Hillingdon Safeguarding Adults Board Annual Report 2024-2025

Contents

1. Living in Hillingdon

Hillingdon is the most westerly London borough and the third-least densely populated of all London boroughs. Home to Heathrow Airport and RAF Northolt, the borough has large areas of green space with 67 Green Flag Awards – the most held by any local authority. Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles, over half of which is countryside including canals, rivers, parks and woodland, interspersed with historic towns and villages.

The borough includes more affluent areas (within the top 20 per cent nationally) as well as areas of deprivation (within the lowest 20 per cent nationally). Our overall population is diverse and growing, and people are living longer.

Between the last two censuses (held in 2011 and 2021), the population in Hillingdon increased by 11.7 per cent, to around 305,900. The population in the borough increased by a greater percentage than the overall population of London (7.7 per cent), and by a greater percentage than the overall population of England (up 6.6 per cent).

The ethnicity profile of the borough has also changed, and the data reveals a reduction of eight per cent in the number of residents born in England to just over 60 per cent. Meanwhile, there has been an increase of nine per cent in residents born in India, and two per cent those born in Pakistan.

We are a single local authority with 109 schools, one acute hospital trust (that has two sites in the borough), a GP confederation that includes 43 of the borough's 45 practices, a single community health and community mental health provider and an established consortium of the five larger third sector organisations in the borough.

2. Key Facts and Figures

Individuals by Gender	Male	Female
Safeguarding Concerns	516	713
S42 Enquiries	160	210

Individuals by Age	18-64	65-74	65-74	75-84	95+
Safeguarding Concerns	714	145	173	169	28
S42 Enquiries	203	49	51	60	7

Individuals by Ethnicity	White	Mixed	Asian, Asian British	Black African, Caribbean, Black British	Other	declined	not known
Safeguarding Concerns	541	27	149	76	419	16	1
S42 Enquiries	196	9	51	27	81	6	0

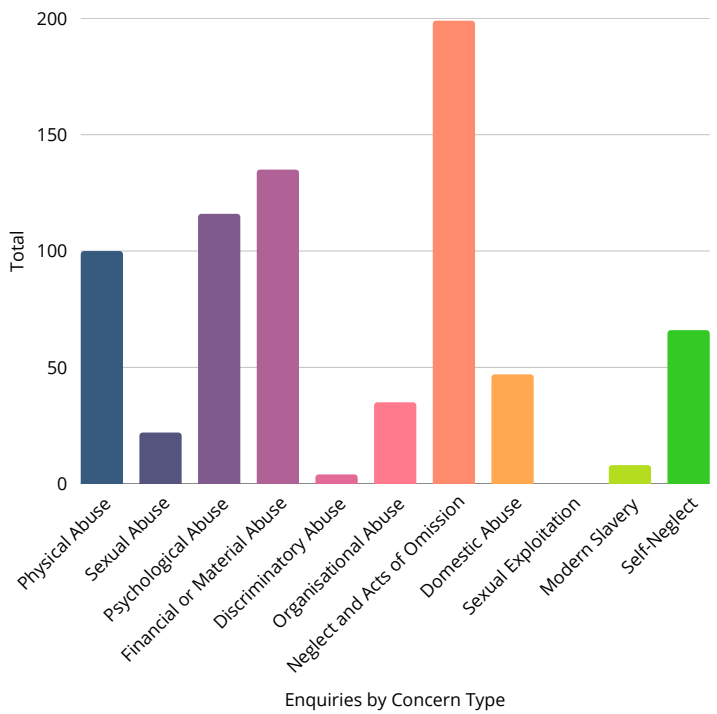
In 2024-2025 the local authority received 13333 Safeguarding Adult Contacts, of these 1229 individuals progressed to a concern. Of these individual adults, 370 were the subject of Safeguarding Enquiries completed under s42 of the Care Act 2014. Some individuals were the subject of more than one enquiry with a total of 394 enquiries completed during the year.

Around a third of safeguarding concerns progress to a formal enquiry, there is no significant difference between genders or ages. In respect of ethnicity 36% of concerns about people of White British ethnicity progressed to a s42 Enquiry, whereas for those of Global Majority ethnicity the figure is 25%.

Making Safeguarding Personal: 80 % of adults were asked their desired outcome, with 91% of desired outcomes fully or partially achieved.

