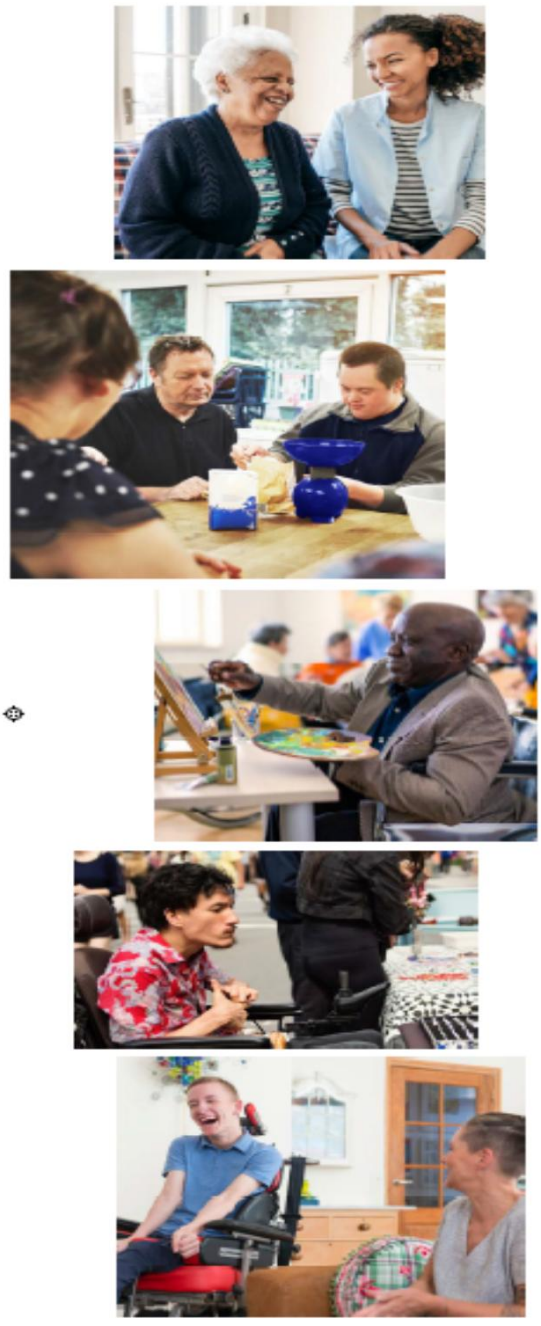
2024-2025



LAMBETH SAFEGUARDING ADULTS BOARD

Annual Report

Safeguarding Adults in Lambeth

CONTENTS PAGE

LAMBETH SAFEGUARDING ADULTS BOARD

ANNUAL REPORT 2024-25

INTRODUCTION FROM THE INDEPENDENT CHAIR

It gives me great pleasure to present the Lambeth Safeguarding Adults Board Annual Report for 2024- 2025 which highlights how our partnership has grown in maturity, depth and confidence as we have worked together to deliver the ambitions in our strategy. As we enter into the last year of our strategy we review and accelerate the progress we need to make, especially those ambitions around better understanding and supporting Lambeth's diverse communities.

In this report we bring together the stories, achievements and learning from across our partnership as we reflect on what more we need to do to keep our most vulnerable communities safe.

The year has continued to present significant challenges across housing, community safety, health and social care. Our communities continue to experience the uncertainty and anxieties of an ongoing cost of living crisis; whilst the ongoing pressures on frontline services and rising levels of complexity mean our staff have had to deliver in extremely challenging services. Strong partnership working, trusted relationships and working collegiately across our different organisations has become even more essential - and our board partners have recognised this through the time we have dedicated to working together to build the right cultures, processes, and oversight. This report highlights the collective efforts of all Board partners to respond to these challenges, promote person-centred safeguarding practice, and above all improve outcomes for those adults at risk in Lambeth. We have prioritised cultural curiosity as a core principle for us, which drives a real appetite to learn and to ask difficult questions with compassion.

I'd like to thank all our practitioners who continued to bring their passion, dedication and professionalism through an extremely challenging year, and have made countless life changing differences to the lives of Lambeth's most vulnerable. Thank you finally to the team that support the Board to function, to lead and to deliver the changes we need to achieve together.

Anu Singh, Independent Chair of the Lambeth Safeguarding Adults Board

SAFEGUARDING ADULTS IN LAMBETH

Safeguarding adults is about protecting someone's right to live in safety, free from abuse and neglect.

It is also about preventing the abuse of adults who might be unable to protect themselves because of their disabilities or care needs. It is a collective responsibility. We want to ensure that all Lambeth residents, health and social care staff and other professionals working in the borough have access to information about Safeguarding Adults that helps them understand what this looks like and what steps we can take to support adults who may be at risk of or experiencing abuse or neglect.

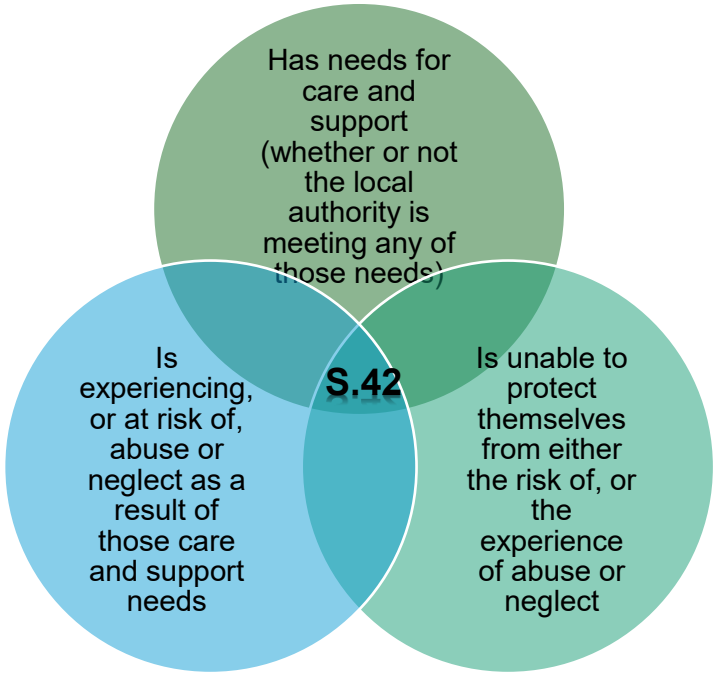
Worried about someone's safety?

If someone is in immediate danger,
Call **999** right away.

To Make an adult Safeguarding Referral (Non-Emergency)

- Online: https://www.lambeth.gov.uk/adult-social-care/safeguarding-adults/make-safeguarding-adults-referral
- By Phone: **020 7926 5555**
  - Press 1 for Support
  - Press 3 for Safeguarding

The Care Act 2014 Section 42 states that safeguarding duties apply to an **adult** who:



WHAT IS THE LAMBETH SAFEGUARDING ADULTS BOARD?

The Lambeth Safeguarding Adults Board (Lambeth SAB) co-ordinates safeguarding adults work in Lambeth. Its main objective is to ensure that safeguarding arrangements across the partnership work effectively to prevent abuse and neglect, and to protect people with care and support needs who may be at risk of abuse and neglect. The SAB seeks assurance that safeguarding practice is person centred and outcomes focused. The local safeguarding arrangements in Lambeth are carried out in accordance with Care Act 2014 and statutory guidance.

The Board has an Independent Chair and is a multi-agency partnership that includes a range of organisations. We want to ensure that all residents and people who work with adults at risk in Lambeth know about safeguarding adults and how to respond should they come across a concern. We do this by maintaining cohesive partnership working.

