Contents

Foreword

I am so pleased to be asked to introduce the Hammersmith and Fulham Safeguarding Adults Board's (H&F SAB) Annual Report. 2024/25 marks the second year of our three-year strategy, with a focus on building on our initiatives in 2023/24. This report highlights continuation of existing projects as well as the introduction of new pieces of work. It provides fascinating detail on how partners rose to the challenge of safeguarding adults locally throughout the last year. It also identifies further opportunities for action as we move into the final stage of our strategic plan and shift our view to reviewing the impact of these initiatives.

I was appointed as Independent Chair to the Board in July 2024 so would like to thank Mike Howard who stepped down after six years as the Chair. I also want to pay tribute to the many people from across our workforce and communities who welcomed me and so generously shared their skills and knowledge to support the H&F SAB's common goals. I have been impressed by the compassion, energy and conscientiousness across the board. I particularly want to pay tribute to our SAB manager, Ceri Gordon, who has

worked tirelessly to enable SAB partners to undertake their many important statutory functions. Her leadership (at a time of considerable structural and financial change across the public sector) to develop tools and practice guidance, thereby embedding learning from Safeguarding Adults Reviews has already been recognised by partners and the workforce. In addition, the work she has done to develop the H&F SAB website is remarkable!

I hope you will agree with me that there is much of interest within this report. I look forward to working with partners and our communities in the coming year. We saw such innovation with services working across geographical and organisational boundaries to pro-actively anticipate need and respond to reduce risk to our most vulnerable residents. It is clear to me that, despite the challenges, the responsibility to safeguard adults must remain 'business as usual'.

Fiona Bateman
Independent Chair

Safeguarding Adults in Hammersmith & Fulham

The Care Act statutory guidance defines adult safeguarding as: "Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances" (14.7).

The Hammersmith & Fulham Safeguarding Adults Board (H&F SAB) is a multi-agency partnership that leads on adult safeguarding work in the borough, and is a statutory body required by the Care Act 2014. The H&F SAB is not an operational body and so not responsible for the delivery of services - our partner agencies lead on the delivery of services for adults with care and support needs. However, the H&F SAB brings partners together and facilitates the building of collaborative relationships to prevent abuse and neglect where possible and ensure timely and proportionate responses when abuse or neglect have occurred. The SAB also has responsibility for providing a systems oversight and quality assurance function. We work across partners and other partnerships within Hammersmith and Fulham, but also with regional and national bodies to raise awareness of risk, opportunities for improved practice and lobby, when needed, for policy change.

If you have reason to believe that an adult with care and support needs is being harmed in any way, by another person please do not ignore it.

In an emergency, or if you suspect you or someone else is in immediate danger, call 999.

If you do not need immediate help from the police or are worried about calling them, you can contact H&F Adult Social Care (ASC) on freephone 0800 145 6095. This phone line is open 8:45am to 5pm, Monday to Friday. You can also email the adult safeguarding hub at safeguardingadults@lbhf.gov.uk.

Outside of these hours you can call 020 8748 8588.

You can find out more about raising adult safeguarding concerns in Hammersmith and Fulham on the H&F Council website.

Safeguarding Adults Reviews

What is a Safeguarding Adults Review?

When an adult at risk either dies or suffers serious harm, and when abuse or neglect (including self-neglect) is thought to have been a factor, Hammersmith & Fulham SAB may seek to review what has happened in order to identify multi-agency learning. This is called a Safeguarding Adults Review (SAR) and is a statutory duty of the SAB under Section 44 of the Care Act. A SAR is a review of past events and only undertaken in specific circumstances.

The main purpose of these reviews is to find out if we can learn anything about the way different organisations worked together to support and protect the person who suffered harm to prevent future harm if similar circumstances arise. This could identify barriers, but it could also identify good practice and help us to make positive changes to the way we work.

These reviews are not the same as safeguarding enquiries which are routinely undertaken in response to live concerns of abuse and neglect of an adult at risk under Section 42 of the Care Act. Safeguarding enquiries aim to determine whether abuse or neglect has happened and put plans in place to protect the adult from future harm. If there is concern about an adult at immediate risk of harm, actions will be taken very quickly to protect the adult at risk of abuse or neglect and anyone else who may also be at risk. The process is a supportive one which seeks to work with the person at risk of harm to achieve personalised outcomes.