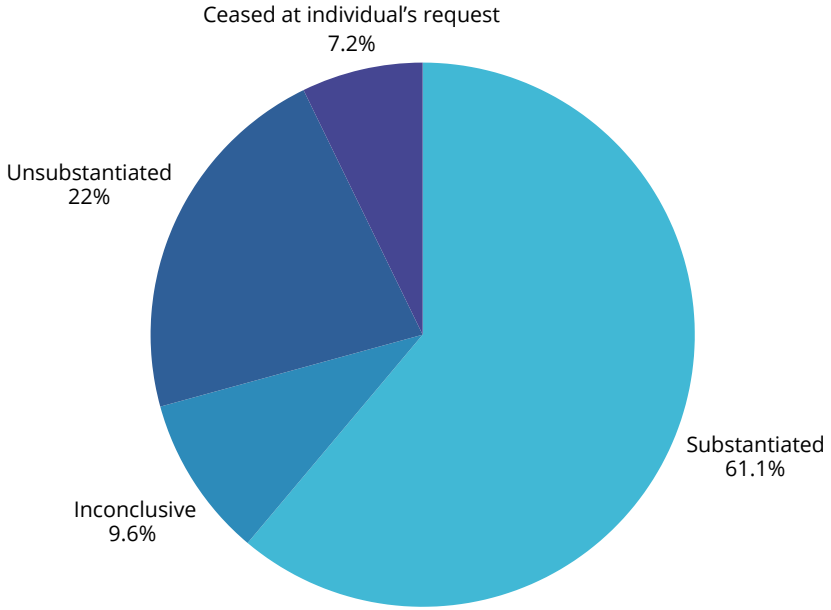
Key Facts and Figures

Concern Type



Neglect and Acts of Omission remains the most common factor within a safeguarding enquiry, this is followed by Financial and Material Abuse, then Psychological Abuse. There have been no enquiries in respect of Sexual Exploitation, with 4 considering risk of Discriminatory Abuse and 8 in respect of Modern Slavery.

Enquiry Outcomes



The most common type of s42 Enquiry outcome is for the risk to be substantiated, with risk reduced for 92% of the adults concerned. Where risk is unsubstantiated, the enquiry resulted in some form of action for over 45% of the adults concerned.

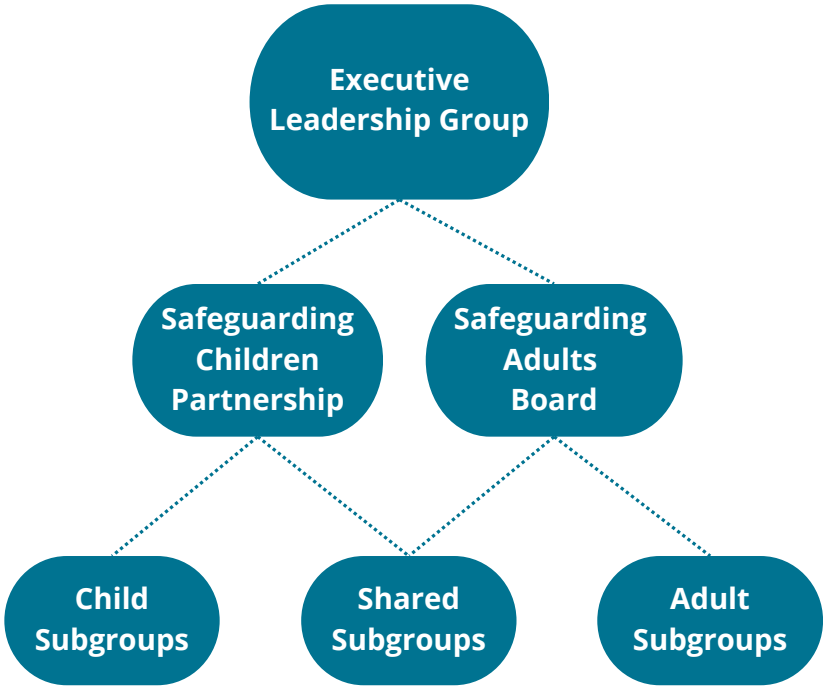
3. Our Safeguarding Arrangements

Hillingdon Safeguarding Partnership is a joint arrangement across the adult and child safeguarding networks. In September 2019 the Hillingdon Safeguarding Children Partnership was launched in line with the statutory requirements set out in the Children and Social Work Act 2017 and Working Together to Safeguard Children 2023.

Under these arrangements The Local Authority shares responsibility with, the North West London NHS Hillingdon Integrated Care Partnership and Metropolitan Police Service, to safeguard children and young people. In 2024 we published an update to our Multi Agency Safeguarding Arrangements, naming our Lead and Delegated Safeguarding Partners.

The **Safeguarding Children Partnership' vision** is for every child and young person to be and feel safe, enjoy good physical, emotional and mental health, have pride in their unique identities, feel that they belong and have opportunities to thrive. The three statutory partners work alongside other relevant agencies in achieving this goal.

The **Safeguarding Adult Board's vision** is for Hillingdon citizens, irrespective of age, race, gender, culture, religion, disability or sexual orientation to be able to live with their rights protected, in safety, free from abuse and the fear of abuse.



Our Safeguarding Arrangements

Hillingdon Safeguarding Partnership is committed to ensuring that all our activities are underpinned by equality of opportunity, celebrating, and valuing diversity, eliminating unlawful discrimination, harassment, and victimisation, and promoting good relations. The Safeguarding Partnership Equality and Diversity Statement sets out how we will achieve this.

