CHSAB Annual Report 2024–25

People should be able to live a life free from harm in communities that are intolerant of abuse, work together to prevent abuse and know what to do when it happens

City and Hackney
Safeguarding Adults Board

Accessibility statement

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Introduction by Claire Solley

I am very pleased to introduce the Annual Report of the City and Hackney Safeguarding Adults Board 2023/24 (the Board), which is a key statutory duty. As the Independent Chair of the Board, I am extremely grateful to all partners for their continued engagement and support to safeguard people living in the City and Hackney in the context of ongoing challenges in responding to changing safeguarding risks and needs. The relationships between the Board's partners continue to be positive and collaborative, and appropriately challenging when seeking assurance that we are all meeting our safeguarding responsibilities.

The annual report describes what the Board has been doing as well as what individual Board partners have achieved during the year. It provides a picture of who is safeguarded and why. This helps to inform the Board's annual strategic plan and priorities for 2024/25. There continues to be learning from Safeguarding Adults Reviews that provide a focus for improvements in safeguarding practice and processes. This is reflected in the annual strategic plan and out priorities for 2024/25. There continue to be significant contextual factors that impact on people's lives and potentially increase safeguarding risks, such as the ongoing increases in the cost of living and the long-term legacy of the Covid-19 pandemic. The Board and its members continue to address these challenges and seek ways in which residents experiencing risks of abuse or neglect can be supported and protected.

I want to use this opportunity to thank all the practitioners and staff from the wide range of partner organisations and agencies, volunteers and residents in City and Hackney who are committed to keeping people safe in the City and Hackney. They have supported and continue to support people at risk of abuse or neglect, often without recognition, and make a huge and significant positive contribution to many peoples' lives.

Dr Adi Cooper OBE,
Independent Chair, City and Hackney Safeguarding Adults Board

What is the Safeguarding Adults Board?

Role

The City and Hackney Safeguarding Adults Board (CHSAB) is a partnership made up of both statutory and non-statutory organisations. A range of organisations attend the Board including health, social care, housing, criminal justice and fire services, voluntary sector and residents who use services in the City of London and Hackney. The role of the CHSAB is to assure itself that organisations based in the City and Hackney have effective safeguarding arrangements. This is to ensure that adults with care and support are protected and prevented from experiencing abuse and neglect.

The CHSAB has three core legal duties under the Care Act 2014:

1) Develop and publish a Strategic Plan outlining how the Board will meet its objectives and how partners will contribute to this
2) Publish an Annual Report detailing actions that the Board has taken to safeguard the community and how successful it has been in achieving this
3) Commission Safeguarding Adults Reviews (SARs) for any cases that meet the criteria.

In addition to this, the CHSAB is able to lead or undertake work in respect of any other adult safeguarding issue it feels appropriate.

Membership

The CHSAB has three statutory partners: the Local Authority, Integrated Care Board and Police service and a wide range of non-statutory partners

Below is a full list of our partners and their attendance at our quarterly Board meetings:

2024-25	
Independent Chair	100%
London Borough of Hackney Adult Social Care	100%
Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture, London Borough of Hackney	100%
City of London Corporation Adult Social Care	100%
North East London Integrated Care Board	100%
Homerton University Hospital	75%
Barts Health NHS Trust	75%

2024-25	
East London NHS Foundation Trust	100%
London Fire Brigade	50%
Metropolitan Police	100%
City of London Police	100%
Hackney Council Voluntary Service	50%
London Borough of Hackney Housing	75%
London Borough of Hackney Benefits and Homeless Prevention	75%
Age UK East London	75%
Turning Point	100%
Older People's Reference Group	100%
Department for Work and Pensions	75%
City and Hackney Public Health	75%
Healthwatch Hackney	75%
Healthwatch City of London	75%

Principles

The Board's strategy and annual strategic plan is underpinned by the six safeguarding principles:

- **Prevention –** It is better to take action before harm occurs.
  "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."
- **Proportionality –** The least intrusive response appropriate to the risk presented.
  "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."
- **Protection –** Support and representation for those in greatest need.
  "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

- **Partnership –** Local solutions through services working together and with their communities. Services share information safely and each service has a workforce well trained in safeguarding. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

  "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

- **Accountability –** Accountability and transparency in delivering safeguarding.

  "I understand the role of everyone involved in my life and so do they."

- **Empowerment –** Support and representation for those in greatest need.

"I was asked what I want as the outcomes from the safeguarding process and this directly informs what happens."

Board Governance

Subgroups

The Board has a number of subgroups in place to ensure the delivery of its annual priorities:

Quality Assurance:

The group examines quantitative and qualitative data to help identify safeguarding trends and issues across the City and Hackney. This information is provided to the Executive group and helps inform the work and priorities of the Board. In 2024/25, the subgroup worked on developing a CHSAB dashboard that could be used to help identify and respond to emerging safeguarding trends. Although not yet finalised, the subgroup has made progress on the dashboard and hope to have a final version ready for the 2025/26 year. The subgroup also made progress on undertaking a multi agency case file audit, with the subgroup agreeing on an audit template as well as a methodology for the audit itself.

SAR action plan task and finish group:

This group was designed to ensure that the actions from our most recent SARs are completed in a timely manner. The group also identified how to ensure that learning from SARs has a long term impact on improving practice. In 2024/25, the group focused on ensuring the recommendations from the 'Steve' SAR were progressed, and supported the organisation of the practitioners and learning events held for the SAR. It also focused on progressing any outstanding learning from previous SARs, including the JL discretionary SAR.

Safeguarding Adults and Case Review

The group fulfils the Board's s44 Care Act duty by considering requests for a Safeguarding Adults Review (SAR). The group reviews referrals and makes recommendations to the Chair when it considers a SAR is required. In 2024/25, the group agreed to undertake two discretionary Safeguarding Adult Reviews, details of which can be found further down the report.

City of London Adult Safeguarding Committee

The City of London has a Safeguarding Adult Committee, which focuses on safeguarding issues affecting residents living in the City of London. The Committee meets quarterly, where it allows partners to share their responses and responsibilities in relation to different safeguarding issues and provides updates in respect of their progress against the Board's strategic priorities. In 2024/25, the Committee received reports on various safeguarding issues pertinent within the City of London, including rough sleeping, social isolation, fire safety and mental capacity.

CHSAB strategic links

The CHSAB has links with partnerships and boards working with residents in the City of London and Hackney, including: the City and Hackney Safeguarding Children's Partnership, Community Safety Partnerships and Health and Wellbeing Boards. The Board will also engage with other partnerships where there may be opportunities to work collaboratively or provide an adult safeguarding expertise.

Budget

In 2024/25 the budget was £234,325 from the partners listed below:

Partner contributions to the CHSAB	CHSAB Partnership 2023/24 (£)
City of London Corporation	(28,875)
East London NHS Foundation Trust	(27,500)
Homerton University Hospital	(12,000)
NHS City and Hackney CCG	(20,000)
Metropolitan Police Authority	(5,000)
Barts Health NHS Trust	(5,000)
City of London Police	(4,400)
LB Hackney	(131,550)
Total income	**234,325**