If you are worried about possible abuse and neglect for yourself or another adult you know, it is important to report your concerns and seek support. .

The role of the Safeguarding Adults Case Review Group

The Safeguarding Adults Case Review Group (SACRG) is a subgroup of the H&F SAB which aims to ensure that our statutory responsibilities are carried out in respect of Safeguarding Adults Reviews (SARs). Its responsibilities include reviewing referrals where cases may meet criteria for a SAR, as well as monitoring responses to recommendations from previous reviews. The group is currently co-chaired by Liz Hughes (Principal Social Worker and Strategic Lead for Adult Safeguarding, LBHF Adult Social Care) and Mark Staples (Detective Chief Inspector, Central West BCU Metropolitan Police Service).

In 2024/25, following reflection on the experiences in engaging with processes for SAR Alison and SAR Brian, the SACRG set out to establish a H&F SAB SAR Policy in collaboration with the Quality in Practice Subgroup. This has led to clearer expectations for all stages of the SAR Process. SAB members reflected on the positive impact of this at our recent Development Day (March 2025) and in response to the Safeguarding Adults Partnership Audit Tool (SAPAT).

In July 2024 the SACRG established a review of historic referrals to the subgroup which did not proceed to a SAR. An initial review of these cases identified that whilst learning was being captured within the SACRG it was not being disseminated more widely, and some of these cases may have met statutory criteria for a SAR under Section 44. In order to ensure the learning is not lost, available records have been reviewed in order to capture case summaries, identify learning themes and confirm next steps (see Appendix 4).

This approach has ensured a proportionate response to case review, with recognition of the passage of time in the cases being revisited. In some cases, the learning from these cases have been fed into other review processes. As part of our objective to share the learning more widely and gather insights on how subsequent changes to local practice expectations would impact on similar cases today, individual case summaries have also been developed into workshop exercises to engage with operational leads and frontline staff. The outcomes of these exercises will be developed into learning briefings for wider dissemination, with reporting to the SAB to support assurance of current safeguarding practice and identify any areas for further exploration by the SAB.

Since this time, the SACRG has also reviewed its Terms of Reference and introduced new decision-making tools which should support clearer discussion of the three criteria for the Section 44 duty and a rationale for the final decision. Moving forward, the SACRG will continue to undertake its core function of reviewing new referrals and making recommendations on whether criteria for SAR is met and what this will look like. The SACRG have recommended an improvement action to review our tracker process for embedding learning from SARs to ensure that this is robust and that we have sufficient

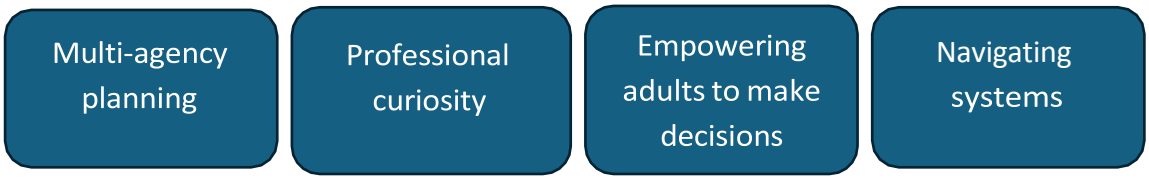
assurance of our responses to SAR learning. This review will be an initial focus of 2025-26, looking to introduce clarity of what it is we want to achieve with each action point and how we will secure assurance from partner organisations to better evidence and monitor progress.

What we've learnt

In March 2025, the H&F SAB accepted the findings of a SAR which explored the circumstances surrounding a near fatal incident leading to life-changing injuries for a young man in his early 20s called 'Hussain' (pseudonym). Hussain was receiving care and support for his health and social care needs from multiple local agencies, but there was a lack of clarity about which agency was leading on identifying relevant services and support for Hussain. In addition to mental health needs, Hussain presented with signs that indicated he may have autism spectrum disorder (ASD) and / or a learning disability. Hussain's family members supported him with all his daily needs, providing significant support during appointments by providing information and responding to questions on Hussain's behalf. Hussain had no formal secondary school education in the UK, and no Education, Health and Care Plan (EHCP) and was subsequently not supported by usual transitions processes.