Our Communication and Engagement Strategy sets out how the Safeguarding Partnership interacts with individuals in receipt of services, the wider community, and professionals. One of the cornerstones of our local arrangements is an emphasis on understanding the lived experience of children, adults, their families, and carers.

The Safeguarding Partnership works directly with children and adults with lived experience, coproducing where appropriate and consulting on the development of strategies and policies. This ensures that we understand the impact of our work and provides a steer for future areas of priority and focus.

Safeguarding children and adults is a complex process requiring collaborative working across a range of professions and disciplines. At times there may be disagreement about the best course of action to take, and the need to resolve professional differences through proportionate use of escalation.

The purpose of our Escalation: Resolving Professional Differences policy is to provide a framework for escalation suitable for all practitioners and managers across agencies within Hillingdon Safeguarding Partnership, including statutory and non-statutory partners. This can include private and voluntary providers of any type of health or social care or education.

In addition to the core strategic documents there are a range of published partnership policies and strategies to inform specific areas of practice. In the last financial year all partnership policies and documents have been reviewed and updated to reflect the development of our arrangements, and those in national guidance.

4. Our Budget

In line with our arrangements the budget for the Safeguarding Partnership consists of contributions from the three statutory partners, and is shared across the child and adult safeguarding partnership.

These contributions fund the salaries of the Safeguarding Partnership Team, our multiagency training, and the delivery of the functions of the Safeguarding Adults Board and Safeguarding Children Partnership.

Where commissioned training is attended by employees of the local authority, the NHS, or the police then there is no charge. Other delegates pay a nominal fee towards the cost of the training. All agencies are subject to the Late Cancellation Policy, this aims to reduce non-attendance at training that has been booked to enable places to be offered to other practitioners.

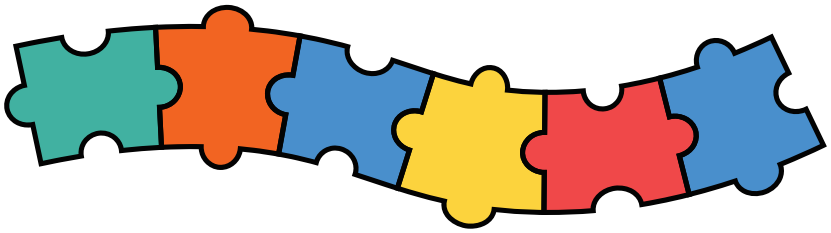
Detail	Contribution	Expenditure
London Borough of Hillingdon	£332,800	
Metropolitan Police Service	£10,000	
North West London ICB	£67,200	
Salaries		£341,423
Training		£26,018
Independent Scrutiny		£5,058
Commissioned Reviews		£9,092
Preventing CSA Conference		£500
Websites and Graphic Design		£830

5. Independent Scrutiny

The Independent Scrutineer for Hillingdon is Alan Caton OBE. Alan is an experienced safeguarding professional and has worked as an independent chair and scrutineer for Local Safeguarding Children Boards and Safeguarding Adults Boards for the past 12 years. Prior to this Alan served as a police officer for Suffolk Constabulary for over 30 years, retiring as the senior officer in charge of the Public Protection Directorate.

Each year the scrutineer is commissioned to focus on a specific area of practice by the Executive Leadership Group. The scrutiny process includes revisiting progress against the areas of consideration previously made.

'It is very reassuring to see that the 'Areas for Consideration' following last year's scrutiny have been considered by the partnership along with being actioned and progressed where necessary'



The terms of reference for scrutiny were developed in line with the 'Six Steps to Independent Scrutiny' model, developed by the University of Bedfordshire, and focussed on the effectiveness and impact of:

- Child Protection Enquiries pursuant to s47 of The Children Act, 1989,
- Adult Safeguarding Enquiries pursuant to s42 of The Care Act, 2014.

This year scrutiny took the form of a multiagency audit, scrutinising a representative sample of child and adult protection enquiries. A comprehensive audit tool was developed, with a roundtable discussion chaired by the Scrutineer.

Adults' Section 42 Enquiries

Safeguarding enquiries for eighteen adults were subject to analysis and audit using an agreed standardised tool by the Safeguarding Partnership Team. The Scrutineer was provided with access to the entire sample, to assure the robustness of the audit. Following this, six representative adults were selected for a multi-agency round table discussion led by the Independent Scrutineer.

There was good representation from the partnership involving senior safeguarding leads from the police, local authority adult's services, Central and North West London NHS Foundation Trust, the Hillingdon Hospital and North West London NHS Integrated Care Partnership.

The audit concluded with a thematic analysis of learning across all eighteen adults, with the Scrutineer highlighting key recommendations as Areas of Consideration for the Executive Leadership Group and local partners.

