explicitly within safeguarding practice, and that safeguarding cannot protect people who remain unseen.

Safeguarding cannot protect people it does not see

BME Safeguarding Network – Lived Experience Session, January 2025

Voices of lived experience

Samah (Forward organisation)

"We start with domestic violence, and abuse such as physical, sexual abuse, financial abuse, also it could be like forced marriage or FGM."

"A lot of women... came with spousal visa and then they have to stay in very bad life... If you talk about anything, I will send you back home and Sometimes it's very hard to bring them back. And with the children as well."

Disclosure barriers for LGBTQ+ survivors

"It's very difficult for them to talk about their sexualities... they always lived with their issues... and they do not trust the Middle Eastern charities." (Sodabeh)

Religious/cultural interpretations as barriers - Jane (Open Age)

"Religion can be used to maintain those lines of abuse... victims can internalise that as normal."

"If you're approaching health professionals where there's no cultural competence... that shame... gets further compounded."

Sodabeh (Middle Eastern Women and Society Organisation)

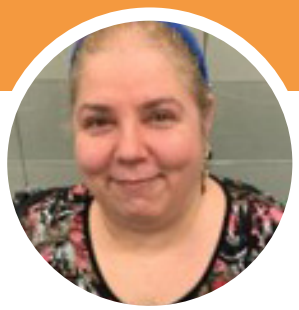
"Especially when they realise that person belongs to [the] LGBTQ communities... We had a case where the lady... got the knife from the hotel kitchen and the police had to move her to keep her safe."

"Lots of Middle Eastern charities... do not deal with this type of cases... they said we do not have any LGBT peoples in our communities. When you deny... then LGBT people never trust you, never come to you."

Reflections

The BME Safeguarding Network's lived experience session in January 2025 was a powerful reminder that safeguarding cannot be effective if people's realities are unseen, unheard or misunderstood. The voices shared in the session were clear: harm is not caused only by abuse itself, but also by the ways in which people can be denied recognition, culturally misinterpreted, or made invisible within services and communities.

Safeguarding Ambassadors report



Mariya Stoeva
Chair of the SAEB Safeguarding Ambassador Group

This year has been one of connection, learning and action for the SAEB Safeguarding Ambassadors. Throughout 2025–2026, we continued to use our lived experience, community knowledge and collective voice to raise awareness of safeguarding issues affecting residents across Kensington and Chelsea and Westminster. We are exceptionally proud of receiving National recognition from the National Prevention Team Award in 2025 at the National SAB Managers Network 'We See You - We Hear You' Awards for our contribution to prevention and co-production.

As Ambassadors, we care deeply about our neighbours, our communities and adults who may be at risk of abuse or neglect. Our role is to help people feel seen, heard, informed and supported, and to make sure safeguarding messages are shared in ways that are clear, inclusive and accessible.

This year we worked alongside the Safeguarding Adults Executive Board, community partners, the police, digital safety teams, local services and voluntary sector organisations. Together, we strengthened awareness, created practical resources and helped ensure that safeguarding conversations were shaped by the realities people experience in their everyday lives.

Awareness

Domestic abuse, ageism and elder abuse

Digital safety

Scams, online safety and trusted advice

Recognition

National Prevention Team Award 2025



Shared Community Engagement themes from across the networks

1. Community voice and lived experience: Across the Group, Network and Ambassadors, lived experience has strengthened the relevance, accessibility and humanity of safeguarding messages. Community testimony has helped partners understand hidden harm, invisibility, fear, stigma and the everyday realities that may prevent people from seeking help.

2. Access, inclusion and translated resources: The launch of our translated "Say No to Abuse" booklets and the ongoing development of Easy Read and accessible materials have strengthened the Board's ability to reach people who may not engage with formal safeguarding language or standard written information.

3. Prevention and early help: Webinars, campaigns, bulletins and community sessions have focused on helping residents, carers, volunteers and professionals recognise risk earlier. This included domestic abuse, economic abuse, cost-of-living pressures, falls prevention, elder abuse, scams, digital exclusion, pressure ulcers and modern slavery planning.

4. Cultural competence and trust: The BME Safeguarding Network reinforced that safeguarding prevention depends on trust, safe spaces and culturally sensitive support. Barriers such as stigma, shame, fear, language, immigration concerns, discrimination and low confidence can delay disclosure and increase risk.

Forward Priorities for 2026–2027

These priorities build on what we learned during 2025-26 and focus on helping communities respond earlier, improving referral routes, targeting prevention and showing the difference our work makes.