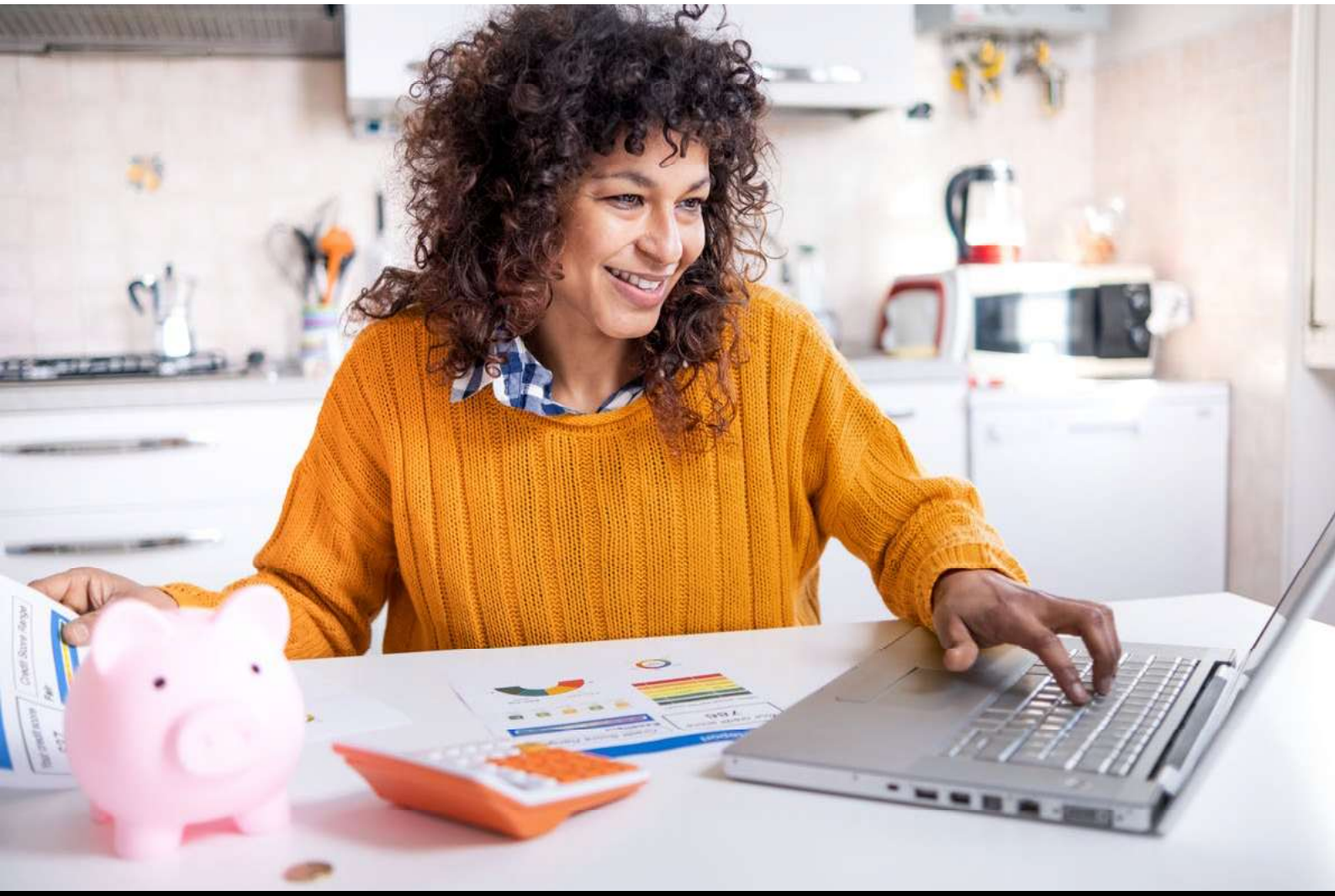
The expenditure for the Board in 2024/25 was £179,138

The remaining £55,186.82 was transferred to the reserve pot.

Supporting the CHSAB

The CHSAB has a full-time Board Manager and Business Support Officer to manage the work of the Board.

CASE STUDY 1:



... Adult Social Care has remained involved, offering continued support focused on safety planning, financial advice, and maintaining independence...

London Borough of Hackney Adult Social Care

Joan was targeted by an individual who posed as a helpful friend offering assistance in her home. Over time, the situation escalated; this person caused damage to the property, behaved threateningly, and attempted to take control of her accommodation. They even demanded payment for building work that was never completed. Joan was supported to explore her options and decide what she wanted to happen next. Through close joint working with the Police, the individual was safely removed from the property, and Joan regained control of her home. Adult Social Care has remained involved, offering continued support focused on safety planning, financial advice, and maintaining independence. Joan has expressed a strong desire to remain self-sufficient, and ongoing support is being tailored to help her do so with confidence and security.

CASE STUDY 2:

East London Foundation Trust

Mr Wilkinson, a 53-year-old man with schizoaffective disorder, had been supported by ELFT mental health services for three years. He was previously engaged with treatment but became increasingly isolated and stopped attending appointments following the death of his partner 18 months earlier. After repeated missed visits, his care team attempted home outreach. During one visit, clinicians found Mr Wilkinson in a significantly deteriorated state. He presented as manic, with disorganised thoughts and speech, and admitted to stopping his medication. He appeared malnourished, and his home environment was cluttered and unsafe, raising concerns about self-neglect. The mental health team escalated concerns to the Trust's safeguarding lead and initiated a Section 42 enquiry. Self-neglect was identified as the primary issue. ELFT led the enquiry in partnership with housing and community day services. Mr Wilkinson was also found to be experiencing complex grief and depression, which further impacted his motivation and self-care. With his consent, Mr Wilkinson was admitted to a mental health ward for short-term stabilisation. He responded well to treatment, and a coordinated discharge plan was developed. This included a deep clean of his home, weekly support from a carer agency, and bereavement-focused psychological therapy. His care coordinator increased contact, and community engagement was encouraged through local groups. This multi-agency, person-centred approach led to a positive outcome. Mr Wilkinson re-engaged with services and his community, and his mental and physical health stabilised. The safeguarding process enabled effective collaboration to reduce risk and support sustained recovery.

Strategic Plan for 2024/25

The City and Hackney Safeguarding Adults Board had the following strategic priorities for 2024/25:

1. **To continue to improve the quality of mental capacity assessments.**
2. **To engage with the community and voluntary sector to support them to build their confidence in delivering their safeguarding duties and raise awareness of adult safeguarding.**
3. **To continue to embed engagement with people with lived experience and ensure that they can influence all aspects of the Board's work.**
4. **To identify and respond to the safeguarding needs of people who are homeless, people experiencing modern day slavery, people experiencing discriminatory abuse (hate crime) and young people (18-25 year olds).**
5. **To work collaboratively with agencies and partnerships across the City and Hackney to respond to the safeguarding needs of residents.**
6. **To support frontline practitioners to respond to complex issues relating to self-neglect.**
7. **To deliver and implement recommendations that arise in relation to both local, regional and national Safeguarding Adults Reviews.**
8. **To ensure that all agencies across the City and Hackney deliver their core duties in relation to safeguarding.**

CHSAB Achievements for 2024/25

Community and Resident Engagement

- The Board engaged with service users via the CHSAB newsletter, which was reinstated in Feb 2024. The purpose of the newsletter is to ensure service users are kept up to date with the work of the Board and are able to join any planned events in the future.
- The Chair of the Board hosted a Patient Panel on Safeguarding in the City of London which was open to residents and explained what safeguarding means, how to raise concerns, and what role the City and Hackney Safeguarding Adults Board plays. This event empowered community members to protect vulnerable adults and clearly communicated important contact points and procedures.
- The Board is part of a wider range of different stakeholder groups that includes the: Carers Partnership Board, Suicide Prevention Board and domestic abuse work streams.

Training and engagement with professionals and community voluntary sector

- The Board commissions a package of training for frontline line staff working across the City and Hackney on a yearly basis. This year the Board commissioned 8 safeguarding courses delivered quarterly throughout the year.
- Courses on offer included the following:
  - Safeguarding awareness training (webinar).
  - Trauma informed approaches to safeguarding (in person).
  - Safeguarding, Self-neglect & Hoarding (webinar).
  - Safeguarding Adults Workshop for Manager & Safeguarding Leads (webinar).
  - SAMs – Exploring the Roles, Responsibilities and Expectations of Safeguarding Adult Managers (webinar).
  - SAE – Undertaking S42 Safeguarding Enquiries (webinar).
  - Safeguarding, mental health and social isolation (webinar).
- In total, over 150 people attended the various different training sessions on offer.

Safeguarding Adults Week

- The Board organised a series of events throughout the whole month of November, in recognition of Safeguarding Adults Week.
- These included events on intergenerational domestic abuse, modern slavery and organised immigration crime as well as a session with the Department for Work and Pensions around the move to Universal Credit and supporting vulnerable residents throughout this transition.
- The City and Hackney Safeguarding Adults Board also organised an in-person learning event for the 'Steve' SAR during November, whereby attendees were able to hear from Jess Harris, a senior research fellow at Kings College London, on Mental Capacity and Multiple Exclusion Homelessness, as well as from Dr Caroline Shulman, an honorary research fellow at University College London, on Palliative Care.
- The learning event was very well attended, with approximately 50 professionals across the City and Hackney SAB partnership joining on the day,

Quality Assurance

- Board partners undertook a self assessment using the Safeguarding Adult Partnership Assessment Tool in Feb 2025, which was analysed by the Board Manager and used as evidence to help guide discussions during the Boards Development Day in April 2025.
- The Quality Assurance Subgroup developed and agreed on an audit template, which will be used by partners when undertaking multi agency case file audits.
- The Independent Chair of the Board continued to meet with Board partners, in order to ensure that all safeguarding issues affecting residents were identified and addressed and that engagement with Board partners continued to increase. These check-ins also helped resolve any issues partners experienced within the system, and served to improve relationships with key stakeholders.
- The Board received presentations from both the London Borough of Hackney and the City of London Corporation on their Adult Social Care Self Assessment as part of the CQC assurance process.

Multi-agency working

- There was Board attendance at a number of partnership groups including the suicide prevention group, strategic vulnerability board, community safety officer group and domestic abuse work streams.