The Board is not responsible for delivery of services, those who plan and make decisions about services locally have representation at the Board and give the Board regular assurance on how their services respond to and protect adults at risk of abuse or neglect.

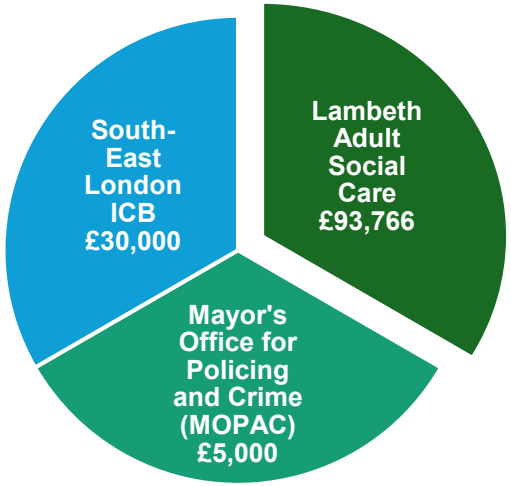
The SAB's statutory functions include:

- Developing and publishing a strategic plan setting out how we will meet objectives and how the partnership will contribute to this
- Publishing an annual report detailing how effective their work has been
- Commission and conduct Safeguarding Adults Reviews for cases which meet the criteria

Financial summary:

While Lambeth Council holds the primary responsibility for Safeguarding Adults, all key statutory partners are encouraged to contribute equitably to the partnership's resource and budget. This approach ensures robust and effective safeguarding practices and responses across the borough.

In the year 2024/25 we received partner contributions from:



THE LOCAL PICTURE: SAFEGUARDING ACTIVITY IN NUMBERS

Safeguarding concerns and enquiries

Lambeth Adult Social care processed 1660 Safeguarding Concerns in 2024-25. 31% of these concerns converted to S42 Safeguarding Enquiries. The volume of safeguarding concerns and enquiries is 13% lower than the previous year, however the conversion rate has remained steady at 31%, demonstrating that partners are making safeguarding referrals with consideration to the application of the criteria for Section 42 Enquiry under the Care Act 2014.

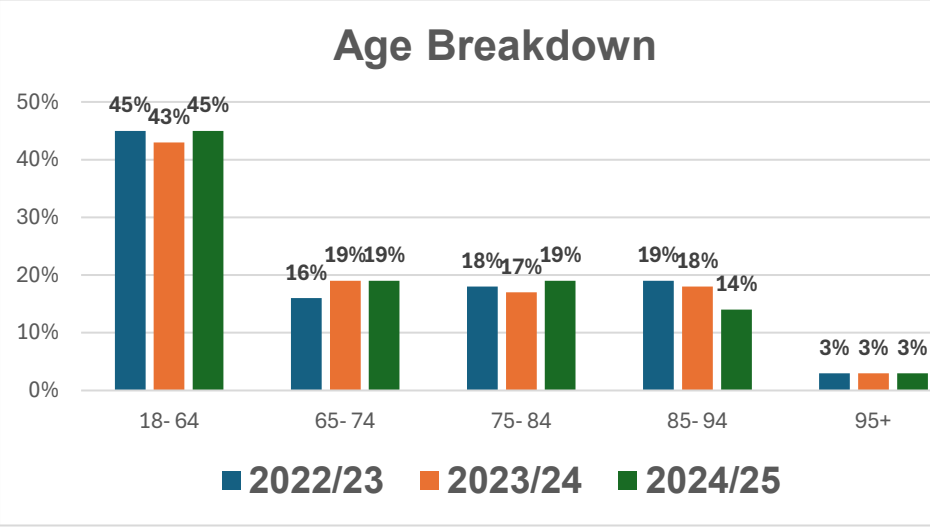
Demographics

In 2024-25, 55% of the enquiries carried out were for adults who were aged 65 and over. The Ethnicity breakdown shows that nearly half (47%) of service users identify as White, followed by a significant proportion (39%) identifying as Black/African/Caribbean. In relation to gender 50% of Safeguarding Enquiries were carried out for females and 50% for males. This is largely representative of the

Lambeth demographic of people who are receiving care and support, which is 52% female and 48% male.

We acknowledge that this represents gender assigned at birth and not the full spectrum of gender identity. We are committed to improving how we collect and report data to better reflect the experiences of trans, non-binary, and gender-diverse individuals receiving care and support in Lambeth.

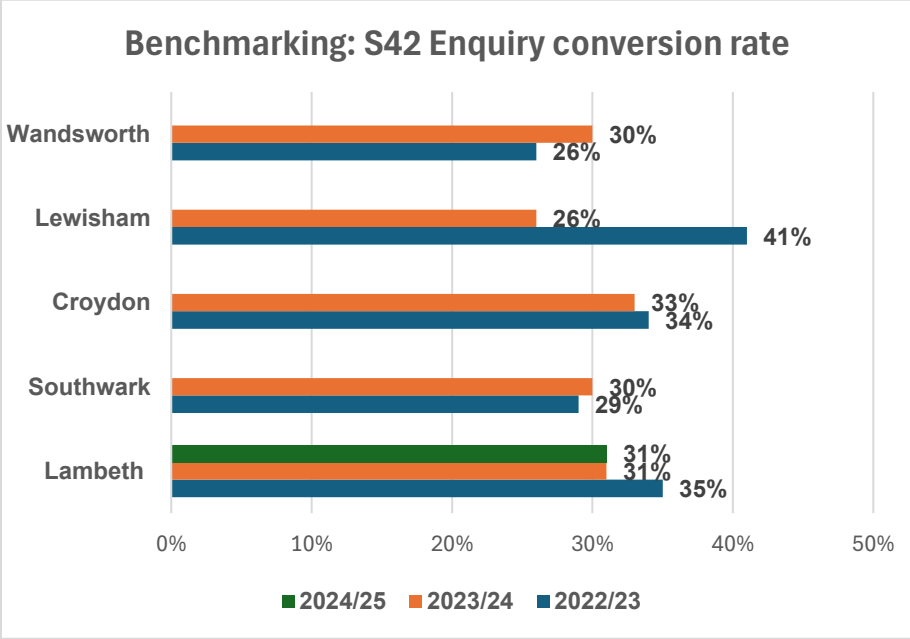
The age breakdown shows that a higher percentage (55%) of adults over the age of 65 have experienced safeguarding enquiries. There is some consistency across the age groups in the past 3 years, with the small decrease in the 85- 94 age category, reflected with a small increase in the 75- 84 age category.



Benchmarking: Conversion rate to S42 Enquiry

In 2024/25 the conversion rate to S42 Enquiry is 31%. This is the same as in 2023/24.

The benchmarking data on S42 enquiry conversion rates highlights Lambeth's consistent approach to safeguarding decision making. While neighbouring boroughs show some variability, Lambeth has maintained a steady trajectory. Lambeth's conversion rate remains similar to neighbouring boroughs and does not appear to be an outlier.



Types of Abuse

Abuse is when someone treats an adult in a way that harms, hurts, or exploits them. It can take many forms – ranging from shouting at someone or undermining their confidence and self-worth, to causing physical pain, suffering and even death. Abuse can happen just once or many times; it can be done on purpose or by someone who may not realise they are doing it.

Neglect and acts of omission

The most common type of abuse recorded is Neglect/Acts of Omission (29%). This is the trend in previous reports and is understandable as the category of abuse includes a wide range of aspects including failure to provide adequate food, shelter, clothing, medical care, or protection from harm. It also encompasses neglect of personal care, emotional needs, and failure to prevent exposure to risk. Given the broad scope of this category, it is understandable that it consistently emerges as the most frequently recorded type of abuse in safeguarding enquiries.