The SAR sought to identify learning in relation to pathways of support where multiple health and social care services are involved, multi-agency working and information sharing, and assessment and appropriate support provision timeliness.

Learning was identified in several areas, including:



Multi-agency planning:

The review found that there was limited evidence of multi-agency approaches, such as identifying a lead professional, holding multi-agency strategy meetings, or the development and management of multi-agency care plans, and risk management plans.

This approach would also have strengthened information sharing, which the review noted could have been improved to affect meaningful and collaborative working relationships.

This learning reinforces the need for the H&F SAB to continue to promote existing resources to support frontline professionals in adopting multi-agency approaches as part of standard responses to potential risk.

Professional curiosity

The review suggested there was a lack of professional curiosity about how Hussain's lived experience may influence his needs.

The H&F SAB has developed resources in response to previous learning to support understanding of professional curiosity which is available for use within team meetings and reflective spaces and will commit to continued promotion of this resource.

Empowering adults to make decisions

Whilst Hussain's family are an important source of support for him, the review noted that professionals had an overreliance on Hussain's family members to make decisions and communicate on his behalf. A timely mental capacity assessment and resulting appropriate actions would likely have increased opportunities for Hussain to be supported to make his own decisions and communicating his views about his treatment, care, and support, independently of his family.

Navigating systems

Hussain and his family found it difficult to navigate the complex local health, social care and housing landscape, and the review has suggested work be undertaken to improve access to information on local systems and services in accessible formats.

The review has also highlighted the need for timely assessment and diagnosis (including Care Act assessments and Carers Assessments) noting the potential this had to improve outcomes for Hussain.

Wider context and good practice

It is important to note that the independent reviewers sought to place this learning within the wider context of increasing operational pressures and limited resources which are faced by all partners. Good practice was also noted, including evidence of timely and proportionate responses to presenting information. For example, professionals responded in an appropriate and timely manner to Hussain's family's concerns that he had undiagnosed ASD by referring him for an ASD assessment in 2021.

Responses to learning

The reviewers for SAR Hussain posed a series of questions to SAB members in relation to the key themes identified within the review.

Partners have been invited to respond to these questions outlining how their individual organisation will respond. This will be used to formulate subsequent SAB action plans.

The SAB has also continued to promote learning from previous reviews and build on our existing thematic action plan. This has included using key themes and topics emerging from local reviews to develop reflective learning spaces.

In addition to responding to the learning from SAR Hussain, we have also continued to develop responses to specific recommendations from previous SARs in H&F.

Responding to abuse of staff

SAR Brian found that on occasion Brian would display racist and abusive behaviour in various settings and towards professionals, and could be aggressive to professionals from all backgrounds. It was recommended that the SAB review local policy and processes for challenging abuse towards staff. Two surveys were developed to get a better understanding of what support was currently in place for staff working in Hammersmith & Fulham. The first was aimed at SAB members and sought to gather assurance on existing policies and guidance within partner organisations. A second survey was aimed at staff to measure awareness of existing policies, procedures and guidance and to gather their views. Partner members have been given access to this data to allow for consideration of internal responses to the feedback from staff and report back to the SAB in order to determine any future role for the partnership.

Supporting multi-agency responses

Both SAR Brian and SAR Alison made recommendations focused on multi-agency working, including promotion of best practice expectations and frameworks which seek to support professionals in practice. The SAB continues to highlight these recommendations and promote tools that can support professionals in this area, with recognition of continued need to increase confidence in establishing multi-agency meetings and shared action plans.

Improving quality of Independent Management Reports (IMRs)

The lead reviewer for SAR Brian also recommended that the SAB consider development of training to support the completion of IMRs to ensure quality and consistency. Following consideration by the SAB, it was agreed that resources needed to be developed as part of wider standards and processes when inviting anyone to be part of a SAR panel.

This work needed to incorporate considerations of how we support staff, with any introductory session needing to caveat what we are going to be talking about in acknowledgement that this content can sometimes be distressing, and some agencies may not have been privy to all information up to this point.