National work

- The City and Hackney Safeguarding Adults Board responded to the letter from the Department of Health and Social Care regarding individuals rough sleeping. The letter made several recommendations to SABs around how Boards can support individuals who are rough sleeping, and sought to seek assurance on mechanisms that are in place within each local authority.
- The Board has also sent published Safeguarding Adults Reviews (SARs) to the national SAR library as well as the National Analysis of Safeguarding Adult Reviews.

CASE STUDY 3:

Barts Health NHS Trust

Lewis, a 58-year-old man with cancer and schizophrenia, was flagged by the hospital nursing team after missing multiple chemotherapy and clinic appointments. He appeared unkempt, had a bedbug infestation, and faced possible eviction from his hostel, raising concerns about his ability to manage his health and living conditions. The hospital safeguarding team reviewed community records and found Lewis was already supported by mental health, homelessness, and community health services. These teams were contacted to share concerns and coordinate a response. A safeguarding referral was also made to Hackney Adult Social Care to ensure hospital concerns were included in ongoing community care planning. This multi-agency collaboration allowed professionals across settings to work together effectively. Community teams helped Lewis attend appointments, while hospital staff made reasonable adjustments such as tailored communication and flexible care delivery to improve his engagement. When Lewis was later admitted, discharge planning benefited from this prior coordination. The care team was already aware of his risks and support needs, enabling a smoother, safer discharge. This coordinated approach ensured Lewis remained central to care decisions. By sharing information and working jointly, professionals reduced treatment disruption, enhanced engagement, and provided appropriate support for both his health and social needs.

Safeguarding Adults Reviews (SARs)

The Board has a statutory duty to undertake Safeguarding Adults Reviews (SAR) under section 44 of the Care Act 2014. The following criteria must be met for a SAR:

1. An adult has died or suffered serious harm.
2. It is suspected or known that it was due to abuse or neglect.
3. There is concern that agencies could have worked better to protect the adult from harm.

The Board is also able to undertake a discretionary SAR under the Care Act, where a case does not meet the threshold for a review but it is considered that there is valuable learning to be gained in terms of addressing abuse and neglect.

In 2024/25, the Board published two discretionary Safeguarding Adults Review.

JL: The discretionary Safeguarding Adults Review (SAR) into the death of JL was commissioned by the City and Hackney Safeguarding Adults Board (SAB) in June 2023 to complement a local learning review by Adult Social Care services in Hackney.

JL was aged 77 when he died in his flat in February 2022. An inquest held in April recorded that his death was caused by pneumonia, frailty, chronic alcoholism, hyperthyroidism and frostbite. The review recommended strengthening input from housing partners within the Board as well as reviewing the Board's Escalation Policy. The Board published the 7 minute briefing in September 2024 which can be found **here**.

Steve: The discretionary Safeguarding Adults Review (SAR) into the death of 'Steve' was commissioned by the City and Hackney Safeguarding Adults Board (SAB) in November 2023. 'Steve' had been known to services in Hackney since April 2020 and was an extremely vulnerable individual who had cancer, and a long history of homelessness, trauma, alcohol misuse and substance misuse. A safeguarding referral was made to Hackney ASC in April 2023 due to concerns about his inappropriate housing, self neglect and inability to manage medication safely. 'Steve' experienced numerous hospital admissions and discharges between Dec 2022 and May 2023. 'Steve' was admitted to hospital in early May 2023 due to a fall and a head injury and died a few days later. The coroner's report noted his cause of death as 1a) Acute Respiratory Failure, 1b) Combined Opioid and Opiate Use and 2) Metastatic Testicular Seminoma, Hypertension, Chronic Obstructive Pulmonary Disease.

A practitioners' event for the 'Steve' SAR was held in July 2024, providing practitioners an opportunity to provide insight and contribute to the review, as well as draw out learning to help inform the recommendations. A further learning event was held in November 2024 for the 'Steve' SAR, where

attendees were able to hear a synopsis of the review, understand the challenges that occurred in supporting 'Steve' and focus on research findings relating to the recommendations that were made; namely palliative care and mental capacity for people that are homeless.

The Board published the 'Steve' SAR in November 2024 which can be found here.

Key Learning and Themes

The JL review made four recommendations including strengthening multi agency coordinations especially around complex safeguarding cases, reviewing policies such as the escalation policy as well as the hospital discharge policy and improving partnership engagement in order to enhance communication, challenge, and the ability to respond to risk holistically.

The Steve SAR made ten recommendations, including improving multi-agency coordination, strengthening safeguarding and escalation pathways, and ensuring timely access to advocacy for people experiencing homelessness. It also called for enhanced workforce training in areas such as palliative care, self-neglect, and mental capacity, as well as better integration between health, housing, and social care services.

...Eight weeks after discharge, a joint review by adult social care and mental health services found Anna's mental health had stabilised...

CASE STUDY 4:

City of London Corporation Adult Social Care

Anna, a woman in her 40s from Eastern Europe, had been rough sleeping across the City of London and surrounding boroughs. A safeguarding concern was raised after she was seen walking into traffic and threatening members of the public. She spoke little English, was not registered with a GP, and was subsequently detained under the Mental Health Act due to significant concerns about her mental state. Following assessment, the City of London assumed Section 117 aftercare responsibility. Anna was assessed as needing supported accommodation upon discharge. A City social worker led on capacity assessment, and a best interests meeting was held with an interpreter, advocate, health professionals, and the social worker to ensure her voice remained central to the process. Anna was discharged into a supported living placement with one-to-one staffing. She was registered with a GP and connected with the local neighbourhood mental health team. She also received immigration support through Praxis. The adult social care team used discretionary funding to provide her with clothing and secure identification, including a passport. Eight weeks after discharge, a joint review by adult social care and mental health services found Anna's mental health had stabilised, and her physical health had improved. Her support team introduced her to local communities who spoke her language and shared her interests, and supported her to access familiar films and media. Anna reported feeling settled and expressed interest in future employment or returning to her home country. Her support hours were reduced as she became more independent. The case demonstrated strong partnership working, legal literacy, and a strengths-based approach, leading to meaningful and sustained outcomes for Anna.

CASE STUDY 5:

Turning Point

Kyle is a 65 year old male with a long history of severe alcohol dependence which resulted in significant cognitive and memory impairments. Kyle was previously residing in a hostel which became unsuitable for his needs as he suffered from frequent seizures and falls putting him at serious risk of injury and potential fatality. The confined space and lack of accessible support further exacerbated these risks. During this period, Kyle experienced multiple hospital admissions due to his deteriorating physical health. Following a referral to Adult Social Care, a care package was implemented. However, despite this support, Kyle continued to suffer from recurrent seizures, resulting in ongoing hospitalisations. Due to these risks, he was relocated to alternative temporary accommodation where a twice-daily care package remained in place. It became evident that Kyle required more stable, supported housing. However,barriers securing appropriate accommodation included historic rent arrears. During this time, Kyle was also subject to financial exploitation by another resident. In response, Turning Point and Social services collaborated to safeguard him with practical support and education around financial safety. A multi-agency approach was taken with services including adult social services, housing, GP, Groundswell worker, and recovery worker from Tuning Point and this was instrumental in resolving his rent arrears and facilitating his transition into supported housing. Kyle has now successfully moved into a safer placement and is able to engage positively with services to address his ongoing needs. Kyle has been able to maintain independence and has been able to reduce his alcohol use.

CASE STUDY 6:

City of London Police

Sara arrived in the UK on a spousal visa with no English, no recourse to public funds, and was completely financially reliant on her husband and in-laws, who subjected her to escalating honour-based violence and coercive control under the guise of protecting family "honour." Her case was escalated to the City of London Multi-Agency Risk Assessment Conference a multi-agency panel convened to safeguard those at highest risk and she was supported by an Independent Domestic Violence Adviser. Together they devised an urgent safety plan while simultaneously securing safe, confidential housing, applying for the Migrant Victims of Domestic Abuse Concession (MVDAC), and obtaining a non-molestation order against the perpetrators. Through this coordinated effort which included police, housing services and guidance from the Independent Domestic Violence Advisor, Sara moved into safety, gained legal protections, accessed vital financial support, and began learning English and managing her own finances, reclaiming autonomy in a life that had been controlled by others.

...Sara moved into safety, gained legal protections, accessed vital financial support, and began learning English and managing her own finances, reclaiming autonomy in a life that had been controlled by others...

Safeguarding data for 2024/25

The safeguarding data for 2024/25 is presented separately for the City of London Corporation, London Borough of Hackney and the East London NHS Foundation Trust.