The majority (70%) of neglect/ acts of omission relate to a service provider. Examples of the types of concerns which may be referred to us that relate to service provisions include: *missed/late scheduled home care visits, missed medication prompt, and concerns about manual handling expertise.*

Case example:

Who: An 84-year-old white British woman, bedbound with multiple health conditions including frailty and diabetes, relies on her son and a care package for support. After a hospital visit, she was found to have a Grade 1 pressure sore, which had not been reported by her care team.

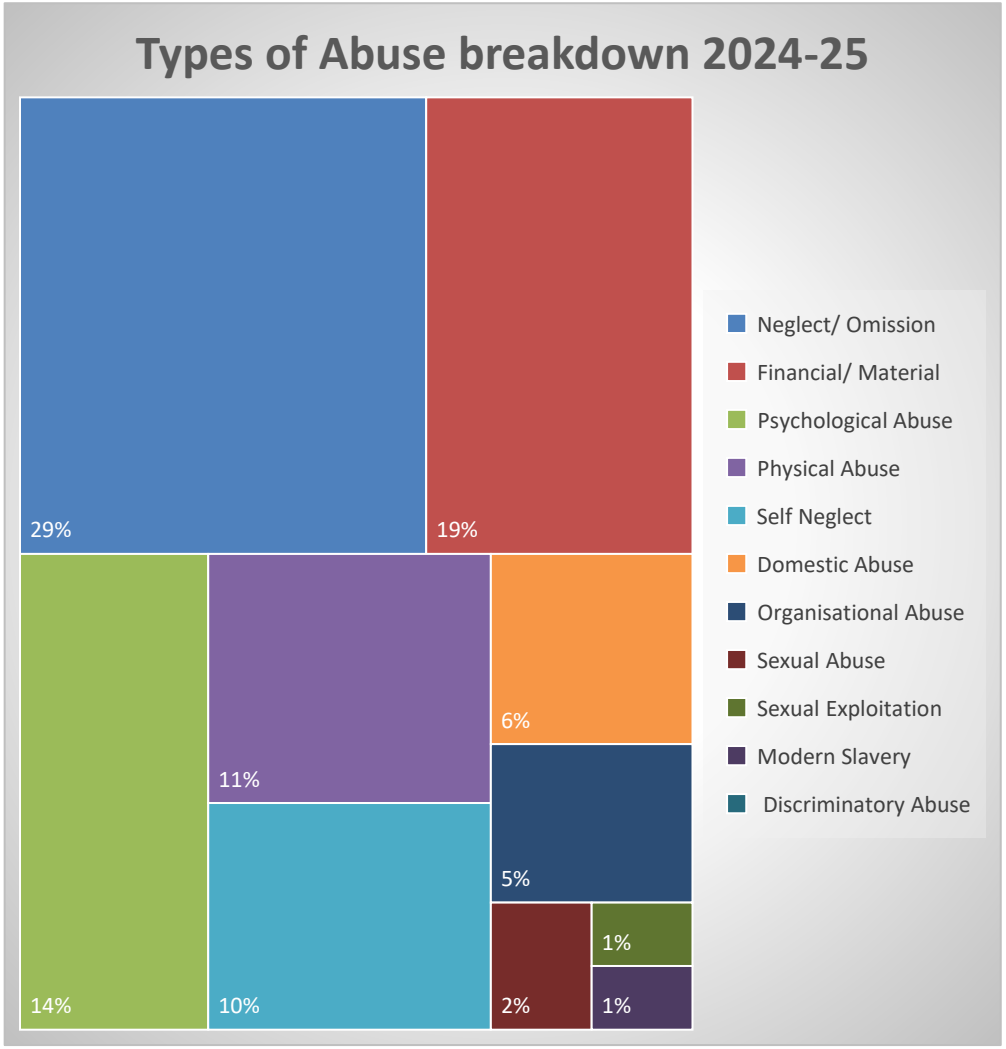
The enquiry: Adult Social Care initiated a S.42 safeguarding enquiry involving the person, her GP, district nurses, the care agency, and her family. The pressure sore was treated and healed, and her care plan was updated to include regular checks on skin integrity, application of cream, and regular re-positioning. The care agency provided refresher training on pressure sore prevention and reporting to their staff.

Outcome: The enquiry outcome confirmed the pressure sore had healed and that she was satisfied with her care. Steps were taken to reduce future risk.

In 2024-25 of the 230 S42 Enquiries in relation to neglect and acts of omission risk outcomes, 95% identified a risk and action was taken, of those where risks was identified and action was taken had 63% risk reduction and 36% risk was removed.

We continue to see higher numbers of ***Financial Abuse (19%) and Psychological Abuse (14%)*** within our reported categories of abuse and work is being done by the Board to understand if there are any emerging themes or factors contributing to this. Cost of living for our residents is a notable area that may contribute to experiences of financial abuse and scams.

Self neglect remains a key area of focus within our SAB initiatives due to the complexity and mortality risk to people who self neglect. There have been 3% fewer S42 enquiries for self neglect than the previous reporting year. This is due to consistent application of a person centred approach where a S9 Care Act Assessment is offered in the first instance (where appropriate) and work is done to link in with the person and their network, including any housing services, early on.



Making Safeguarding Personal

Under the Care Act 2014, all agencies with safeguarding responsibilities are required to implement the principles of Making Safeguarding Personal (MSP). This approach ensures that safeguarding practice is person-led, outcome-focused, and promotes participation, choice, and control. It aims to enhance individuals' quality of life while improving safety and wellbeing. All agencies are expected to provide assurance to the Safeguarding Adults Board that MSP is embedded in their practice and that safeguarding interventions are aligned with the individual's desired outcomes.

In Lambeth, 85% of individuals involved in safeguarding enquiries were asked about their desired outcomes and had them recorded. Of those, 99% reported that their outcomes were either fully or partially met—an increase of 4% compared to the previous year. This demonstrates that practitioners recognise the importance of engaging individuals in meaningful conversations about what they want to achieve from the safeguarding process. It also shows that these outcomes are being clearly recorded and that safeguarding actions are tailored to support the person's wishes.

One of the ongoing challenges in setting safeguarding outcomes is that individuals may express goals that fall outside the remit of safeguarding. To support practitioners in navigating these conversations, a series of practice sessions held during National Safeguarding Adults Week in November 2024 provided valuable reminders and practical tools to help frame outcome-focused discussions effectively.

The goal of adult safeguarding is to reduce or remove the risk the specific safeguarding concern poses to the person. 94% of concluded safeguarding enquiries in 2024/25 resulted in risk being identified and action taken. Furthermore, 93% of these individuals experienced either the removal or reduction of the identified risk. This reflects a strong commitment to effective risk mitigation and person-centred safeguarding practice. Where the risk remains, it is typically because people have chosen to accept it and are aware of its consequences.

In 2024–25, the most common location of risk identified in concluded Section 42 enquiries was the adult's own home, accounting for 60% of all cases. There are 36 registered care homes in Lambeth, this is reflected in the second highest location of abuse, with 14% taking place in residential and nursing homes.