- To seek assurance that multi-agency planning meetings are held at an early stage in s42 enquiries to ensure all relevant information is gathered and shared to enable better protections and outcomes
- To seek assurance that mental capacity assessments are considered and used appropriately and to be assured that all professionals are thoroughly trained in the MCA Act principles and assessment process
- To seek assurance that adults at risk, who have difficulties participating in enquiries have appropriate representation under s68 of The Care Act, 2014. Also, that there is adequate training on the role and importance of advocacy in safeguarding

Areas for Consideration

In response to the areas of consideration identified, the SAB has a developed a comprehensive plan comprised of assurance activity and proactive development of training, and multiagency strategies. Progress against the areas of consideration will be monitored within the Safeguarding Adults Board, with the oversight and scrutiny of the Executive Leadership Group.

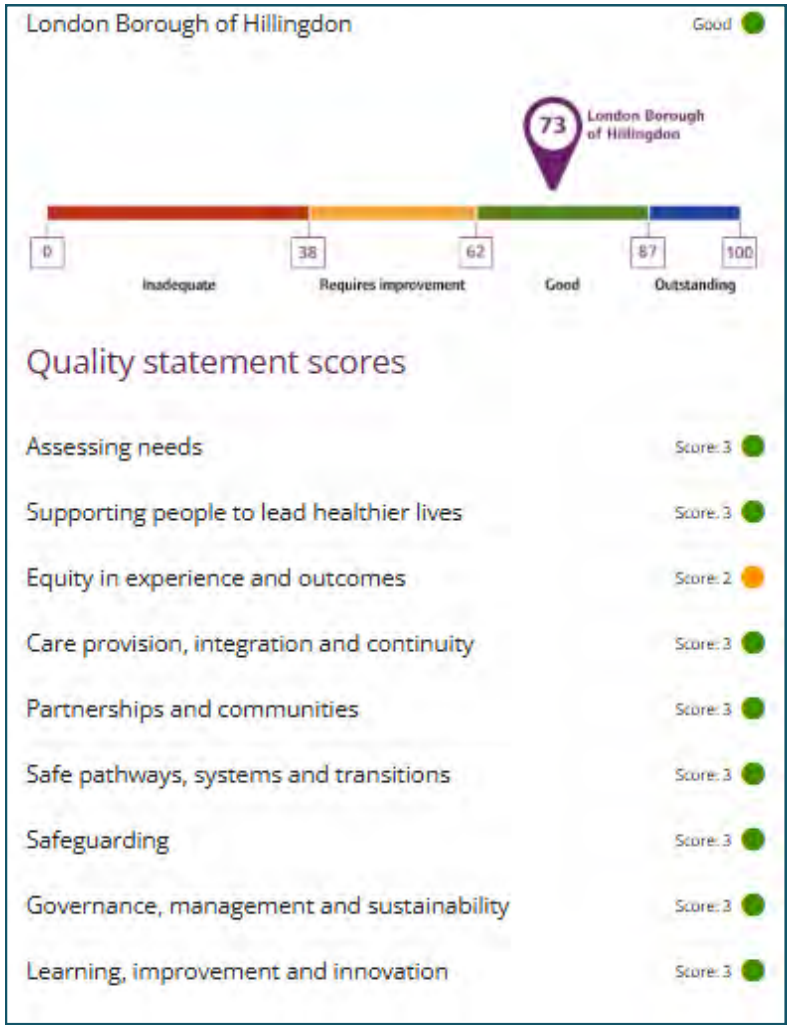
Independent Scrutiny - Outcome

…there continues to be many strengths to the safeguarding arrangements for both children and adults across Hillingdon. I have found a strong partnership that is open to scrutiny and challenge and one that strives to continually learn and improve practice. As last year, I have not
come across any areas of poor practice or weaknesses in service provision. The areas I have outlined for the partnership to further consider, are there to help the partnership on its journey to improve collaboration and coordination and therefore consequently, to improve outcomes for children, families and adults in Hillingdon.

There is strong leadership from the ELG and a clear sense of joint and equal responsibility from the three safeguarding partners. The partnership is one that is built on high support, high challenge and where difficult conversations are encouraged.'

Alan Caton, OBE, 2025

6. Adult Social Care CQC Inspection



During the course of the year the London Borough of Hillingdon Adult Social Care Services were inspected by the Care Quality Commission. Inspectors judged the service to be 'good' with an overall score of 73%.

Key areas of focus included partnerships, inequalities, unpaid carers, technology enabled care, and coproduction and engagement.

Inspectors found effective systems, processes, practices to make sure people were protected from abuse and neglect. These included person-centred assessment and care planning with people, effective quality assurance and support of registered care providers, whether commissioned by the local authority or not, and robust safeguarding arrangements. Some partners however, said there could be more information around who to contact in the local authority when they have issues or wanted to support people, including for safeguarding.

In respect of the role and function of the Safeguarding Adults Board Inspectors noted a coordinated approach to safeguarding adults in Hillingdon. Highlighting the impact of the multiagency Safeguarding Partnership, the clarity of the business plan and annual report and role of the Independent Scrutineer. There was also consideration of the impact of subgroups, learning from practice and professional development activity led by the SAB, with positive evidence of impact on frontline practice.

7. The Safeguarding Adults Board

In 2024-2025 the Safeguarding Adults Board was chaired by Graham Puckering, Assistant Director, Adult Social Care and Health. This responsibility will transfer to the Metropolitan Police Service in the next year.