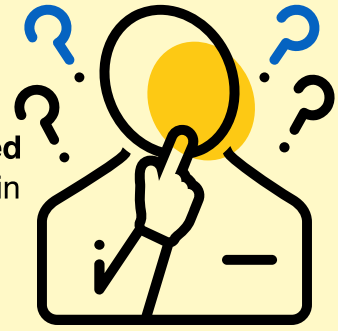
City of London Corporation Performance Data for 2024/25

49 safeguarding concerns were raised.

49

30 of those concerns led to a Section 42 Enquiry.

21 S42 enquiries concluded in 2024-25 compared to **19** the previous year. **62%** of adults were asked about their desired outcomes, and they were expressed. From that total, **69%** had their outcomes fully or partially met.



Concerns and Enquiries

The trend over the last five years shows, concerns have **decreased from 57** in 2020/21 **to 49** in 2023/24 and have stayed the same in 2024/25. The conversion rate (the proportion of concerns that turned into enquiries) was **63%** in 2023/45 before experiencing a slight decrease to **61%** in 2024/25.

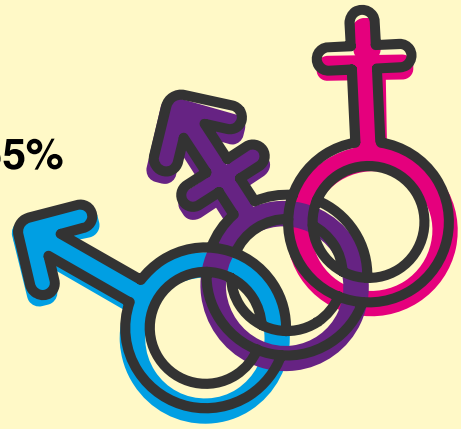
For the concerns and enquiries rates per **100,000** population, we use data from the NHS Safeguarding Adults Collection (SAC), which incorporates mid-year population estimates from the Office for National Statistics (ONS). This approach allows us to compare our rates with those of other local authorities and with the national average.

The rate of safeguarding concerns per **100,000 has generally increased** in line with the national average since 2016/17. However, it has **recently fallen, decreasing from 626** in 2022/23 **to 478** in 2024/25. Similarly, the rate of safeguarding enquiries per **100** (including enquiries commenced during the reporting period) **has declined from 283** in 2023/24 **to 195** in 2024/25.

Ethnicity

The adult population structure of the city of London is mostly from the white ethnic background. The data shows the consistency that adults are at risk to be mostly from the white background. Out of **44** individuals that had a concern in the year, **30** were from a white ethnic background..

Gender



The male population in the City of London makes up **55%** in the **18+** group in the 2021 Census. The data shows the male clients had slightly more safeguarding concerns this year than female clients which is similar to previous years.

The data shows of the **44** individuals who had a concern during the year 2024-25, **15** were in the **18-64 age grouping**. The remaining **29** individuals were in the **65+** grouping.

Type of Risk

Upon concluding **21** S42 Enquiries, a total of **28** distinct risks were identified. The most prevalent risk noted this year in safeguarding enquiries was Neglect and Acts of Omission, accounting for **32%** of all cases. This was closely followed by Self-Neglect, which constituted **29%** of the risks. Financial or Material Abuse represented **18%** of the total risks identified.

In terms of the concerns raised during the 2024-25 period, Self-Neglect again topped the list, representing **33%** of all cases. This was followed by Neglect and acts of omission at **27%**, Financial or Material abuse at **14%**, and Physical at **14%**.

Source of Referral and Risk

In line with the national and London average, the data shows **79%** of client's risk comes from someone known to the individual. This is an increase from the previous year 2023-24 of **64%**. **A significant decrease in service providers at 14% compared to 32% the previous year.**

Location of Risk

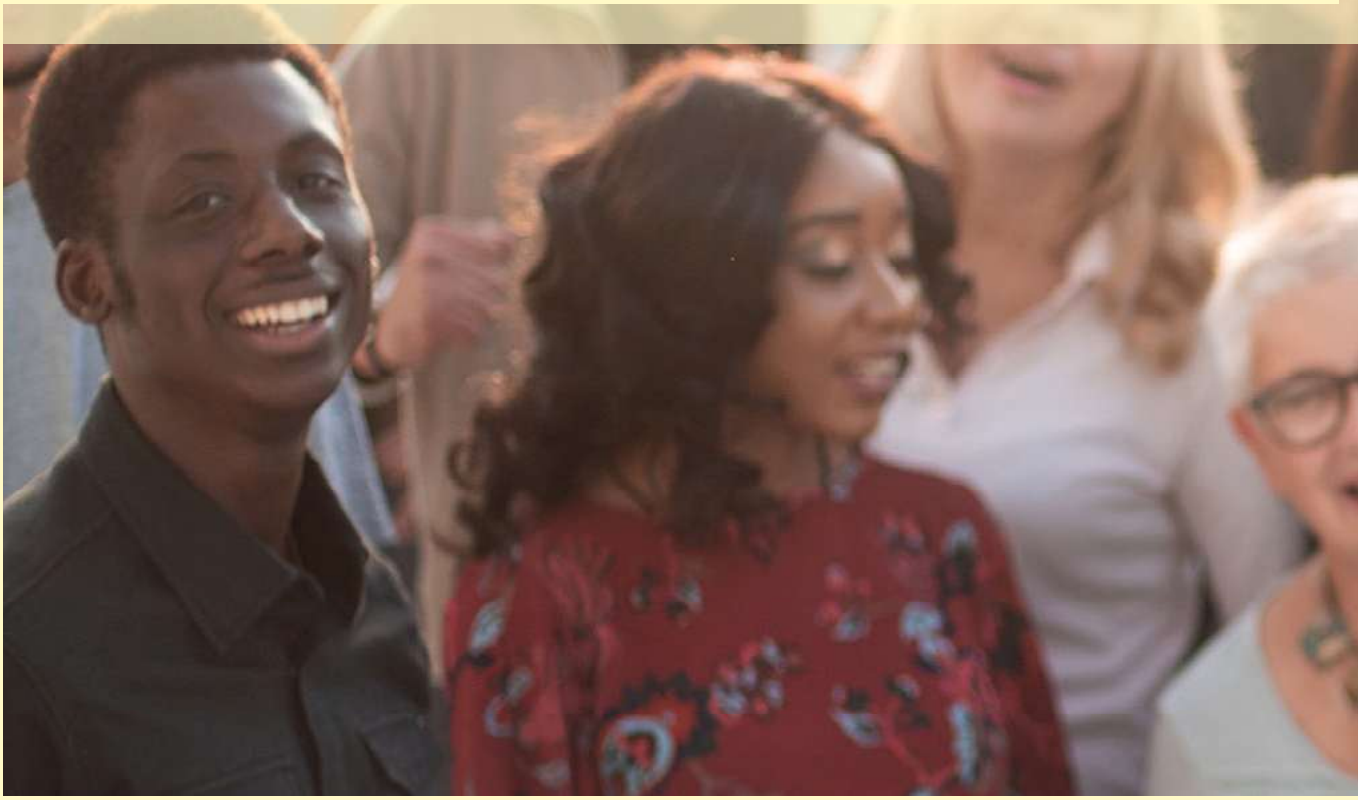
The **majority** of safeguarding enquiries related to alleged abuse that happened within the **person's own home. Four** happened in hospital-acute, **one** enquiry happened in the community, **one** in the hospital-community **and four** in other locations. The continued increase in cases in people's own home is consistent with national data which identifies that abuse typically happens within someone's own home.

Making Safeguarding Personal

There were **21** concluded S42 enquiries in 2024-25 nineteen the previous year. **62%** of adults were asked about their desired outcomes and they were expressed. Of which 69% had their outcomes fully or partially met. **The local management system recording has been improved to capture the outcomes better than in previous years** and there has been some discussions at Safeguarding Adults Board Quality Assurance group around whether further improvements could be made to the form data fields to capture a more in-depth understanding of the MSP data.

Deprivation of Liberty Safeguards

	2022/23	2023/24	2024/25
Number of DoLS referrals received	**30**	**30**	**30**
Number of DoLS authorised	**30**	**35**	**34**
DoLS Not Granted	**0**	**0**	**0**
Applications withdrawn	**0**	**0**	**0**



...The male population in the City of London makes up 55% in the 18+ group in the 2021 Census. The data shows the male clients had slightly more safeguarding concerns this year than female clients which is similar to previous years.

London Borough of Hackney Performance Data for 2024/25

Data has been collated using LBH Dashboard in respect of Concerns received by LBH and allocated to LBH (i.e. not those allocated to ELFT or those not progressing to a SAM Decision).