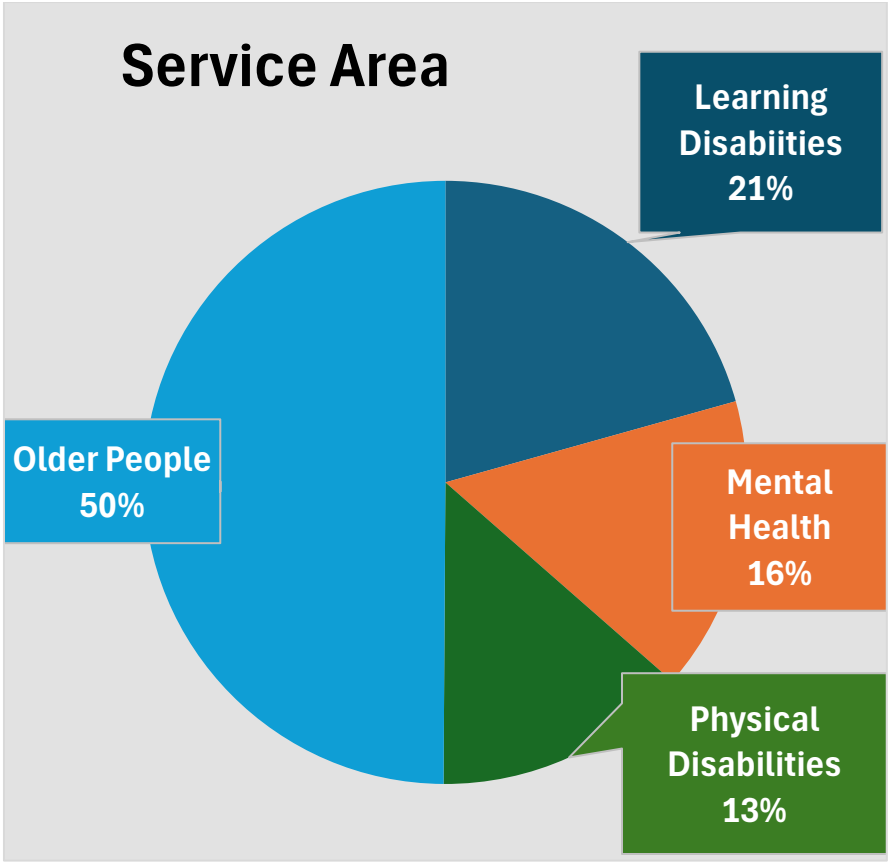
Equality, Diversity and Inclusion (EDI)

The SAB applies an EDI lens to safeguarding data, breaking down S42 enquiries by primary support reason, gender, ethnicity, and age to identify if there are any disparities, themes, or trends, to inform targeted interventions.

Notably, more than one category of abuse can be selected for an individual at a time. For example someone may be experiencing domestic abuse, and this could include elements of financial and psychological abuse. For the annual report we have broken down the data through abuse type and continue to build up a holistic understanding and picture of who is experiencing safeguarding in Lambeth, and their outcomes.

Service area of adults who experienced S42 safeguarding enquiry

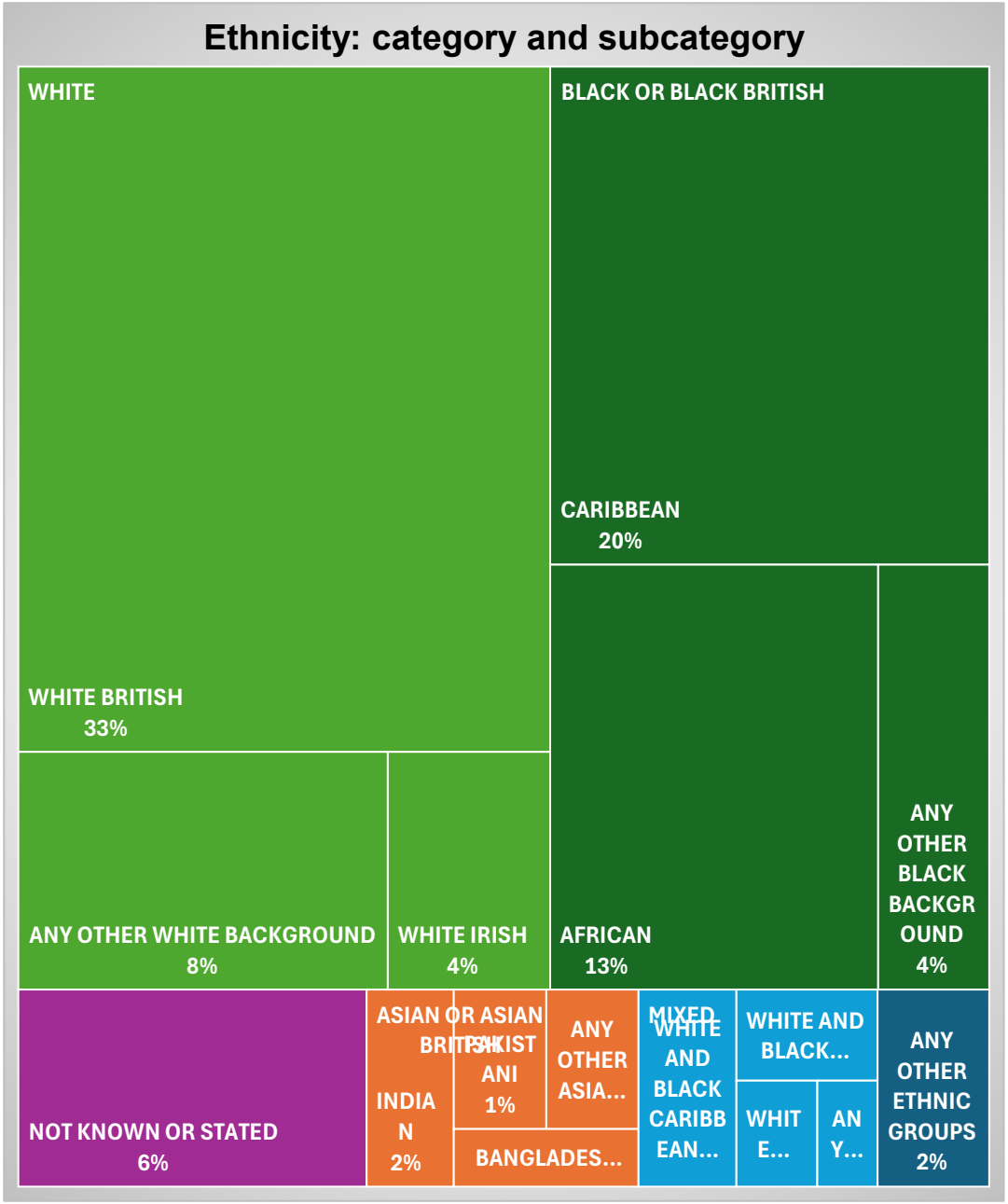
Older people represent 50% of adults undergoing safeguarding enquiries, closely aligning with Lambeth's Adult Social Care data where 49% of service users fall into the older people category. Mental Health service users are slightly overrepresented in safeguarding enquiries at 16%, compared to 11% across the broader Adult Social Care service line. This may reflect the increased complexity and risk factors associated with mental health needs, which can lead to a higher likelihood of safeguarding concerns being identified. Mental Health and safeguarding is an area of focus for the SAB and work is being done to better understand this in 2025/26.



Ethnicity

We have improved in our recording of protected characteristics. This is particularly evident in recording ethnicity, in 2023/24 12% of ethnicity was not recorded. This has halved to 6% in 2024/25. This continues to be an area of focus so we know more about the backgrounds of those we support in the safeguarding process.

In further analysis with data from our Short and Long Term (SALT) report we can now see that safeguarding referrals and ethnicity are in proportion and representative as to the service users we support



DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) ACTIVITY 2024/25

In 2024/25, Lambeth saw a continued rise in demand for DoLS assessments, with a 19% increase in requests from 1155 the previous year to 1380.

Lambeth has two large acute hospitals operating in their borders: King's College Hospital and St Thomas's Hospital. In 2024/25,31% of our DoLS referrals were received from these two hospitals. This volume provides some assurance that staff in the hospitals are able to identify when a deprivation of liberty is taking place and when a DoLS referral should be considered. They are supported by the Trust Safeguarding Leads and their teams, in quality assuring and as an escalation point for any complex situations. The DoLS Team in Lambeth ASC closely monitors all acute hospital cases, with weekly reviews and strong communication with major hospitals to identify any cases needing allocation.