The newly drafted Term of Reference for the SACRG sets out responsibilities and expectations for future SAR processes to support this aim, including proposal for introductory meeting at start of process. This is complemented by new H&F SAB guidance on completion of IMRs.

Newly commissioned SARs

The number of referrals being received at the SACRG has increased in 2024/25, rising to nine from just three referrals in 2023/24[1]. The quality of referrals has also improved following review of the SACRG referral form, and many of the new referrals have led to a decision to commission a SAR. The following reviews have been commissioned in 2024/25:

***Adult D**:* Adult D was a 58-year-old man who had care and support needs relating to his learning disability and mobility. Adult D died in December 2023. His death was linked to bowel perforation and sigmoid volvulus (where the sigmoid colon twists on itself). A package of care was in place to support Adult D with personal care, meal preparation and accessing the community. Adult D lived alone in his own home and had previously lived with his brother, with whom he was very close prior to his brother's death in 2022. Early themes identified in Adult D's case include timeliness of assessment and appropriate care planning, identification of and response to risk, including information sharing, and timely exploration of mental capacity.

Thematic Review of Suicide: This SAR aims to better understand what is happening locally that means death by suicide is happening at a greater rate in H&F than our neighbours. A thematic review model will be adopted, examining key issues and learning from a selected sample of cases in order to identify insights into safeguarding strategies that can enhance the effectiveness of interventions to reduce suicide rates in H&F. This review has been funded by LBHF Public Health.

Adult E and Adult F: This SAR has been commissioned in response to two separate referrals reviewed by the H&F SACRG where domestic abuse was a feature. In both cases there was identification of an adult at risk who had survived a serious assault. As the adults had experienced significant harm as a result of the abuse it was agreed that Section 44 criteria for a Safeguarding Adults Review were met. Whilst there were different circumstances in the two cases, it was felt that there were similar themes, and it was proposed that a joint approach could be taken to the reviews. The SACRG have proposed that key lines of enquiry will include identification and response to domestic abuse, including exploration of generational and cultural silence, multi-agency responses, support for carers, and application of the Mental Capacity Act.

***Thematic Review: Chemsex**:* This SAR has been commissioned in response to case of Adult H, a young man who experienced poor mental health which was compounded by high-risk drug use, including chemsex. During a welfare check by hostel staff in December 2024, Adult H was found to be unresponsive. Adult H is one of three recent chemsex deaths in Hammersmith & Fulham since September 2024. As this is a new

[1] This data is based on date of referral rather than date of decision by SACRG. Some referrals will have been considered by SACRG in following financial year (2025/26).

and emerging phenomenon noticed by NHS, drug treatment and criminal justice agencies, we want to understand thematically what can be learned from these three deaths in addition to the specific learning from Adult H's case. This review will be funded by LBHF Public Health.

Adult I: The SACRG made recommendation to proceed with a SAR in response to the death of Adult I, a 54-year-old man who was receiving palliative care at the time of this death. He required support with mobility, and carers provided support with daily living tasks, and had a history of rough sleeping dating back to his childhood. Adult I had also experienced neglect in his childhood. The impact of actions taken in response to the recommendations from SAR Brian (published in 2023) will also be considered in this review, which will seek to identify recurring learning themes. This includes areas such as impact of homelessness, past trauma, and drug use on engagement, the effectiveness of information sharing, case coordination and decision making and understanding of organisational duties.

Our progress against our strategic aims

2024/25 marked the second year of our three-year strategic plan, where we sought to build on the projects we established in 2023/24. With this focus, the SAB has accomplished a number of key initiatives including our first multi-agency audit, development of new SAB-led learning opportunities and the introduction of new escalation pathways.

Our strategy has three priority areas, each with their own focused aims and measurements for success.

Effective systems and processes: We will use an evidence-based approach to develop our responses to potential abuse and neglect and areas of complexity

Responses to self-neglect

We set out to embed key messages of the SAB multi-agency self-neglect guidance (agreed in 2023/24) as part of our ongoing commitment to improve our response to, and understanding of, self-neglect and make use of analysis to identify pathways for earlier interventions and support. In December 2024, the Quality in Practice subgroup (chaired by Helena Peros, H&F Designated Professional Safeguarding Adults, NHS North West London ICB and Mark Dronfield Senior Operations Manager, Turning Point) presented the findings of a multi-agency self-neglect audit which identified recommendations to support improved responses to self-neglect.