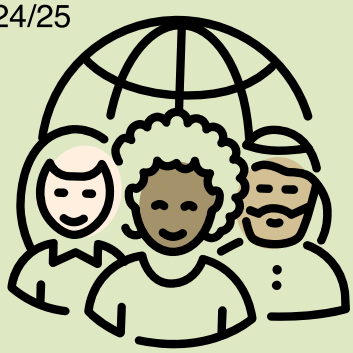
Concerns and Enquiries

1780 safeguarding concerns were raised.

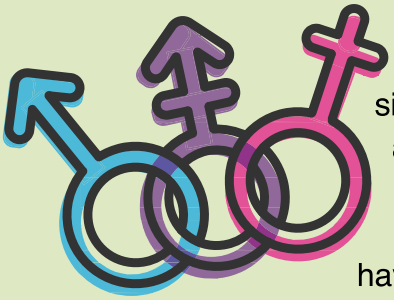
The number of accepted section 42 enquiries (538) is generally in line with the previous two years (a little lower, and S42 Enquiries concluded in 2024-25 period is also lower).

Ethnicity

The proportion of concerns broken down by ethnicity for 2024/25 remains very similar to previous years. The most concerns continue to relate to adults from a White or Black African, Caribbean, or British background, and generally consistent with the demographic profile of the borough. The proportion without a declaration remains similar to last year at **8.3%.**



Gender



The proportion of concerns split by gender remains very similar to previous years, with females still the majority, **amounting to 51.7% of concerns.** This is consistent with the 2021 census for Hackney, which shows the borough has more females compared to males, and therefore expected to have a higher proportion of concerns.

The highest number of concerns being raised in respect of age has remained the same as previous year; **those between the ages of 26-64.** This contrasts with the national picture of safeguarding, which highlights that abuse is typically experienced by older adults. The younger demographic within Hackney could be an explanation for this.

Type of risk

The most common form of abuse reported **continues to be self-neglect, which makes up 28.2%** of all concerns reported. **Financial or Material Abuse and Neglect and Acts of Omission make up second and third most common types of abuse** (a reversal in 2nd and 3rd place since last year).

Source of Referral and Risk

The data shows that the source of risk is most likely to be someone known to the individual, **which makes 80.4% of concerns referred** to adult safeguarding.There has been an increase in the service provider being identified as the source of risk, **from 8.8% in** 2023/24 **to 12.5% in** 2024/25.

The number of safeguarding concerns from Hospitals remains the most common source of referrals, amounting to 23.6%. There continues to be a consistent number of concerns raised by friends and family, which is encouraging for the Board and evidence of the engagement work done with many community groups over the past couple of years.

Location of Risk

The data continues to show that most abuse occurs within the home, which is consistent with previous years and likely to correlate to self-neglect being the most common type of abuse.

Making Safeguarding Personal

In **92.2% of concluded section 42 enquiries,** adults were asked what their desired outcome was. This is **slightly higher than the previous year's figure of 89%.** Of those that were asked and expressed their desired outcomes, **94.1%** had their desires partially or fully achieved **(up from 92% last year)**. This information is helpful to help ensure that safeguarding is person-centred and the process focuses on the wishes and needs of the individual.

Deprivation of Liberty Safeguards

	2022/23	2023/24	2024/25
Number of DoLS referrals received	**917**	**843**	**971**
Number of DoLS authorised	**568**	**542**	**587**
DoLS Not Granted	**56**	**80**	**64**
Applications withdrawn	**293**	**221**	**320**

East London NHS Foundation Trust Performance Data for 2024/25

Concerns and Enquiries

515 safeguarding concerns were raised. This is an increase of 36% compared to 2023/24 (when 377 concerns were raised).

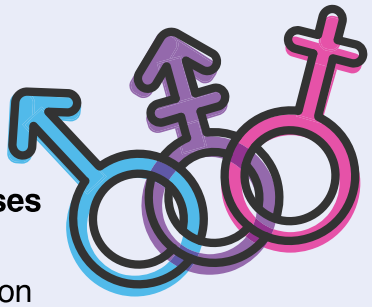
143 of those concerns led to a Section 42 Enquiry

The proportion of concerns that were accepted as s42 enquiries was 28%, which is broadly in line with 2023/24 (30%).

Ethnicity

The majority of safeguarding cases relate to adults from a Black background (37%), with **32% relating to adults from a White background, 15% from a Mixed background,** and **9% from an Asian background.** While this does not mirror the borough population profile, it is broadly representative of our Adult Social Care service user population, which is likely to be a more appropriate comparator of vulnerable adults.

Gender



A significantly higher proportion of safeguarding cases relate to males (58%) than the borough population (48%), though again, this mirrors the over-representation of males within the mental health service user population, so is indicative of the wider inequalities around mental health rather than relating to safeguarding specifically.

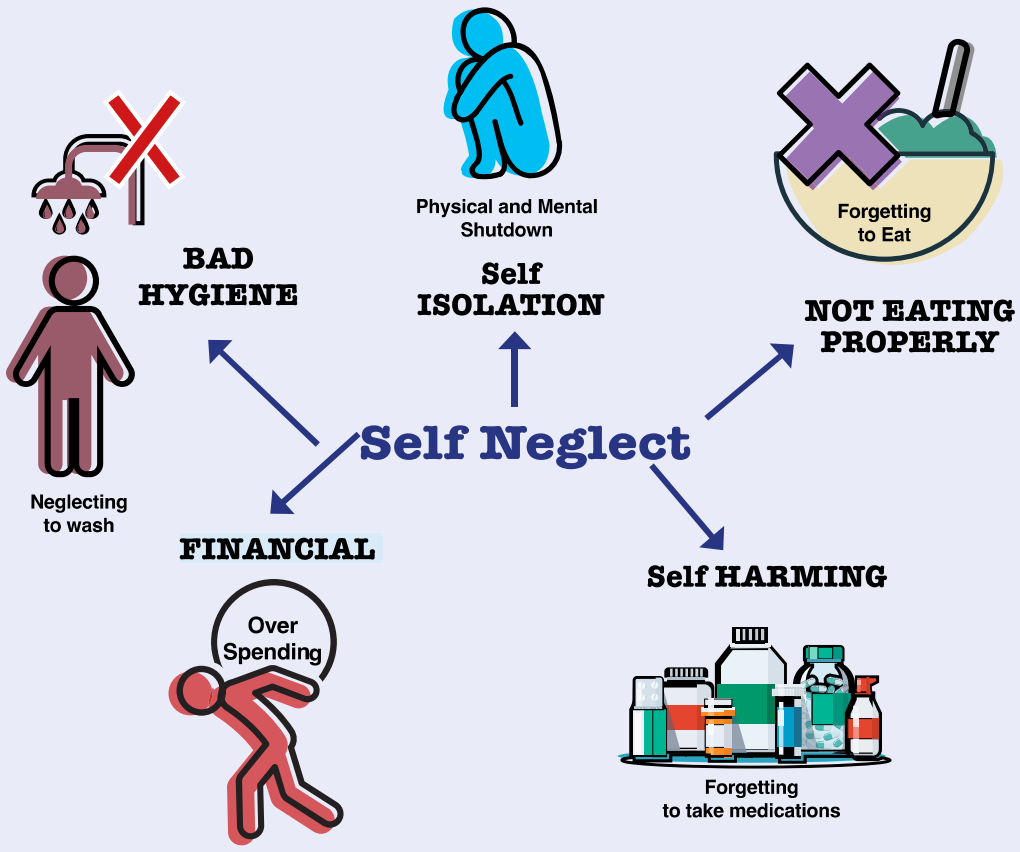
The **largest proportion** of safeguarding cases relates to **adults aged 18-64 (89%), with 8%** coming from **65-74 year olds,** and **the remaining 3% from over 75s.**

Type of Risk

The top three types of abuse reported for the year 2024/2025 were:

- Self-neglect **(30%)**
- Financial or Material Abuse **(19%)**
- Physical abuse at **(11%)**

Self-neglect has seen a significant increase in both the proportion and number of concerns since last year; **with 155 concerns (30%) reported in 2024/25, compared to 68 concerns (18%) in 2023/24.**



As a result of this, we have carried out self-neglect specific audits and subsequently developed bespoke self-neglect training to all services to bolster knowledge, competence and practice.

Source of Referral and Risk

Similar to previous years and consistent with national trends, the source of risk is most likely to be someone known to the individual, **which makes up 85%** of safeguarding concerns.