The Safeguarding Adults Board is made up of senior safeguarding leads across the borough including:

- The London Borough of Hillingdon Adults Services
- North West London Integrated Care Partnership
- Metropolitan Police Service
- Central and North West London NHS Foundation Trust
- The Hillingdon Hospital
- The Safer Hillingdon Partnership
- Prevent and Stronger Communities Lead
- The Probation Service
- Voluntary and Community Sector Organisations
- Border Force

The Partnership Board meets four times per year and is generally well attended, with proactive engagement in the event of non attendance to identify and remove any barriers where necessary.

In October 2024 the Board held a reflective session focussing on the impact of various strands of strategic work on safeguarding practice. This included the effectiveness of awareness raising activity as a preventative tool, the impact of practice development activity and the value added by subgroups and multiagency Task & Finish Groups.

Feedback from members has been used to inform plans for the coming year, with a reduction in those areas deemed not to have the most impact (awareness raising activity, newsletters and webinars) and focus on those deemed as making the most difference (commissioned training, audits).

The chair of the Safeguarding Adults Board attends the Executive Leadership Group to provide a quarterly update of progress made.

In the coming year the Safeguarding Partnership will be developing some guidance around the roles and responsibilities of Chairs and members. It is anticipated that this will support increased impact of strategic work.

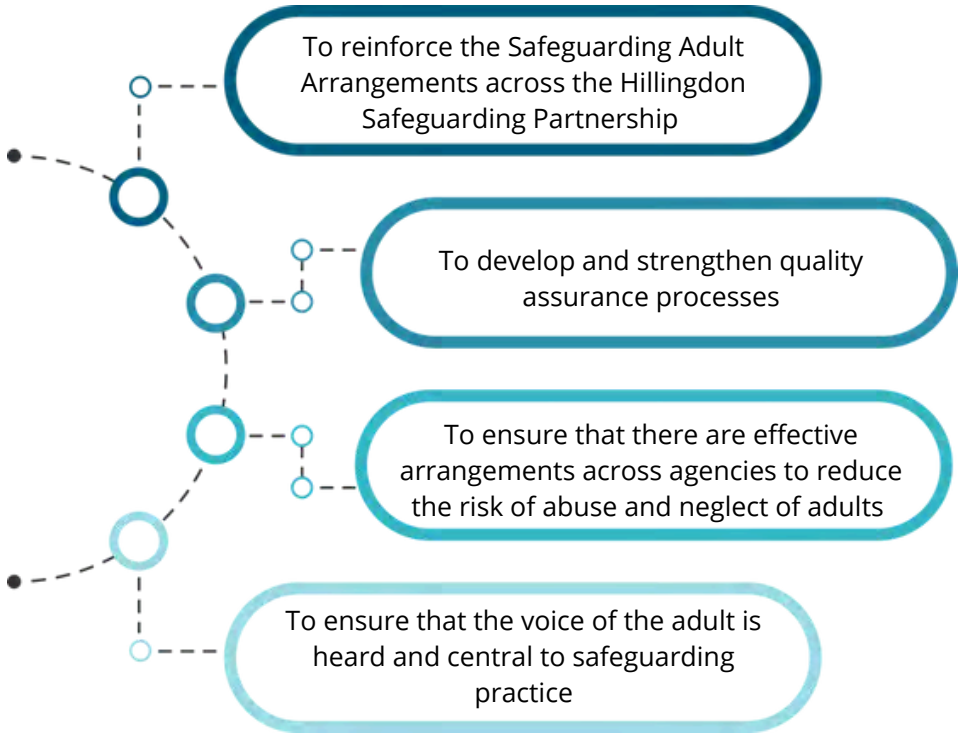
8. Our Business Plan 2024-2027

The strategic direction of the Safeguarding Adults Board is informed by our three year business plan. Each priority is supported by underpinning actions, with progress monitored against measurable outcomes.

In common with SABs across the region there is an ongoing challenge with securing a consistent and reliable multiagency dataset to inform strategic decision making. In the last year the local authority has made considerable progress with the implementation of a Power BI Dashboard, however the capacity to include data from health services and police is reduced due to incompatibility between recording systems and functionality. This continues to be an area of focus in Hillingdon, and more widely across London.

In addition to the overarching priorities the Board sets areas of focus, in 2024-2025 these were:

1. Neglect
2. Preventing Fatal Fires
3. Cuckooing & Exploitation
4. Transitional Safeguarding



Progress Against Priorities

Priority 1: Reinforce Safeguarding Arrangements

Our Multi Agency Safeguarding Arrangements were updated and published in December 2024

The SAB Learning from Practice Framework, Escalation Policy and Communication & Engagement Strategy have been updated.

We have worked closely with related strategic boards to ensure that our work is collaborative and complementary, this reduces duplication and increases the effectiveness of strategic leadership

We are continuing to build new links with the community and voluntary sector, with representatives attending the SAB and contributing to the work of subgroups

Through the year our SAB forward plan ensured that every agency participates actively, with themed and focused discussions of specific issues as they arise.