The audit findings pointed to the importance of professional strategy meetings being held at the beginning of any process to enable risk assessment and identification of a lead agency; any agency should be able to call this meeting proportionate to their role,

under the risk assessment process. Professionals must also ensure that concerns are being responded to, and we need to collectively encourage a culture of owning responsibility for our concerns and ensuring that someone is picking up on referrals being made. To help embed this, it was recommended:

- That the H&F SAB seeks to embed this as best practice in multi-agency responses to risk via promotion of existing resources, including risk management tools and multi-agency meeting and action planning templates, which considers whether all appropriate agencies are being involved in the discussion and timely information sharing.
- That the H&F SAB establishes a multi-agency escalation pathway, in line with existing SAB work-plan for 2024/25.

The audit panel also reflected on the importance of professionals avoiding assumptions and pre-judgments (including those based on presentation without official diagnosis). This could impact professional curiosity, and there could be more to the story that is being missed by making these assumptions. It is important to be clear on source of information, as it may influence how person is supported, and professionals must be careful in their use of language when making referrals and keep it factual. Links were also made to professional challenges in the presumption of mental capacity and responding to repeated 'unwise decisions'. Recommendations were made:

- That the partnership considers how best to embed lessons on application of the Mental Capacity Assessments within the context of self-neglect.
- That The H&F SAB supports messaging in relation to use of language and professional curiosity, with each partner agency committing to support this aim by ensuring messages are shared within their organisation.

These recommendations will be taken forward in 2025/26.

In addition to the focus on the self-neglect audit, the SAB has continued to promote the existing multi-agency guidance and accompanying tools. Over the year we held six 'Lunch and Learns' to explore topics that link to the guidance, including a focused session which presented the findings of the multi-agency audit.

Self-neglect remains a key theme for our partnership, and our focus in the next year will be to determine how we measure our impact.

Understanding of how abuse and neglect impacts different communities

The Quality in Practice subgroup have incorporated regular data reporting via the quarterly dashboard which provides breakdown of demographics across safeguarding concerns received in Hammersmith & Fulham.

The SACRG have also sought to ensure that newly commissioned SARs seek to understand the impact of a person's cultural background and how intersectionality with

other characteristics such as age and disability have influenced their experiences, and that this is clear within key lines of enquiry. Once published these reviews will complement the reflections already provided by SAR Brian last year, which explored the impact of Brian's background on his interactions with services.

The SAB will continue to ensure that this approach is embedded in SAB business as part of standard practice.

Ensuring effectiveness of safeguarding activity

The SAB has sought to strengthen its assurance processes in order to ensure the effectiveness of safeguarding activity and that safeguarding practice is continuously improving. As part of this, the SAB has introduced regular themed assurance pieces to its quarterly SAB meetings, whereby SAB members have been asked to respond to focused questions outlining the data they collect and how this can be used to assure ourselves of responses to specific areas of safeguarding, sharing examples of services or programmes which target a specific need. Themed assurance pieces to date have included transitional safeguarding and adult safeguarding and homelessness, the latter of which informed response to ministerial letter sent in May 2024 with recommendations for SABs regarding individuals who are rough sleeping (see Appendix 1 for more details of these assurance pieces).

The Quality in Practice subgroup also plays a key role in scrutinising local data and has identified areas for further analysis, allowing for more in-depth understanding of local responses to risk of abuse or neglect. This has included a review of cases which did not proceed to enquiry which has led to development of new briefing to support professionals when raising an adult safeguarding concern, with plans to develop more in-depth guidance in the next year.

The Quality in Practice subgroup is now firmly established in its core activity and will continue to provide this oversight whilst responding to emerging themes or learning leading to specific assurance pieces.

Partner spotlight: In May 2024, Adult Social Care commissioned a review in collaboration with partners in Health and Care and undertaken by Making Connections to consider how we discharge our duty of care under the 2014 Care Act. This led to a safeguarding improvement plan to develop local responses to adult safeguarding – find out more about the actions taken in our partner spotlight.