Location of Risk

The data continues to show that **most abuse occurs within the home (51%),** which is **consistent with high levels of self-neglect and abuse from known individuals. Mental Health hospitals are the second most common location at 32%** of concerns, illustrating the really positive work that has been carried out with the psychiatric wards in responding to concerns and reviewing within a safeguarding framework. The Matrons regularly attend SAM forums and involve the Named Professional for Safeguarding in delivering robust safeguarding processes. **Of the remaining concerns, 10% occur in the wider community, 2% in a community service, 2% in residential care homes, 1% in acute hospitals and 3% in other locations.**

Making Safeguarding Personal

In **59%** of completed enquiries, adults were asked about their desired outcomes. In a further **24%** of cases, it was not recorded whether this was asked, and **17%** it was not asked. Of those asked, **73% stated that their outcomes had been fully or partially achieved,** while **15%** stated they were not achieved, and **12%** the response was not recorded. MSP remains a priority in MH and ELF has been working with clinicians to address the process issue of not always documenting views of outcomes. The ASC Service Review in ELFT has MSP and safeguarding as a priority and we are confident that the new reporting process will allow the service user perspective to be clearly heard.

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CHSAB Board Partners Safeguarding Achievements

This section outlines the Board Partners main achievements in relation to adult safeguarding for 2024/25:

London Borough of Hackney Adult Social Care

- Adult safeguarding first and foremost is about the outcomes that can be achieved for the adult at risk, focused on their recovery and resilience. In Hackney, we are proud of the continuing focus on 'making safeguarding personal', meaning adults are supported to express what they would like to happen in response to concerns of abuse. At the end of a safeguarding enquiry, we ask the adult to what extent those outcomes were achieved and 94.1% of residents report we helped them fully or partially achieve what matters to them.
- We have seen a culture fostered that promotes organisational learning, where we have capacity to reflect, adapt and improve. During the last year, we continued to focus on ensuring all actions that arose from safeguarding adult reviews, audit or individual cases were evidenced as being embedded into how we work. For example, following one review we have strengthened the knowledge and understanding of the intersection of homelessness and adults who may have need for care and support under the Care Act.
- Our commitment to a human rights approach and ensuring people are enabled to live with as much choice as possible and least restriction, means we place great importance on the Deprivation of Liberty Safeguards. In Hackney we are really proud that there is no 'backlog' of applications, which is an issue elsewhere nationally, and that we are able to utilise the safeguards within these legal rules to have additional assurance that people, who lack mental capacity, are not being deprived of their liberty in care homes or hospitals.

City of London Corporation Adult Social Care

- We have continued to strengthen our Early Intervention and Prevention work, aligning this with the second principle of safeguarding; preventing harm before it occurs. This has involved a focused review of both in-house and commissioned services to understand how effectively they identify and respond to emerging risks. By using data analysis and service user feedback, we have been able to assess the real-world impact of these interventions, identify gaps, and target improvements.
- Following an independent safeguarding audit in October 2023, the Adult Social Care workforce engaged in a comprehensive cycle of learning and reflection to strengthen practice. This included targeted development in

key areas such as decision-making at the point of safeguarding concerns, application of the Mental Capacity Act (MCA) within safeguarding contexts, and Making Safeguarding Personal (MSP). The process not only helped to address areas of improvement identified by the audit but also reinforced a culture of continuous learning and professional accountability across teams.

North East London Integrated Care Board

- We have embedded safeguarding across many areas of our organisation, ensuring it is a key focus in groups such as the Homeless Health Steering Group and the Refugee Health Steering Group. This helps us address the complex needs of vulnerable populations more effectively.
- We are proud to lead the national work on the NHS England Case Review Tracker, which brings together important data from Safeguarding Adult Reviews, Domestic Homicide Reviews, and Children's Safeguarding Reviews. This helps improve learning and safety across the health system.
- Our Learning Disability Mortality Review Programme is making strong progress. We have developed clear learning pathways that support staff in understanding both effective practices and where improvements are needed, ensuring lessons from these reviews are put into action.
- In response to growing demand, we have expanded domestic violence training and case management support for staff working in primary care and community health settings. This strengthens their ability to identify and respond to domestic abuse, improving outcomes for those affected.

Homerton University Hospital NHS Foundation Trust

- We devised a complex patient panel following a high number of absconsions, complex safeguarding incidents and the need to have a Multi Disciplinary Team forum to support staff with pts that have complex behavioural & social needs. The Head of Safeguarding Adults co-chairs with the Head of PT therapies and meets weekly face to face for one hour. Themes so far have included – Challenging behaviour on the wards, concerns around mental capacity and complex discharge planning.
- We commissioned Prevent training with the Prevent Lead in the London Borough of Hackney. These sessions are now face to face sessions and take place bi monthly. We have also launched a digital version of the training.
- We have made significant improvements to the Mental Capacity Act form on EPR. The updated form is now more user-friendly and offers a better direction to clinicians who struggle with this part of their work duties. This will likely lead to assessments being of better quality and withstand scrutiny when challenged – if recorded allows to withstand more legal scrutiny.

East London Foundation Trust

- We have continued to build on a strong and sustainable safeguarding leadership framework. This includes active collaboration through the Directorate Management Adults and Children's Safeguarding Sub-Group, the SAM Forum, our weekly Complex Case Panel, and dedicated safeguarding drop-in sessions within community teams. These platforms ensure robust oversight and timely response to safeguarding concerns across the Trust.
- We provide regular, bespoke safeguarding training across ELFT, with consistently high levels of staff compliance. Our Corporate Safeguarding Team actively reviews safeguarding data to tailor training to current needs; for example, delivering Self-Neglect training in response to identified risks. Domestic abuse training modules are now readily accessible through the ELFT Learning Academy, and DIAS (Domestic Abuse Intervention Service) drop-in sessions are available to staff within our community teams, offering practical support and advice.
- Our Community Mental Health Services are undergoing a significant transformation through the Adult Social Care (ASC) Review and ELFT's wider Service Redesign. As part of this work, safeguarding processes are being strengthened to ensure every safeguarding concern receives oversight from a Social Care SAM within the London Borough of Hackney (LBH). This will enhance support to both community-based mental health services and inpatient psychiatric care, ensuring safeguarding remains at the heart of service delivery.

Barts Health NHS Trust

- We have significantly improved the number of DOLS referrals via a significant training and improvement program across the Trust. The quality of these referrals has also improved (checked as part of our audit program) with recording clearer, quality of capacity assessments has improved etc.
- We have reviewed and rolled out a new Level Adult 3 face to face training, revised in line with new intercollegiate guidance and NHS E Core Skills training framework. This has meant staff receiving this training (which includes MCA/DOLs training) has gone up from a few hundred to around 7000 across the Trust. We are on track to reach the compliance rate (85%) within three years.
- We have introduced a Trust wide safeguarding audit program, which includes domestic abuse processes, self-neglect, MCA ec.

Metropolitan Police Service

- We worked closely with experts inside and outside the Met to develop a clear framework for Vulnerability and Public Protection Notices (VPTN),

aligning our definitions with the Care Act. We also updated our Standard Operating Procedures and improved the SharePoint site so officers can easily access the information they need.

- We provided training to around 4,400 frontline officers and MASH teams on completing VPTNs, common issues, and key adult safeguarding topics like consent and identifying adults at risk. We developed the training with input from our partner organisations to reflect real issues on the ground.
- Together with partners and MASH teams, we created a new decision-making guide to help officers better understand safeguarding legislation when making referrals. This has improved referral quality, reducing inappropriate referrals to Adult Social Care by 15%, allowing them to focus on those most at risk. Feedback from partners has been very positive.

City of London Police

- We have launched and implemented a new Victim Strategy in February 2025, which aims to put the wellbeing of victims at the heart of policing. It has helped improve communications with victims, embedded procedural justice, and ensured real-time feedback was acted upon.
- We have also delivered Operation Reframe, in partnership with the City Corporation, Hackney Council, Good Night Out, and local licensed venues with an aim to bring targeted focus to women's safety in the night-time economy. Through training, posters, social media campaigns, and the “Ask for Angela” scheme in bars, the initiative has helped address harassment and sexual violence in late-night venues.
- We have also developed Operation Servator, which aims to disrupt terrorism and serious crime within the City of London. We work closely with businesses and community partners to ensure everyone understands how they can help by reporting anything unusual.

Turning Point

- We have seen an increase in referrals to safeguarding adults, demonstrating that our staff are vigilant in identifying concerns and taking prompt action to protect vulnerable individuals. This reflects our ongoing commitment to raising awareness and ensuring that safeguarding remains a top priority in our service.
- Compliance with our mandatory safeguarding adult awareness training remains high, ensuring all staff have the knowledge and skills needed to recognise and respond effectively to safeguarding issues. This strong training culture helps us maintain high standards of care and protection for the people we support.
- Over the past year, we have actively participated in a wide range of professional and external safeguarding meetings. This engagement

strengthens our collaboration with partners and enhances our ability to share information, learn best practices, and improve outcomes for adults at risk within our service.