Priority	What we will do	Intended impact
Community Safeguarding Train-the-Trainer Programme	Pilot and evaluate a model that equips community leaders, staff and volunteers with clear safeguarding messages, tools and confidence to cascade learning locally.	Stronger community capacity and more confident local safeguarding conversations.
BME Safeguarding Network workplan	Develop a plan which is culturally supportive in understanding better how to respond to domestic abuse, carer burn out and digital risks such as online abuse.	Clearer community priorities shaped by cultural insight.
Safeguarding Ambassador priorities	Develop practical resources on memory-related risk and the Herbert Protocol, voice scam calls.	Accessible prevention messages shaped by lived experience and focused on emerging risks.
Modern slavery and exploitation	Increase community awareness and understanding of Modern Slavery, Exploitation, and Hidden Harms, ensuring adults at risk are better able to recognise concerns and know how to respond or report	Improve recognition of hidden harm through an Easy Read Modern Slavery leaflet and an Anti-Slavery Week webinar, covering key indicators, help-seeking routes, duty to notify and use of the National Referral Mechanism.

Appendix 4
QA Subgroup end of year report 2025 - 26

Quality Assurance Subgroup end of year report 2025–26



Co-Chairs – Quality Assurance Subgroup

Delyth Shaw
Strategic Safeguarding Lead, Bi-borough Adult Social Care

Kerry Loveless
Detective Chief Inspector, Adult Safeguarding (CSU, RMU, Triage & CAT) Central West (AW) BCU

This report summarises the work of the Safeguarding Adults Executive Board quality Assurance Subgroup during 2025–26.

1. Quality Assurance Framework

The Quality Assurance Subgroup provides assurance to the Safeguarding Adults Executive Board that multi-agency safeguarding arrangements across the Bi-Borough are impactful in terms of being effective, evidence-informed and focused on improving outcomes for adults. During 2025–26, the subgroup developed a Quality Assurance Framework to outline the mechanisms through which assurance will be provided to understand system performance, identify emerging risks, inform improvement activity and contribute to a culture of continuous learning.

2. The Four Pillars of Quality Assurance

Pillar	Purpose	2025–26 activity
1. Multi-agency data and performance assurance	To develop a stronger shared understanding of safeguarding demand, activity, outcomes, trends and emerging risks across the partnership.	Development and strengthening of a multi-agency dataset.
2. Multi-agency audit activity	To test the quality and consistency of safeguarding practice and ensure learning, including from SARs, leads to measurable improvement.	Development of a programme of audit activity.
3. Annual Self-Assessment / SAPAT	To seek evidence as to the effectiveness of safeguarding arrangements across the Bi-Borough	Oversight of SAPAT planning and annual assurance requirements.
4. Adult, stakeholder and partner feedback	To ensure that the experience of adults, carers and stakeholders informs safeguarding practice, service improvement and Board assurance.	Development of the revised adult and stakeholder feedback process.

3. Summary of progress and impact of activity

3.1 Multi-agency Data Set

The subgroup has made significant progress in developing a more meaningful multi-agency safeguarding dataset. Rather than relying solely on local authority safeguarding activity, the subgroup agreed that assurance should draw on wider partner intelligence and should help the Board answer the "so what?" question: what the data tells us about impact on risk, quality, and outcomes.

Analysis presented to the subgroup highlighted:

- Increasing safeguarding activity overall (in line with the national picture).
- Referrals from health partners making up the largest referral source.
- A significant proportion of concerns (40%) being related to crimes reported to the police.
- Variation in the types of abuse according to referrer – for example London Ambulance Service are more likely to make referrals in relation to neglect, London Fire Brigade for hoarding and self-neglect and cuckooing by police.
- Areas of social deprivation correlated with a higher volume of safeguarding activity.
- Increasing Deprivation of Liberty Safeguards (DoLS) applications across both boroughs, with Westminster City Council receiving a higher proportion of referrals from hospitals and the Royal Borough of Kensington and Chelsea from care homes.
- An increase in the number of Section 21A challenges made to the Court of Protection for people under DoLS reflecting a greater awareness of people right's and of the need to challenge placements where people are objecting to their care and support arrangements.
- That provider data reflects the effectiveness of the prevention focus and partnership working between Commissioners, Quality Assurance Team and provider services in keeping risks low and avoiding the need to progress cases to a full Provider Support process

- Police and Mental Health services data on S135 and S136 detentions under the Mental Health Act and consideration of the impact of the changes brought in through the 'Right Care, Right Person' strategy.
- London Fire Brigade data on Home Fire Safety Visit referrals and outcomes.
- Pressure ulcer recording in the context of safeguarding and to seek assurance that the Pressure Ulcer Protocol is being used consistently and effectively.
- Local authority data in relation to the interface between unpaid carers and safeguarding concerns.
- Following the launch of the SAEB Persons in Positions of Trust (PIPOT) Framework in April 2026, PIPOT data from key health partners to seek assurance that responses and outcomes align with the overarching principles of the framework.