Supporting multi-agency escalation pathways

Last year, SAR Brian highlighted the importance of knowing when to escalate agency concerns regarding work relating to the Safeguarding of Adults at Risk.

In December 2024, the SAB agreed a new escalation pathway, which was published on the H&F SAB website in April 2025 following final amendments.

The terms of reference for the High-Risk Panel have also been adjusted to ensure that this complements the new pathway, reestablishing the role of the High-Risk Panel as part of the escalation mechanism once all usual multi-agency pathways have been considered.

Creating a culture of learning: We will promote continuous improvement in safeguarding practice by learning from experience and supporting workforce development.

Joint development of multi-agency resources and learning opportunities

This year, the SAB wanted to renew our collective commitment to the joint development of multi-agency resources and learning opportunities which promote learning and best practice, with specific focus on multi-agency working.

As part of these aims, the SAB launched a programme of 'Lunch & Learns' which focused on key areas of learning identified by the SAB, including self-neglect, trauma informed practice and transitional safeguarding. These are open to all professionals working in H&F and registration numbers are gradually increasing, however we have continued to see a high drop-out rate from initial sign-up with attendance averaging at 36%. As we explore how the SAB's programme of focused workshops will be renewed in 2025/26, we will consider how different approaches may support aims to increase our reach and see greater numbers of professionals accessing this space.

We also have examples of training sessions designed and delivered by partners in response to specific areas of learning including our very first 'Lunch & Learn' delivered by Sally Jackson (Partnership Manager, Standing Together) which focused on domestic abuse and older adults, and a workshop which explored mental capacity and substance use using the example of SAR Brian delivered by Dr Effie Kavatha and Mark Dronfield (Turning Point). These follow the workshop on home fire safety previously delivered by Jim Berry (London Fire Brigade) in 2023/24.

The Quality in Practice subgroup has also continued to contribute to the design of shared resources in response to learning, such as new guidance to support professionals when referring safeguarding concerns to the local authority. Responses submitted to the SAB survey also outline work within organisations that support this objective, and Quality in Practice subgroup members also regularly share details of external training opportunities with links to local learning so that these can be shared more widely.

Partner Spotlight: As part of the annual participation in the Safeguarding Adults Partnership Audit Tool, our partners have shared details about internal learning and development offers. In addition to assurance on delivery of mandatory training, partners shared examples of how they seek to embed learning. One example of best practice comes from the safeguarding team at Central London Community Healthcare NHS Trust. The team hold journal club webinars open to all staff to share learning from national and local SARs, as well as writing and disseminating 7-minute learnings via the monthly quality forums and through bespoke training sessions to share learning from national and local SARs. Primary Care Providers have also reported feeling that they are better informed about SAR outcomes than in previous years. Recognition must be given to the work of the Designated Lead Professional for Adult Safeguarding in promoting this learning, with a dedicated slot for adult safeguarding at each quarterly GP forum. In addition, the Designated Lead Professionals facilitate bi-monthly reflective safeguarding supervision for Continuing Healthcare and Complex Mental Health Placements staff which provides an opportunity to discuss the practice issues identified in the SAB 7-min briefings and other learning.

Increasing engagement with frontline staff

The SAB wants to support frontline staff to feel confident to respond to adult safeguarding concerns.

As part of these efforts, the SAB has established mechanisms for seeking to share resources and guidance with frontline staff, including the now embedded newsletter and website. The 'Lunch & Learns' have also been a first step in trying to increase our engagement with frontline staff and have been designed so that they provide space for professionals to share their own experiences and insights on adult safeguarding practice.

It is recognised that more is needed to strengthen this engagement, and plans are in place to allow for more direct input on the development of future priorities as we near the end of our three-year strategy. A particular focus for the SAB in the next year will be to seek to increase confidence in establishing multi-agency meetings and shared action plans in response to risk and for this to be a standard part of practice prior to any escalation, including to High-Risk Panel, utilising tools developed by the SAB.