London Borough of Hackney Benefits and Homeless Prevention

- We continue to develop our Shared Planning approach for applicants with more than two support needs, ensuring we collectively safeguard our residents. We work closely with partners like the Greenhouse service and Homerton Mental Health discharge team, meeting weekly to discuss homeless patients on mental health wards and share vital care and risk information for safe housing decisions.
- Our team includes two embedded social workers; one generalist and one mental health specialist who support frontline staff in assisting residents facing multiple disadvantages. They run weekly drop-in sessions and quarterly learning sessions covering key topics such as mental health crisis pathways, Care Act Assessments, and Mental Capacity Assessments. In 2024, we welcomed our second student social worker and began mentoring to expand in-reach support for single homeless and rough sleepers
- We assist many residents who fall into the “Edge of Care” group, presenting complex needs that don’t meet statutory thresholds for Adult Social Care or Mental Health services. To better support these residents, we’ve delivered trauma-informed and reflective practice training to all frontline officers, alongside mandatory training on improving access for clients experiencing multiple disadvantages and co-occurring conditions.

Age UK

- We launched 'centring safeguarding' programme across the organisation which included a review and launch of our safeguarding policy, radically streamlining our safeguarding process to remove barriers to staff in raising their concerns, reducing risk through delegation of responsibility across a wider group of colleagues and new bespoke training programme of deep dives into trending themes e.g. Self neglect and capacity and consent.

London Borough of Hackney Domestic Abuse Intervention Service

- We launched the Hackney trauma-informed multi-agency guidance: responding to child victims of domestic abuse, the UK’s first local guidance focused on trauma caused by domestic abuse.The guidance helps professionals working with parents or carers to understand and respond to trauma caused by domestic abuse.

- We achieved Respect accreditation of both our Domestic Abuse Prevention Programme and the Intensive Case Management approach used with those harming family members through intergenerational domestic abuse. Hackney is the only Local Authority service to have achieved dual accreditation for these two areas of work.
- We took over the commissioning and overseeing of refuge provision in Hackney, thus enabling greater integration of the refuges within the wider VAWG partnership.
- We launched the Hackney Sexual Exploitation Meeting, a monthly multi agency meeting which takes a proactive approach to safeguarding those at risk and disrupting those causing harm.

CASE STUDY 7:

Metropolitan Police

A joint community problem-solving initiative was launched to tackle serious anti-social behaviour linked to several high-risk properties. These homes had become centres for drug-related activity, causing distress to local residents and businesses. Vulnerable tenants were being exploited by drug users who used the addresses for criminal purposes. Neighbourhood police officers carried out targeted patrols, welfare checks, and gathered evidence, leading to the issuance of Anti-Social Behaviour Warnings and Community Protection Notices. Their work focused on disrupting offending and protecting vulnerable individuals. Working closely with the housing association and support partners, a joint action plan was developed. Regular meetings allowed agencies to share information, assess risks, and coordinate interventions. Vulnerable tenants were offered additional support, while housing providers took enforcement actions, including Notices Seeking Possession and injunctions against perpetrators. As a result, anti-social behaviour significantly decreased. Exploitative individuals were removed or legally barred from returning, and properties were secured to prevent further misuse. Vulnerable residents received safeguarding support, helping them regain safety and stability. This case highlights the power of partnership working; combining enforcement and support to address complex issues and achieve lasting positive outcomes for both individuals and the wider community.

...This case highlights the complex balance of risk, capacity, and autonomy. It demonstrates the importance of multi-agency collaboration, executive capacity assessments, and creative problem solving to support individuals in high-risk situations.

CASE STUDY 8:

Homerton University Hospital

David, a 73-year-old man with multiple long-term conditions, lived at home with his 17-year-old son. Though separated from his wife, he maintained occasional contact with her and received remote support from his adult daughter, who helped with online grocery orders. David was under the care of district nurses and the foot health team for leg ulcers and a sacral pressure ulcer, and received a four times daily care package. Concerns grew around David's non-engagement with his care plan. He often sat for long hours with his legs down, worsening his swelling and wounds, and regularly slept in a recliner while lying on his pressure ulcer. Despite appropriate equipment being in place, he continued to make decisions that placed him at risk. A bedbug infestation triggered a safeguarding referral. The community safeguarding practitioner coordinated emergency fumigation and arranged temporary respite accommodation. However, David soon returned home, stating he disliked the respite setting. Care was arranged for his son during this period. After his return, professionals raised further concerns about David's hygiene, nutrition, and non-concordance with treatment. Although he had previously been assessed to have capacity, his ongoing choices suggested impaired decision-making. A joint visit was arranged with the GP and tissue viability nurse, and a mental capacity assessment found David lacked executive capacity; he could understand information, but struggled to act in ways that kept him safe. The safeguarding team led a series of personalised interventions. These included delivery of a second air mattress to encourage bed use, repositioning the TV to allow him to lie flat and still watch it, and setting alarms on his phone to prompt pressure relief and leg elevation. Carers were advised to escalate concerns about unmet needs directly to district nurses or family. Despite ongoing support, David's condition worsened. The safeguarding practitioner had repeated discussions with him about respite care. Although initially resistant, he agreed to a trial placement outside the borough, secured through collaborative work with the local authority. The new setting better matched his preferences. David responded well and, after six weeks, chose to remain there permanently. This case highlights the complex balance of risk, capacity, and autonomy. It demonstrates the importance of multi-agency collaboration, executive capacity assessments, and creative problem solving to support individuals in high-risk situations.

Appendix A:

CHSAB Annual Strategic Plan 2024-25

City and Hackney
Safeguarding Adults Board

CHSAB Annual Strategic Plan 2025 – 2026

The CHSAB Plan addresses the **six key objectives** contained in the CHSAB's Strategy for 2025 – 2028

Strategic Objectives	We will:
1. Make Safeguarding Everyone's Responsibility	Embed a culture of shared responsibility by ensuring residents, staff, volunteers and organisations understand what adult safeguarding is and their role in preventing and responding to abuse, neglect or self neglect
2. Embed the views and experiences of residents, people who draw on care and support, and carers in everything we do	Ensure residents, people who draw on care and support, and carers, including seldom heard voices, are involved and their feedback is used to shape the SAB's activity; safeguarding policies, procedures and practice
3. Gain assurance that multi agency systems are safe and reflect Making Safeguarding Personal	Review, update and implement robust governance, oversight, quality assurance and improvement mechanisms to gain assurance about safeguarding arrangements and practice; ensuring this is in accordance with Making Safeguarding Personal
4. A culture of continuous learning and development	Foster an open and transparent learning culture that encourages reflection, shares learning and promotes continuous development; and use learning from local, regional and national reviews in order to continually improve and shape our training and other professional development activities
5. Strengthen our use of data and insight to underpin SAB activity and key priorities	Develop and embed our existing multi-agency adult safeguarding data set to understand current or emerging themes and to underpin SAB activity and key priorities
6. Building Effective Multi-Agency Partnerships	Strengthen our multi-agency collaboration and partnership working with relevant partnerships (such as the Community Safety partnership, The Children's Safeguarding Partnership and the Health and Wellbeing Board), across North East London and London

Subgroup	Chair
City of London Adult Safeguarding Subcommittee	Claire Solley
SAR & Case Review	Claire Solley
Performance and Quality Assurance	Proposed joint chair with Anita Marsden and Mary O'Reardon
SAR Action Plan Group (Meets as needed) - links to Performance and Quality Assurance	Mary O'Reardon
Workforce Development (virtual group as and when needed via email)	Shohel Ahmed
Self- Neglect	TBC
Homelessness	TBC
Financial Abuse	TBC
Community engagement	TBC

This priority supports CHSAB to meet Strategic Objectives 1, 2 and 3

Golden Thread: Making Safeguarding Personal, Mental Capacity Act and Equity

Priority	Key actions	Objectives	Intended Outcomes
1. Develop and Implement a Community Engagement Strategy	1.1 Co-produce a Community Engagement Strategy with residents 1.2 Coordinate community engagement activity with existing/ developing plans/pathways across City and Hackney 1.3 Raise awareness of what adult safeguarding is, including seldom heard voices, what to do if someone has concerns or someone discloses abuse to them, how to report concerns and what happens next 1.4 Gather insight and feedback from people with lived experience, specifically those who have experience of adult safeguarding and develop and embed systems to use this to continuously improve 1.5 Develop mechanisms/framework for resident representation at CHSAB	Raise awareness of adult safeguarding with the public and professionals, including seldom heard voices; to prevent abuse, neglect and self neglect; and ensure our responses are timely and coordinated Improve engagement with all communities, including seldom heard voices Understand and ensure the voice and lived experience of adults at risk and carers shapes adult safeguarding arrangements, practice and CHSAB's key priorities Embed effective partnership working across CHSAB organisations; the community, voluntary and faith sector; and care providers	Improved outcomes for residents Increased understanding for residents, volunteers and staff of what adult safeguarding is, what to do when they have concerns and what will happen next Increase our preventative approach to abuse, neglect and self neglect - including reducing social isolation Address inequity in adult safeguarding Increase in adult safeguarding concerns received reflecting all communities Adults with lived experience involved in co-producing policies, procedures, training, adult safeguarding practice and CHSAB's key priorities Feedback from residents is used to continually improve adult safeguarding arrangements and reflects Making Safeguarding Personal (making sure the adult is at the centre - please see definition of this below) Strengthened multi-agency collaboration to prevent and respond to abuse, neglect and self neglect