Priority 2: Develop and Strengthen Quality Assurance Processes

We acknowledge that the development of a shared dataset continues to be a challenge for Hillingdon. The local authority has successfully implemented Power BI, a data analysis tool that allows for live identification of themes and patterns

Our Risk Register is updated and reviewed by the Executive Leadership Group, with actions assigned to reduce risk wherever possible to do so.

We have implemented a multiagency quality assurance schedule to provide a breadth of information about local safeguarding practice. In the last year we have audited Adult Safeguarding Enquiries, and reflected on compliance and engagement with our Equality, Diversity and Inclusion Statement. We have also used the Safeguarding Adult Partnership Audit Tool (SAPAT).

Progress Against Priorities

Priority 3: Effective arrangements to reduce the risk of abuse and neglect of adults

This year our areas of priority focus were Neglect, Fire Safety, Cuckooing & Exploitation and Transitional Safeguarding

Our Multiagency Training programme provides a range of opportunities for practitioners from all disciplines, and is closely linked to learning from local audits and practice, and the progression of national priorities

We have continued to reinforce our 'think family' approach, so that child and adult practitioners both understand, and are equipped to respond to, the needs of all family members

Our awareness raising campaigns are designed to be accessible to frontline practitioners, with some resources suitable to be displayed in publicly accessible spaces, for example libraries, hospitals, schools and GP surgeries

Priority 4: Ensure that the voice of the adult is heard, and is central to safeguarding practice

We have built on our 'Voice of the Person' work to develop a subgroup focussed on engaging with adults with lived experience of safeguarding services.

This subgroup operates 'virtually' to enable adults and carers to participate fully, there is a reporting line directly to the SAB.

To date the Safeguarding Voices Group has contributed to the development of our SAB Neglect Strategy

We have also championed the involvement of adults, and their families within our learning from serious incidents. With contributions made to our training and development programmes.

9. Safeguarding Voices

The purpose of this subgroup is to ensure that the work of the Board is informed by the voices of those with lived experience. Members are people with lived experience of safeguarding support, care and support, or as unpaid carers. The subgroup operates 'virtually' according to the needs and preferences of members. Members are supported by the Safeguarding Partnership Team to contribute when, and as much as, they would like to.

Aims:

- To ensure that the voices and experiences of adults, their carers and representatives are amplified
- To provide insight that informs the direction and focus of strategic safeguarding work in Hillingdon
- To identify opportunities for development, and to highlight good practice
- To make recommendations to the SAB about key areas of safeguarding practice
- To act as a conduit for feedback from the diverse consultation, and co-production groups, that already exist across the multi-agency partnership

Members maintain confidentiality regarding any personal experiences shared within the group. Any advice, or feedback, collated for the SAB is delivered on behalf of the subgroup, and not by individual members. This ensures a safe and supportive environment for all who contribute.

Decisions are made collaboratively, with the aim of reaching a consensus. When necessary, a simple majority vote is used. A summary of the subgroup's activity is shared with the SAB on a quarterly basis.

1. Coproduction of the Safeguarding Partnership's Community Engagement Strategy 2024-27
2. Coproduction of audit plan to explore informal carers' experiences of support and safeguarding
3. Development of members through access to training a range of safeguarding related topics, including Care Act, DOLS and mental capacity
4. Consultation with group to inform development of the partnership's Adult Neglect Strategy

Group members have planned and delivered an engagement session with the Learning Disabilities Partnership Board's Expert Reference Group, to broaden our reach and understanding of different experiences.

10. Safeguarding Adults from Neglect

The Neglect Subgroup set out to develop, and seek assurance about, systemwide activity to prevent, identify and respond effectively to neglect of adults with care and support needs. This included neglect by family and friends, professionals, including providers of direct care, healthcare and social care, and anyone else who owes a duty of care to adults with care and support needs. The group met 7 times from 2023-2025.

Areas of focus were:

- Training needs
- Improving awareness of and response to criminal neglect
- Awareness raising of the difference between neglect and poor care
- Ensuring carers are identified and supported effectively
- Developing and quality assuring safeguarding interventions for people experiencing neglect
- Risk associated with points of transition.

1. The development and publication of our Partnership Adult Neglect Strategy
2. The introduction of Neglect practice resources and commissioned training
3. The Metropolitan Police Service delivered a professional development day focussed on criminal neglect concerns.
4. The Adult Social Care Single Point of Access now includes a specific reminder of the risk of neglect when care packages are cancelled.

We facilitated discussions between the Care Provider Forum and the hospital's discharge team and hospital safeguarding team to establish clearer pathways for addressing issues in communication at points of transition.

Communication and escalation pathways are now established between Adult Social Care and Police.

We liaised with London Ambulance Service around the interface with care home providers, and support to residents at points of transition to hospital.