3.2 Multi-agency Audit Activity

Following the completion of the multi-agency audit into the application of the Mental Capacity Act in practice, the subgroup undertook a quality assurance exercise to review mental capacity and safeguarding data, looking at cases in which mental capacity assessments were completed as part of a Section 42 enquiry. This highlighted that formal mental capacity assessments were completed in a quarter of Section 42 enquiries and that most assessments found that the adults lacked mental capacity to the specific decision under consideration. Neglect / acts of omission was the most common abuse type for cases in which mental capacity assessments were completed.

This audit activity led to recommendations being made to improve the recording within the social care database when completing mental capacity assessments, including a new coding option for cases where capacity is not relevant to the safeguarding concern, making it mandatory for practitioners to record a rational when capacity is "not assessed" and clarifying practice expectations so that Mental Capacity Act recording better reflects decision-making and safeguarding outcomes overall.

3.3 Annual Self-Assessment / SAPAT

The subgroup contributed to the Safeguarding Adults Partnership Audit Tool process and supported the Board's wider annual assurance cycle. This included discussion of minimum expectations across London Safeguarding Adults Boards: reviewing achievements, agreeing annual report contributions, discussing challenges and setting priorities for the business plan. The subgroup's role in SAPAT will continue to develop, ensuring that audit findings, self-assessment evidence and partner challenge are connected to the Quality Assurance Framework and future improvement planning.

3.4 Adult and Stakeholder Feedback

The subgroup had oversight of changes to the adult and stakeholder feedback process for safeguarding enquiries. The aim was to move beyond counting activity and gather stronger more qualitative evidence about peoples lived experiences: whether adults and families felt listened to, involved and safer as a result of safeguarding interventions. Additionally, to ensure we have a robust mechanism for obtaining feedback from partners and stakeholders involved in enquiry processes.

A pilot of the revised process took place over March–June 2026 to introduce a more flexible and proportionate model, with Safeguarding Adults Managers seeking feedback at the end of Section 42 enquiries where safe and appropriate. The results of the pilot reflected positive feedback that safeguarding enquires are carried out with compassionate, trauma-informed and sensitive practice. People valued practitioners who listened carefully, respected the adult's wishes, explained options and helped them feel more confident that concerns had been addressed. Stakeholders described enquiries as clear, supportive and well managed, with effective safeguarding leads, good governance oversight, timely sharing of outcomes and collaborative multi-agency working.

The pilot also identified clear improvement messages. Some adults and partners were positive about the outcome but unclear about what was happening during the enquiry or did not receive timely updates when there were unavoidable delays. The pilot also reflected that feedback needs to be sought more routinely throughout the enquiry process – from beginning to middle to end.

Why this matters: The pilot strengthens Making Safeguarding Personal by placing adult, family and partner voice at the centre of quality assurance. It gives the Board direct insight into whether people feel listened to, safer, informed and involved, while creating a clearer route for feedback to influence supervision, training, operational practice and partnership improvement. The next step is to embed the process as business as usual, report themes regularly to the Quality Assurance Subgroup and SAEB and use the learning to strengthen communication throughout safeguarding enquiries.

"The social worker was very professional and compassionate"

"I am dealing with the aftermath but I'm a strong individual. I am happy with the support and advice I was given by the LEO and thankful that my wishes were respected"

"The issue was dealt with and executed excellently"

"I appreciate everything the LEO has done and he has helped immensely"

4. Priorities for 2026–27

1. Publish the Quality Assurance Framework, ensuring it aligns with other established assurance frameworks, such as the Quality Management Systems in place in health services.
2. Build upon the multi-agency dataset and strengthen partner contributions to include police and CNWL mental health data, London Fire Brigade Home Fire Safety Visit information, carers' data, PIPOT assurance and health-related safeguarding intelligence.
3. Roll out the adult and stakeholder feedback model as business as usual, with regular reporting to the subgroup and SAEB and a focus on improving communication throughout safeguarding enquiries.
4. Develop a programme of multi-agency audit activity, including an audit to evaluate the impact of the Self-Neglect and Hoarding Strategy and Cuckooking on practice