The DoLS Team ensures equitable access by working with independent assessors and interpreters to meet the needs of Lambeth's diverse population. In 2024/25 approximately 30 interpreter bookings were made, in addition to using s12 Drs and BIAs who speak other languages, so could directly translate.

Advocacy

In 2024/25, Lambeth continued to deliver a broad range of statutory advocacy services, including Care Act advocacy, Independent Mental Capacity Advocacy (IMCA), Relevant Person's Professional Representatives (RPPR), Independent Mental Health Advocacy (IMHA), and Independent Health Complaints Advocacy (IHCA), alongside a small amount of non-statutory advocacy.

In 31% of safeguarding enquiries it was identified that the person lacked capacity in relation to the safeguarding matters being reviewed and in 97% of cases it was recorded that the person was supported by an advocate, family member or friend, in relation to this. In one case we determined that the person lacked capacity but they passed away before an advocate was identified and the enquiry was concluded.

For our 2024-25 DoLS cases, 55 IMCAs and 308 Professional RPRs were instructed; 48% of people subject to a DoLS authorisation had/have a Professional RPR advocating for them for the duration of the authorisation.

LAMBETH SAB STRATEGIC PLAN (2023-2026)

The Safeguarding Adults Board (SAB) has a strategic plan to set clear priorities, align partner efforts, and ensure a coordinated, proactive approach to safeguarding adults—focusing on communication, partnership, and equality, diversity and inclusion in safeguarding work.

This plan spans a three-year period, providing a long-term vision for safeguarding priorities.

The year 2024/25 was focused on consolidating progress and embedding key approaches across the partnership to strengthen consistency and impact.

COMMUNICATION

In 2024–2025, LSAB strengthened its communication both internally across the partnership and externally with the community

Referral Feedback Improvements: Adult Social Care (ASC) introduced new outcome letter templates to improve communication with referrers and service users. These letters explain the outcome of safeguarding concerns and enquiries in accessible language, supporting the principles of Making Safeguarding Personal

7-Minute Briefings and Bulletins: Learning from Safeguarding Adults Reviews (SARs) and audits was shared through a variety of formats across each organisations including through 7-minute briefings, bulletins, webinars and screen savers. These were used to reinforce key messages and learning during practice weeks, including National safeguarding Adults Week.

Community Engagement: The LSAB continued to support the Community Engagement Group (CEG), which co-produced easy-read safeguarding materials and hosted roadshows to raise awareness among seldom-heard groups.

PARTNERSHIP

The LSAB has continued to foster strong multi-agency collaboration, with a focus on shared responsibility and joint learning

Complex Case Framework (CCF): The Board reviewed and promoted the use of the CCF, which supports multi-agency responses to high-risk cases that fall outside safeguarding thresholds. A tri-borough review with Southwark and Bromley is underway to align practice and improve consistency and the learning from this will support the next steps to further embedding this risk management tool.

Performance and Quality Subgroup: This subgroup led audits on safeguarding referrals, identifying areas for improvement and supporting the development of training and policy updates. It also coordinated the Board's response to the Ministerial Letter on Rough Sleeping, ensuring that governance, strategic planning, and SAR considerations were in place

SAR Learning Integration: Learning from SARs was embedded through training, policy updates, and supervision. SAR Martin and SARs H, I, and J were used as case studies in ASC training, and themes such as executive functioning and professional curiosity were incorporated into safeguarding webinars. The National SAR Analysis was reviewed in the SAR sub group and key learning has been referenced in work undertaken.

Cross-Board Collaboration: The LSAB worked closely with the Lambeth Children's Partnership and Safer Lambeth Partnership to align learning from SARs, Domestic Abuse Death Reviews (DADRs), Offensive Weapon Reviews (OWRs), and Alcohol-Related Deaths (ARDs), supporting a "Think Family" approach. This is an ongoing initiative and the outputs of this will be evident in 2025/26.

EQUALITY, DIVERSITY AND INCLUSION (EDI)

EDI remained a central focus of the Board's work, with efforts to improve data quality, accessibility, and culturally competent practice

Data Analysis and Reporting: ASC analysed safeguarding data by protected characteristics and compared it to borough-wide demographics. This helped identify trends and gaps in service access, informing targeted outreach and training. Notably, self neglect and financial abuse emerged as frequent referral types and ASC carried out a self neglect audit to better understand the types of referrals being received. It highlighted the continued importance of multi- agency working and risk assessment, and the usefulness of the complex case framework as a tool. Improved ethnicity recording was highlighted and remains an area of focus for the SAB to understand the diverse community in Lambeth. This was presented at October 24 and January 25 Board for reflection and discussion within the partnership.

Accessible Communication: The Board prioritised the development of easy-read materials and avoided the use of unexplained acronyms in public-facing documents. This was particularly important for engaging with people with sensory impairments and learning disabilities. The SAB website is being updated and all documents reviewed to ensure accessibility and relevance.

Training and Awareness: SAR learning and safeguarding training included themes of unconscious bias, cultural competence, and the impact of structural inequalities. SLaM's safeguarding training incorporated themes from SARs and was updated in line with the Intercollegiate Document.

National Safeguarding Adults Week (NSAW) 2024: was a success, with the South East London Safeguarding Adults Boards—Lewisham, Lambeth, Bromley, Southwark, and Bexley—collaborating for the first time to deliver over 30 expert-led sessions. Lambeth SAB led a well-attended session on executive functioning and safeguarding, drawing 116 participants.

Inclusive Practice Audits: The MCA audit and safeguarding audits included a focus on how well practitioners considered executive functioning, fluctuating capacity, and the role of advocacy—key issues for safeguarding adults with complex needs

WHAT HAVE WE DONE IN THE LAST YEAR?

Performance and Quality Subgroup Summary: 2024–2025

The Performance and Quality (P&Q) Subgroup continues to provide robust oversight and assurance to the Lambeth Safeguarding Adults Board (LSAB), supporting the delivery of its strategic priorities through audit, data analysis, and inter-agency collaboration. The group has met regularly to review safeguarding performance, identify areas for improvement, and ensure that learning is embedded across the partnership.

1. Referral Audit

The subgroup reviewed referral data from July to September 2024, which showed a smaller % of the 1,910 referrals received by the safeguarding hub progressed to a Section 42 enquiry. This highlighted the significant volume of non-safeguarding work being managed by a small team.

Key insights included:

The quality and clarity of referral information is key in ensuring the right information is provided to support decision making around risk and safeguarding

The importance of consistent feedback to referrers and service users.

There may be opportunities to learn from other boroughs as we continue to streamline our referral systems.

Agreement to this approach as ongoing quality assurance work

2. National Safeguarding Adults Week (NSAW) 2024

The South—East London Safeguarding Adults Boards—Lewisham, Lambeth, Bromley, Southwark, and Bexley—collaborated for the first time to deliver over 30 expert-led sessions. P&Q subgroup members helped coordinate preparations for NSAW 2024, including dissemination of the training calendar and promotion of key sessions such as the Executive Functioning webinar which was led by Lambeth SAB and had 116 attendees.

3. Response to Ministerial Letter on Rough Sleeping

The subgroup discussed the government's May 2024 ministerial letter on rough sleeping, which included four key recommendations	Establishing governance and accountability structures.
	Appointing a named board member for rough sleeping.
	Developing strategic plans and procedures.
	Considering if SAR criteria is met for deaths of people who sleep rough.