11. Cuckooing & Adult Exploitation

The Adult Exploitation and Cuckooing Subgroup sets out to develop, and seek assurance about, systemwide activity to prevent, identify and respond effectively to the exploitation and cuckooing of adults with care and support needs. Strategic objectives sit under the overarching aims of preventing, identifying and responding effectively to exploitation and cuckooing, and have been collectively developed and agreed by relevant partners.

Areas of focus include:

- Mapping prevalence where possible to do so
- Awareness raising activity, including of Community Multi-Agency Risk Assessment Conference (CMARAC)
- Reducing risk and vulnerability
- Training and professional development resources
- Launch of the Adult Exploitation Risk Assessment Checklist
- Embedding the Cuckooing Protocol

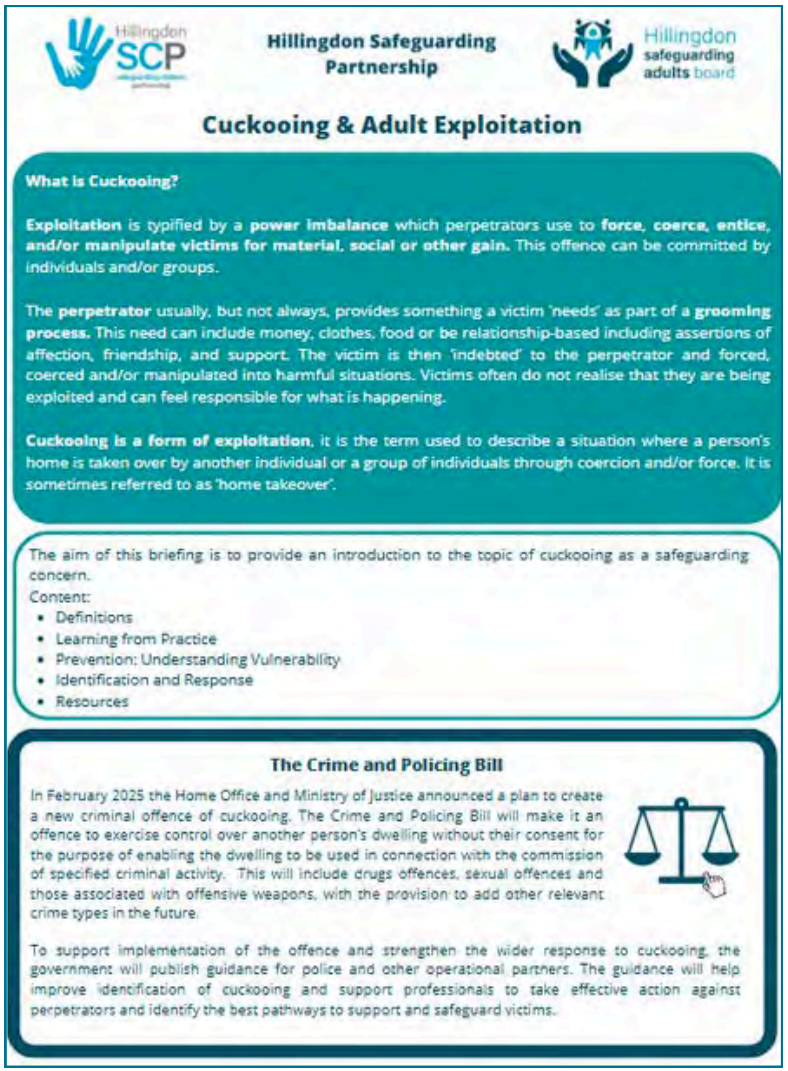
1. Launch of the London Borough of Hillingdon Cuckooing Protocol
2. Development and launch of the Cuckooing Assessment Checklist
3. Assessment Checklist formally adopted by Adult Social Care, CNWL and the Probation Service
4. 76 multiagency practitioners attended cuckooing and adult exploitation workshops

There is a direct link with CMARAC, ensuring that patterns, themes and learning from practice continue to inform strategic direction

We have contributed to a national analysis of themes, and recurring recommendations, in serious safeguarding incidents involving cuckooing. This has informed the development of our local response.

This subgroup is chaired by Kirstine Brown, Deputy Head of Service for Hillingdon & Ealing Probation Service. This ensures that the SAB considers how to work with perpetrators to reduce the risk of harm to adults.

Cuckooing & Adult Exploitation



Hillingdon Safeguarding Partnership

Hillingdon safeguarding adults board

Cuckooing & Adult Exploitation

What is Cuckooing?

Exploitation is typified by a **power imbalance** which perpetrators use to **force, coerce, entice, and/or manipulate victims for material, social or other gain.** This offence can be committed by individuals and/or groups.

The **perpetrator** usually, but not always, provides something a victim 'needs' as part of a **grooming process.** This need can include money, clothes, food or be relationship-based including assertions of affection, friendship, and support. The victim is then 'indebted' to the perpetrator and forced, coerced and/or manipulated into harmful situations. Victims often do not realise that they are being exploited and can feel responsible for what is happening.