This priority supports CHSAB to meet Strategic Objectives 2, 3,4 and 5

Golden Thread: Making Safeguarding Personal, Mental Capacity Act and Equity

Priority	Key actions	Objectives	Intended Outcomes
2. Establish a Multi-Agency Dashboard and Conduct regular multi-agency audits	2.1 Identify and agree data for a CHSAB multi-agency dashboard 2.2 Design and launch a multi-agency dashboard 2.3 Using evidence base, agree forward plan and complete multi agency audits to establish impact of CHSAB activity, especially related to Safeguarding Adult Review learning and recommendations - identify good practice and areas of improvement	Enable early identification of trends and current or emerging risks Inform CHSAB key priorities Understand the impact of CHSAB activity and embedding of learning and recommendations from reviews to underpin adult safeguarding learning needs for staff, volunteers and members of the public and systems and practice improvement Improve visibility of safeguarding data across the multi-agency system	Improved outcomes for residents CHSAB strategy reflects real-time issues and community needs needs Emerging concerns are identified early, and targeted interventions are made before the risk escalates CHSAB is assured on quality of practice and safety of multi agency systems Good multi agency audit outcomes Training and system and practice development are evidence-led Shared learning opportunities that inform improvements in practice, policy, and training. SAB partners have access to timely, integrated data to enable informed decisions

This priority supports CHSAB to meet Strategic Objectives 1,2 3, 4, and 6

Golden Thread: Making Safeguarding Personal, Mental Capacity Act and Equity

Priority	Key actions	Objectives	Intended Outcomes
3. Ensure Learning from Safeguarding Adult Reviews (SARs) and Other Reviews are complete timely and learning is shared	3.1 Review and promote our current arrangements related to SAR referrals 3.2 Develop our current oversight and governance arrangements related to the completion of actions related to the learning and recommendation in SARs 3.3 Develop our current oversight and governance arrangements related to sharing the learning and recommendations from SARs 3.4 Develop a framework to share and embed learning and recommendations from other reviews ie Domestic Abuse Related Death Reviews, Children Safeguarding Practice Reviews, LeDeR etc...t	Assurance that SAR referrals are made as required Robust oversight, scrutiny and governance related to SAR learning and recommendations Robust oversight, scrutiny and governance related to embedding learning and recommendations from SARs and other reviews Sustain a culture of openness, reflection and continuous learning	Improved outcomes for residents SAR referral processes are well embedded and people understand when and how to make a SAR referral Learning and recommendations from SARs and other reviews are complete timely and learning is shared timely and effectively A safe and open culture of learning and reflection across all agencies at all levels SAR learning and recommendations are reflected in practice improvement and workforce development activity

This priority supports CHSAB to meet Strategic Objectives 1,2,3,4,5 and 6

Golden Thread: Making Safeguarding Personal, Mental Capacity Act and Equity

Priority	Key actions	Objectives	Intended Outcomes
4. Implement the updated London Association of Directors of Adult Social Services (ADASS) Pan-London Adult Safeguarding Policies and Procedures	4.1 Share the draft Pan-London Policies and Procedures with CHSAB members 4.2 Share and promote the updated Pan-London Policies and Procedures with CHSAB members to cascade within their networks 4.3 Review and revise local safeguarding policies, procedures, pathway and practice to align with the Pan-London Policies and Procedures	Ensure all CHSAB members are aware of and understand the updated Pan-London Policies and Procedures and cascade these within their networks Local safeguarding policies, protocols, pathways and practice reflect the updated Pan-London Policies and Procedures reflect	Improved outcomes for residents Consistent safeguarding practice across all sectors in accordance with best practice and statutory duties and responsibilities Strengthened multi-agency collaboration to prevent and respond to abuse, neglect and self neglect

This priority supports CHSAB to meet Strategic Objectives 1,2, 3 and 4

Golden Thread: Making Safeguarding Personal, Mental Capacity Act and Equity

Priority	Key actions	Objectives	Intended Outcomes
5. Improve outcomes for people experiencing homelessness by preventing abuse and neglect and strengthening safeguarding responses	5.1 Implement and action the recommendations made from the 'Deep Dive' analysis of safeguarding concerns for adults who live in temporary and supported accommodation in Hackney and best practice guidance 5.2 Raise awareness of safeguarding risks for individuals who are homeless in City and Hackney through targeted communications and training for frontline staff	Minimise the risk of abuse and neglect for individuals experiencing homelessness. Improve our response to safeguarding concerns by addressing systemic barriers and gaps in safeguarding responses within temporary and supported accommodation settings by having appropriate supports and services in place; and developing our multi-agency policies, procedures, pathways and practice. Develop and deliver targeted training for professionals working in housing, health, social care, outreach, and voluntary sector settings to improve understanding of safeguarding risks linked to homelessness.	Improved outcomes for individuals experiencing homelessness. Increased awareness and understanding among professionals of safeguarding risks associated with individuals experiencing homelessness. Clear evidence that learning from the deep dive and best practice research is embedded in local policy, procedures, pathways and frontline practice. Improved quality and consistency of safeguarding responses to individuals experiencing homelessness, evidenced through audits.

This priority supports CHSAB to meet Strategic Objectives 1,2, 3,4 and 5

Golden Thread: Making Safeguarding Personal, Mental Capacity Act and Equity

Priority	Key actions	Objectives	Intended Outcomes
6. Minimise the risk of self-neglect and strengthen our multi-agency response	6.1 Raise awareness of self-neglect with individuals and communities. 6.2 Understand the effectiveness of our preventative approach and response to self-neglect through a multi-agency audit. 6.3 Continue to offer and promote training to practitioners on recognising, assessing risk and responding to self-neglect. 6.4 Promote the use of the CHSABs self-neglect guidance and toolkit to ensure consistency in response.	Minimise the risk of self-neglect. Ensure high-quality training is available and promoted across communities and partner agencies on preventing, recognising, assessing, and responding to self-neglect. Continuously improve our effective multi-agency preventative approach to self-neglect. Continuously improve our supports and services in place; and develop our multi-agency policies, procedures, pathways and practice when self neglect occurs. Ensure staff across all partner agencies understand their roles and responsibilities in responding to self-neglect, and can confidently use local policies, procedures, guidance and tools and can work effectively within our multi-agency system	Improved outcomes for individuals at risk of, or experiencing, self-neglect. Greater public and professional awareness of self-neglect and how to respond. Improved quality and consistency of our preventative and safeguarding responses to self-neglect, evidenced through audits.

This priority supports CHSAB to meet Strategic Objectives 1,2,3,4,5 and 6

Golden Thread: Making Safeguarding Personal, Mental Capacity Act and Equality and Inclusion

Priority	Key actions	Objectives	Intended Outcomes
7. Minimise the risk of and strengthen our multi-agency response to financial abuse.	7.1 Coordinate a local campaign to raise awareness of financial abuse, including fraud and emerging scams 7.2 Understand the effectiveness of our preventative approach and response to financial abuse through a multi-agency audit 7.3 Provide training to frontline staff on recognising financial abuse, how to prevent it and respond effectively when concern are raised 7.4 Develop services and supports; and local multi-agency policies, procedures, pathways and practice to prevent financial abuse and respond effectively when concerns are raised	Minimise the risk of financial abuse. Continuously improve our effective multi-agency preventative approach to financial abuse. Continuously improve our supports and services in place; and develop our multi-agency policies, procedures, pathways and practice when financial abuse occurs. Ensure staff across all partner agencies understand their roles and responsibilities in responding to financial abuse, and can confidently use local policies, procedures, guidance and tools and can work effectively within our multi-agency systems.	Improved outcomes for adults at risk of, or experiencing, financial abuse Greater public and professional awareness of financial abuse and how to respond. Increased number of safeguarding concerns received relating to financial abuse, particularly from underreported communities. Improved quality and consistency of our preventative and safeguarding responses to financial abuse, evidenced through audits

- **Making Safeguarding Personal** is central to adult safeguarding and means adult safeguarding should be person-led and outcome-focused, engaging the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Accessibility statement

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