Through discussions it was determined that these areas are already addressed by key organisations of the LSAB partnership. Members reflected on systemic issues such as eviction practices, short-term accommodation offers, and rigid eligibility criteria that contribute to rough sleeping. The group agreed that prevention and system-wide change are essential and committed to raising these issues at the South East London (SEL) Safeguarding Board, remaining on the SAB's agenda for 2025/26.

Complex Case Pathway Framework

The complex case framework (CCF), introduced in 2021 following learning from Safeguarding Adult Reviews (SARs) across Lambeth, Bromley, and Southwark, continues to be a key tool for managing risk in cases that do not meet the threshold for a Section 42 safeguarding enquiry but where multi-agency coordination is essential. In 2024–2025, the LSAB has made significant efforts to review, refine, and embed the framework across the partnership.

Review and Feedback

A comprehensive review was undertaken in 2023–2024, including a survey of practitioners across Adult Social Care, SLaM, housing, and provider services. Key findings included:

- Confusion about the name "pathway," which led some to believe it was a formal service or statutory process.
- Inconsistent understanding of roles and responsibilities, particularly outside of Adult Social Care.
- Challenges in securing engagement from partner agencies, with some defaulting responsibility to accommodation providers.
- A need for clearer escalation routes when agencies fail to attend meetings or follow through on actions

Promotion and Training

In response to the feedback received, the LSAB undertook a series of promotional and training activities:

- The framework was featured in sessions during Mental Capacity Act Week and National Safeguarding Adults Week 2024.
- The Safeguarding Adults Lead in Adult Social Care delivered briefings to housing teams, provider forums, and team meetings, on behalf of the SAB, to raise awareness and gather feedback.
- A need for clearer escalation routes when agencies fail to attend meetings or follow through on actions

Embedding Improvements 2024–2025

The LSAB has committed to several actions to strengthen the framework's use and impact:

- Tri- Borough Review: Collaborating with Bromley and Southwark SABs to align tools and processes across boroughs, enabling a tri-borough approach to complex case management.
- Reviewing the framework as part of a policy and procedure task and finish group and ensuring any resources are up to date on SAB website
- Improving audit and recording processes to track usage and outcomes more consistently. (2025/26)
- Relaunching the tool with a revised name and format, alongside a refreshed promotional campaign (2025/26)
- Embedding in practice with a commitment from all Board members to continue to embed the framework internally and to develop monitoring mechanisms to better understand frequency of use and outcomes for people.

Looking forward, 2025/26

The LSAB recognises that further work is needed to assure itself that the outcomes of the complex case framework are having the intended impact which is to share and mitigate risk, keeping the person at the centre.

As a result, all members agree that it is a priority to ensure consistent use of the framework, particularly in relation to executive functioning, fluctuating capacity, and shared ownership of risk.

Embedding the Complex Case Framework and developing reflective learning sessions to illustrate the positive impact this tool can have, remains a strategic priority for 2025–2026.

MCA Subgroup

The Mental Capacity Act (MCA) Subgroup has delivered a structured and impactful programme of work throughout 2024–2025, with a strong focus on audit, practice development, and resource creation to support consistent and person-centred application of the MCA across Lambeth's safeguarding partnership.

1. Audit and Assurance Activity

A key achievement this year was the completion of a cross-partnership audit using the updated 2024 MCA audit tool, which was co-designed and agreed by the subgroup. The audit aimed to assess the quality and consistency of mental capacity assessments across a range of decision complexities—simple, intermediate, and complex. 68 case files were audited across multiple agencies, including:

- South London and Maudsley NHS Foundation Trust (SLaM)
- Guys and St Thomas' NHS Foundation Trust (GSTT)
- Lambeth Adult Social Care
- Kings College Hospital (KCH)
- Local GP surgeries

The audit provided general assurance that staff across the partnership demonstrate a good understanding of the MCA and apply its principles in a person-centred way. However, it also highlighted areas where understanding and practice could be strengthened. Feedback on individual cases is being provided by safeguarding leads within each organisation

2. Practice Development and Thematic Learning

The audit revealed some inconsistencies in how mental capacity assessments are conducted and recorded across agencies. In response, the subgroup identified several thematic priorities for improvement in Quarters 3 and 4:

- Clarifying thresholds for seeking legal advice and applying to the Court of Protection, especially in cases involving executive functioning impairments.
- Promoting supported decision-making and ensuring clear options are presented and documented within assessments.

- Developing a tool to support best interest (BI) decision-making using a balance sheet approach.
- Reviewing and updating organisational policies and procedures to ensure they reflect current MCA guidance and embed an MCA lens throughout.

3. Resource Development and Toolkit Finalisation

The subgroup also progressed the development of a comprehensive MCA resource pack for frontline staff. This included:

- Collating and reviewing all locally used MCA-related documents.
- Agreeing on a final set of documents to be included in the toolkit.
- Creating a shared access link for partners to use the resource pack

This work was supported by a Microsoft Form to gather partner feedback on proposed documents, ensuring the toolkit reflects the needs and practices of all agencies.

4. Planning for 2025–2026

Looking ahead, the subgroup has begun analysing themes from the audit to inform the 2025–2026 development plan. This includes:

- Creating rapid-read resources and case studies for frontline staff.
- Preparing for the next MCA Practice Week in May 2025

Reviewing the subgroup's Terms of Reference, membership, and policy framework to ensure readiness for the new financial year.

LAMBETH SAFEGUARDING ADULTS BOARD (LSAB)

The Board meets quarterly and has good attendance by LSAB Partners. The meetings are interactive and collaborative, led by our three-year strategic and yearly targeted work plans that are agreed with partners at our annual development day.

The development day held in March 2024 was an in-person event, chaired by our Independent Chair, Anu Singh, and attended by partners from Health, Adult Social Care, Housing, Community Safety and the Metropolitan Police. At the development day, partners shared their key achievements and challenges using the Safeguarding Adults Partnership Audit Tool (SAPAT), resulting in valuable discussions as they reflected on the previous year and looked ahead to the coming year's focus and areas of priority in relation to safeguarding adults' work. The board members' achievements and reflections can be viewed on page 22.

In 2024/25 our Board meetings have continued to evolve as spaces for meaningful reflection and learning. A key innovation has been the use of vignettes—short, real-world case studies presented by Board members—to bring safeguarding practice to life. These stories have sparked rich discussions and helped surface priorities for the Safeguarding Adults Board (SAB) to take forward.

A particularly powerful moment came with the screening of the short film *Tina*, produced by Inner Eye. The film confronts the realities of end-of-life care, especially for people with lived experience of homelessness. Commissioned by King's College NHS Foundation Trust and funded by the Burdett Trust for Nursing, *Tina* was developed in collaboration with Groundswell, a charity led by people with lived experience. The film has been instrumental in deepening our understanding of dignity, compassion, and the systemic challenges faced by some of our most vulnerable residents.

TINA MAIN FILM 07/12/23 (youtube.com)

Staff across the partnership have responded with empathy and insight, using the film and vignettes as springboards for reflection on their own practice. These contributions have enriched Board-level dialogue and reinforced our commitment to embedding lived experience at the heart of safeguarding.

COMMUNITY ENGAGEMENT GROUP

The groups aim is to continually raise awareness of adult safeguarding and protecting adults at risk.

Members of CEG had the opportunity to present what their organisation do, who they support, and what their current safeguarding challenges are.

In 2024/25 we had presentations from

- *Black Thrive* - Culturally Appropriate Peer Support Advocacy.
- *Lambeth Healthwatch* – Advocacy support for service users in Lambeth.
- *Guys and St Thomas*'s foundation trust engagement team
- *PALS- Kings college hospital*
- *Carers hub- Their role and different groups.*

Design and development of a safeguarding leaflet

We collaborated to create a simple one-page document to raise awareness of what safeguarding is and how to report it.