Ensuring the voice of lived experience informs our work

It has been a key objective of the SAB to ensure that we develop mechanisms to capture the voice of those with lived experience of adult safeguarding enquiries in H&F and using this to inform practice. This was highlighted in our last annual report as an area for improvement.

In response to this, new templates have been developed to allow feedback on experiences of safeguarding processes. These templates include prompts to think about how we are involving people in safeguarding work and whether we are giving opportunities for people to express their views and wishes. There is a plan for an initial trial of these tools by Libra Advocacy Services beginning in April 2025, before considering how other partner agencies can utilise these tools.

As we seek to develop our plans for new strategy in 2026/27, we will also be seeking to introduce stronger co-production, allowing direct input into the SAB's priorities.

Partner Spotlight: Our partners have lots of examples of proactive and positive engagement with adults with lived experience. This includes patient participation groups and co-production groups. Imperial College Healthcare NHS Trust have also highlighted plans to adapt Martha's Rule to assist people with vulnerabilities to be able to raise a cause of concern regarding their care.

Communication and partnership: We will work to build active partnerships and expand our network.

Building stronger relationships with local voluntary and community sector

We want to build stronger relationships with the local voluntary and community sector (VCS) in our borough, as we recognise that these groups often have a strong insight into local issues and can help the SAB to increase our engagement with residents.

Initial planning work to strengthen our relationships with the VCS began in September 2024 working with key SAB members such as Libra Advocacy Ltd and Carers Network.

This has led to a proposal that the SAB offer support to the VCS via a focus groups offering practical support – for example support to collectively work through an audit process for VCS services, establishing a peer support network to share resources and advice. It has not yet been possible to deliver a targeted session built around this offer despite exploration of different approaches to doing so, however it is hoped that this will be delivered as part of our 2025/26 workplan.

The SAB Chair and SAB Manager have also recently been invited to attend key forum spaces such as the Providers of Older People's Services Forum. Following these interactions, we are also exploring engagement with the newly re-vitalised residents' forums to increase our reach.

We are very much at the start of this journey, and as we establish the above offers, we will be able to review the impact and consider the links to service users and residents.

Developing mechanisms to raise awareness of adult safeguarding

Much of our focus in the initial stages of this strategy has been on establishing resources which support professional practice. The SAB recognises the need to ensure we also develop mechanisms to raise awareness within H&F communities on how to spot signs of potential abuse and neglect, and how to seek support and as such this was stated as a specific aim for 2024/25.

Many of the SAB's partners delivered awareness raising campaigns as part of National Safeguarding Adults Week in November 2024. For example, Adult Social Care colleagues established a presence in Hammersmith throughout the week to share information about adult safeguarding and engage with residents. This activity was also supported by London Fire Brigade who joined stalls to share information about home fire safety. There is ambition to improve on this as part of November 2025 activities, involving a greater range of partners and visiting different locations.

As part of this activity, new leaflets were drafted focusing on both a general introduction to adult safeguarding and more focused information on self-neglect. The SAB website has also been used to introduce new content aimed at adults at risk, carers and H&F residents, and these resources will be continually developed throughout 2025/26.

As we move into the final year of our strategy, we will also be exploring how we ensure our resources are accessible to all without overreliance on digital literacy.

Our next steps

At our Development Day in March 2025, SAB members reviewed our achievements in the last year and considered our future challenges in order to identify specific aims for the next year. These aims will be incorporated into our wider work plan as we enter the final year of our three year strategic plan, with our focus in the final year being to review our impact.

A key focus for the Quality in Practice subgroup in 2025-26 will be to consider the impact of the resources which have been generated by the SAB in the last couple of years. This will include reviewing data in relation to allegations against Persons in Position of Trust (PiPOT) and establishing mechanisms to assess the impact of learning tools and guidance, with specific focus on the discriminatory abuse briefing and multi-agency self-neglect guidance and tools – including use of escalation. The Safeguarding Adults Case Review Group will continue to undertake its core function of reviewing new referrals and making recommendations on whether criteria for a SAR is met and what this will look like, as well as reviewing the way in which we seek assurance on our responses to learning to ensure that we can evidence change.

To find out more about our plans, see our latest updates on workplan which complements our overarching strategic plan.