Safeguarding Adults- Community Engagement Roadshow

Following feedback from the community engagement groups last year we continued our work in helping community groups better understand the work from the LSAB through presentations at organisations in the community. This included:

- Carers Day- Lambeth Carers Hub
- Provider Forums
- Housing local community group
- Healthwatch Q&A with service user participants
- Breaking Out of the Bubble
- Lambeth Links

What next for the community engagement group?

- Enhanced understanding of EDI and its impact on safeguarding
- Continuation of forging relationships with new voluntary sector organisations and networking as part of CEG
- Testing website accessibility and collecting feedback on experiences of safeguarding adults

SAFEGUARDING ADULTS' REVIEWS

Under S.44 of the Care Act 2014, the LSAB is responsible for the coordination of Safeguarding Adults Reviews (SARs). These are statutory independent reviews commissioned where there has been an incident of serious harm or death involving an adult at risk in their area.

The most recent SAR commissioned by Lambeth SAB was a thematic review of 3 cases, known as SAR H, I and J in 2022. This review was undertaken by Steve Chamberlain, independent reviewer and the report on the learning can be viewed here.

Lambeth SAR subgroup

The Lambeth SAR sub group consists of partners from Health, Adult Social Care, the Police and Housing. Since SAR HI and J was commissioned, the Lambeth safeguarding adults board have not commissioned another SAR however there have been three referrals that have been reviewed by the members of the SAR sub group and have not met the criteria. In some of these cases management reviews or serious incident pathways were completed and single agency learning was identified.

Embedding Learning from Safeguarding Adults Reviews (SARs): 2024–2025

The LSAB and its partners have taken a multi-layered approach to embedding learning from SARs, ensuring that insights from both local and national reviews are translated into practice, policy, and culture across the safeguarding system.

1. Dissemination of Learning

Partners reported a range of methods for sharing SAR learning internally and across the system:

- 7-minute briefings, bulletins, and screen savers to deliver digestible learning to frontline staff.
- Directorate learning events, safeguarding supervision, and governance forums to reflect on SAR themes.
- Embedding SAR themes into safeguarding training, including bespoke sessions on executive functioning, professional curiosity, and transitional safeguarding.
- Annual presentations to Board Directors and updates through safeguarding committees

2. Policy and Training Revisions

Several organisations have reviewed and updated their safeguarding policies and training packages to reflect SAR findings:

- South London and Maudsley NHS Foundation Trust (SLaM) embedded SAR themes into their revised Level

3 safeguarding training, including topics such as self-neglect, contextual safeguarding, and fire risk

- Adult Social Care (ASC) incorporated SAR Martin and SARs H, I, and J into their November 2024 safeguarding training, using these cases to highlight the importance of risk escalation and partnership working

3. Practice Improvement and Quality Assurance

- Adult Social Care has quality assurance arrangements which includes regular case file audit programme that includes SAR-related themes such as mental capacity, executive functioning, and risk management.
- In Adult Social Care, the Independent Management Review (IMR) framework is used to identify complex cases for learning, with outcomes shared through webinars and practice weeks
- SLaM developed a Safeguarding Health Outcomes Framework (SHOF) and a centralised tracker to monitor SAR themes and ensure they are addressed in practice

4. Cross-Partnership Collaboration

The LSAB has prioritised joint learning across the three Lambeth boards (SAB, Lambeth Safeguarding Children's Partnership (LSCP), and Safer Lambeth Partnership), particularly where themes overlap across SARs, Domestic Abuse Death Reviews (DADRs), Offensive Weapon Reviews (OWRs), and Alcohol-Related Deaths (ARDs).

5. National SAR Analysis Integration

The LSAB has reviewed the findings of the second National SAR Analysis and used them to inform local policy and practice. This includes:

- Greater emphasis on protected characteristics and equity in the SAR process.
- Strengthening the application of the Mental Capacity Act in complex cases, particularly where executive functioning and fluctuating capacity are factors.
- Enhancing psychological understanding of self-neglect and hoarding, and improving data sharing and engagement strategies with housing and health partners

BOARD MEMBER ACHIEVEMENTS AND REFLECTIONS FOR 2024/25

South London and Maudsley NHS Foundation Trust (SLaM)

In the past year, South London and Maudsley NHS Trust has continued to strengthen further its safeguarding agenda as part of the Trust Wide Safeguarding Improvement programme. The significant safeguarding risk which was documented in both the Trust Board Assurance Framework and Integrated Care Board risk registers was closed and stood down, with the remaining risk managed through the Trust and Directorate Risk Registers. As a result, the SLaM Centralised Safeguarding Team was recognised as the Corporate Team of the Year Award winning at the 2025 staff award event. The team was nominated as being instrumental in embedding a culture where safeguarding is everyone's responsibility.

The team has strengthened policies, training and governance while driving transformational change. SLaM has maintained strong and effective engagement with the LSAB and partner agencies, adopting a 'Think Family' approach to safeguarding, actively collaborating with multi-agency partners and regulatory bodies to share information and contributing meaningfully to a multi-agency approach in addressing complex safeguarding concerns. Notable achievements include the creation of an MCA Toolkit, improved safeguarding supervision, successful embedding of the Managing Safeguarding Allegations Against People Employed in a Position of Trust (PiPoT) Policy in practice, involvement in production of the Trust Sexual Safety Policy and Sexual Safety e-learning training package which is based on real-life scenarios. SLaM has recruited a Domestic Abuse Lead who is improving the Domestic Abuse strategy in the Trust, the Safeguarding Coordinator and Safeguarding Administrator who are instrumental in streamlining safeguarding activities and communication. Since the new Police issued Domestic abuse Protection Notices(DAPNs) and Civil Domestic Abuse Protection Order (DAPO) legislated in Domestic Abuse Act 2021 which impose restrictions and mandates perpetrators to attend perpetrator support programmes such as engagement with substance abuse services or mental health services, SLaM has made good progress working alongside the Drive Project, DAPO Leads and SLaM Clinicians to triage SLaM pathway. Learning from SARs and other reviews is disseminated through bulletins, training, and governance forums. There is clear evidence of improved safeguarding awareness and practice across teams within SLAM. Teams are showing a stronger understanding of safeguarding, reflecting a cultural shift toward prioritising safety. This is demonstrated by an increase in both the number and quality of safeguarding

referrals, as well as a rise in staff seeking guidance through consultations. Safeguarding supervision sessions also reveal greater professional curiosity and deeper concern for service users' wellbeing. Despite financial pressures and staffing challenges, SLaM continues to prioritise safeguarding through collaborative working, data analysis, and community engagement.

Guys & St Thomas's NHS Foundation Trust (GSTT)

GSTT has demonstrated a strong commitment to safeguarding through active participation in partnership meetings and the consistent use of the complex case pathway. The Trust has improved internal communication via webinars, updated web content, and community engagement initiatives. However, challenges remain with imbedding standardized referral practices across hospital sites, IT integration issues following a merger, and the operational burden of attending multiple Safeguarding Adults Boards. GSTT has highlighted the need for better understanding of the Mental Capacity Act (MCA) among partners, particularly during out-of-hours scenarios. The Trust continues to manage highly complex cases and advocates for more integrated, collective risk assessments and decision-making across agencies.

Lambeth Housing

Lambeth Housing has maintained a strong safeguarding focus, aligned with its Housing Strategy, “A place we can all call home 2024–2030.” Key achievements include working towards Domestic Abuse Housing Alliance (DAHA) accreditation, vulnerability assessments for residents, and targeted work on rough sleeping and domestic abuse. Despite financial and workforce pressures, the team has prioritised collaboration and learning, contributing to multi-agency pathways such as MARAC and complex case management. Ongoing efforts aim to embed safeguarding across housing operations and ensure vulnerable residents receive timely and effective support.

Age UK Lambeth (AUKL)

Age UK Lambeth has maintained its safeguarding focus despite leadership transitions. The organisation ensures all staff receive annual safeguarding training and has refined its safeguarding policy. It supports staff through peer support, supervision, and a Customer Relationship Management (CRM) system that tracks safeguarding concerns. Challenges include navigating responsibilities between ASC and the SEL ICB and limited resources for addressing hoarding and fire risks. Age UK Lambeth has advocated for better access to translation services and engagement with seldom-heard communities. Learning is shared via intranet bulletins and meetings, and the organisation continues to build staff confidence in identifying and reporting safeguarding concerns.

Integrated Care Board (ICB)

The ICB has played a key role in promoting preventative safeguarding and culturally appropriate services. It has supported Lambeth GPs through safeguarding case studies, Level 3 training, and supervision for safeguarding professionals. The ICB has also contributed to quality surveillance of community providers and collaborated with children's safeguarding teams under the Think Family approach. Learning is embedded through audits, training, and structured supervision. The ICB continues to focus on improving demographic data collection, raising awareness of self-neglect and hoarding, and sharing safeguarding innovations across boroughs. These efforts aim to ensure a consistent, high-quality safeguarding approach across the health and care system.

Metropolitan Police Service (MPS)

The Metropolitan Police have made strategic progress in adult safeguarding by establishing a pan-London forum with Adult Social Care (ASC) leads to address systemic issues and share learning. The appointment of Adult Safeguarding Basic Command Unit (BCU) Leads has strengthened local governance, supported by regular training and supervision. A redesigned Adult Decision-Making Document has improved the quality and appropriateness of referrals to ASC. A centralised tracker now captures and disseminates learning from Safeguarding Adult Reviews (SARs), ensuring that themes are embedded in training and policy. The force has also enhanced its response to mental health crises through the reintroduction of the RCRP Governance Board, new custody pathways, and dedicated ambulances for mental health-related calls. These initiatives reflect a commitment to reducing the criminalisation of mental health and improving multi-agency collaboration.

Kings College Hospital Trust (KCH)

King's College Hospital has demonstrated resilience and innovation in the face of persistent challenges, including high staff turnover and increased Accident & Emergency (A&E) attendances due to mental health and housing crises. The Trust has maintained high compliance with mandatory safeguarding training and enhanced its reporting capabilities through new patient recording systems. A key achievement has been the development of a Clinical Vulnerabilities Service to support complex cases. The Trust continues to advocate for system-wide awareness of the impact of remote working and the need for integrated responses to vulnerable patients. Learning has been embedded through internal audits, safeguarding assurance committees, and active participation in MCA subgroups. The Trust is also exploring how to better evaluate safeguarding outcomes and leverage community social capital to improve service delivery

Lambeth Adult Social Care

Over the past year, Adult Social Care (ASC) has continued to strengthen safeguarding practice through improved communication, deeper partnership engagement, and a stronger focus on equality, diversity, and inclusion.

Communication

- We have maintained strong, stable relationships across the Safeguarding Adults Board (SAB), ensuring effective escalation of concerns and shared learning. New partner representatives, including housing and police, received clear role inductions to support their engagement. Internally, we introduced a new outcome letter template to improve how safeguarding decisions are communicated to service users and partners, supporting the principles of Making Safeguarding Personal (MSP).

- Monthly safeguarding surgeries and performance oversight mechanisms have enhanced our ability to reflect on complex cases and improve practice in real time.

Partnership - Supporting Staff and Service Users

- We support staff managing high-risk cases through visible leadership, monthly safeguarding surgeries, and performance monitoring.
- ASC Quality Assurance Framework supports regular case file audits, including safeguarding, and this has been a focus for us in 2024/25 with over 1000 audits completed. All learning and practice improvements identified have been highlighted through 7 minute briefings, and during in person practice month sessions which are led and coordinated by the Safeguarding and Quality Assurance service in the department.
- We continue to engage with people with lived experience through community events, feedback groups, and the national social care survey. This ensures that service users' voices remain central to shaping our services.
- We launched a Feedback Form, enabling individuals who have received a service from ASC, to let us know if they felt listened to, treated with respect and that they received the help they needed. The responses have been largely positive and the aim for 2025/26 is to further embed this practice with it being a standard offer to anyone following the conclusion of an intervention with one of our workers.

Equality, Diversity & Inclusion (EDI)

- We analysed safeguarding data against borough demographics to identify trends in abuse types and affected populations. A key challenge remains in how we, as a partnership, use this data strategically to demonstrate our collective impact on supporting the most vulnerable.
- We continue to incorporate learning from Safeguarding Adult Reviews (SARs) into training and practice. SAR Martin, for example, was central to our November 2024 training, which engaged over 200 staff in reflective, in-person sessions. We also use 7-minute briefings and webinars to disseminate learning from SARs and thematic reviews.

The Probation Service (PS)

Lambeth is a statutory criminal justice agency responsible for supervising eligible offenders both in custody and in the community. We manage sentencing across England and Wales and deliver Accredited Programmes, Unpaid Work, and Structured Interventions. Through a unified delivery model, we have enhanced service user rehabilitation and desistance outcomes.

Across London, the Probation Service delivers Accredited Programmes, Structured Interventions, Unpaid Work, and Senior Attendance Centres, while continuing to manage sentences in both custody and the community.

Sentence Management focuses on building strong, effective relationships between probation practitioners and individuals on probation. By applying the right skills, behaviours, and activities, we aim to support positive life changes and reduce reoffending. All PS staff are trained to understand their safeguarding responsibilities, including how to escalate concerns when necessary. Learning from Safeguarding Adult Reviews (SARs) is shared at the borough level and informs broader service improvements.

We actively participate in multi-agency forums and the local Community Safety Partnership to address contextual safeguarding and support targeted groups. To aid the transition from youth to adult criminal justice services, a PS Probation Officer is seconded to the Youth Justice Service. Co-location of teams within both the Local Authority and PS fosters strong partnerships and effective joint working

The London Fire Brigade (LFB)

London Fire Brigade in Lambeth has been working across the Borough to promote and improve the interface with the public, professionals in the information they provider to Lambeth with requesting fire safety inspection or in referrals regarding Person at Risk (P.A.R.) safeguarding and welfare forms. In Lambeth after working with the Safeguarding Adults Team at Lambeth Council the Lambeth Fire Team have produced an Aide Memoir to help improve the quality and quantity of information gathered at the scene where a Person at Risk is identified to assist with decision making in the Safeguarding Hub. Through the advice and guidance gathered at the Safeguarding Board in Lambeth we are feeding this through to assist in Policy development in the London Fire Brigade.

There has been development of a home fire safety app which carers and service users can use to check if their home is fire safe.

The fire brigade have attended a recent meeting with Adult Social Care feeding back on information relating to hoarding and improving quality of referrals from 3rd parties and are developing a program to assist in the specialized supported living sector. Through working with Adult Commissioning we have over the past year had a program to assist the supported care home sector in the area. By the end of July 2025 every care home in the Southern part of the Borough will have been visited all caring professionals working in these establishments will have been offered a Fire Safety presentation to help in their work, a similar package is available to residents in these establishments where it is deemed appropriate.

We continue to joint work and attend all board subgroups to see how we can improve on the effectiveness and co-operation between our organisations in Lambeth. This includes feedback from Fire deaths at the SAR subgroup.

LOOKING FORWARD 2025/26:

Our key priorities for 2023 to 2026:

The Lambeth SAB strategic plan for 2023-26 can be viewed here this strategy was developed by all Safeguarding Adults Board Partners in consultation with members of the Board's subgroups.