Cuckooing is a form of exploitation, it is the term used to describe a situation where a person's home is taken over by another individual or a group of individuals through coercion and/or force. It is sometimes referred to as 'home takeover'.

The aim of this briefing is to provide an introduction to the topic of cuckooing as a safeguarding concern.

Content:

- Definitions
- Learning from Practice
- Prevention: Understanding Vulnerability
- Identification and Response
- Resources

The Crime and Policing Bill

In February 2025 the Home Office and Ministry of Justice announced a plan to create a new criminal offence of cuckooing. The Crime and Policing Bill will make it an offence to exercise control over another person's dwelling without their consent for the purpose of enabling the dwelling to be used in connection with the commission of specified criminal activity. This will include drugs offences, sexual offences and those associated with offensive weapons, with the provision to add other relevant crime types in the future.

To support implementation of the offence and strengthen the wider response to cuckooing, the government will publish guidance for police and other operational partners. The guidance will help improve identification of cuckooing and support professionals to take effective action against perpetrators and identify the best pathways to support and safeguard victims.

A key area of focus for the SAB this year has been to develop our response to cuckooing and adult exploitation. We have started this through developing an assessment tool that supports frontline practitioners and managers to identify signs and indicators that an adult is suffering this form of harm. In parallel to this, the Safer Hillingdon (Community Safety) Partnership has implemented the London Borough of Hillingdon Cuckooing Protocol.

Where there is known, or suspected, cuckooing a referral is made to the Community Multi Agency Risk Assessment Conference (CMARAC). Depending upon the specific circumstances this can lead to a formal multiagency discussion or, where risks are managed, the concern is recorded to enable accurate understanding of the prevalence of cuckooing in the borough.

We acknowledge that this is a developing area of practice in Hillingdon, and will be an area of focus as we move into the new year. In particular there is a need to build our capacity to disrupt perpetrators. It is anticipated that cuckooing will become a criminal offence in it's own right, and that there will be increasing national attention to this area of practice.

In 2025-2026 the SAB will undertake an audit to understand the impact of the protocol in practice, and to make use of recommendations to refine and further develop safeguarding practice.

12. Preventing Fatal Fires

Adults with care and support needs are more likely than the wider population to die in fires. The main contributory factors of a fire fatality are:

- how able the person was to respond to the fire (i.e. were they mobile; were they awake; were they impaired by drugs or alcohol);
- how early the fire is discovered, how quickly fire service is called and the arrival time/ response of the fire service;
- the materials involved in the fire (smoking, non-retardant bedding and pressure relieving mattresses, clothing or hoist materials, emollient creams all increase risk);
- the size and construction of the room/building;
- the proximity of the victim to the fire.

In Hillingdon there have been no fire death related Safeguarding Adult Reviews since 2012. However, regional learning prompted the SAB to seek quality assurance of arrangements locally in terms of the preventative measures taken, the awareness of fire risks for adults with care and support needs, and clear pathways for professionals to follow when they are concerned about fire risk.

The task and finish group met 4 times. It had good representation from across safeguarding partners and was chaired by the London Fire Brigade Borough Commander. The group met for the final time in October 2024.

13. Complex Needs & Homelessness

In response to the May 2024 ministerial letter to SABs about safeguarding adults facing multiple exclusion homlessness, and against the background of learning from relevant national analyses of SARs, this group seeks to enhance local partnership arrangements for safeguarding people with complex needs and high risks, with a particular focus on people affected by rough sleeping, multiple exclusion homelessness and/or high risk substance use.

Aims of the group:

- Ensure there are robust and clear pathways to support safeguarding responses to people misusing substances, and/or multiple exclusion homelessness, who are facing high risks.
- Develop strategies for sustainable dissemination of relevant knowledge and expertise across the professional network.
- Support sustainable resilience of the professional network to manage high risk, loss and secondary trauma associated with working with people facing very high risks.

1. Reviewed local pathways and practices against findings from the Alcohol Change UK analysis of alcohol related SARs
2. Identified need for social care to secure clinical consultation to inform safeguarding plans for dependent drinkers at risk of self-neglect - pathway to be establshed
3. Reviewed local pathways and practices against findings of NIHR and KCL analysis of SARs related to rough sleeping and homelessness
4. Identified local training needs relating to Alcohol Related Brain Damage, dementia and alcohol withdrawal

We have reinforced links with related groups to ensure consistency and impact through sharing information. This includes the Combatting Drugs and Alcohol Board and Hillingdon Homelessness Strategy Delivery Single Homeless and Rough Sleepers Group

We commissioned training from Alcohol Change UK on use of the law to support effective safeguarding of highly vulnerable dependent drinkers.

14. Transitional Safeguarding

In recognition of the need for cross partnership working our Transitional Safeguarding Task & Finish Group was developed collaboratively by the Safeguarding Children Partnership, the Safeguarding Adults Board and the Safer Hillingdon (Community Safety Partnership). This has ensured the availability and input of a broad range of expertise to support the evolution of transitional safeguarding in the borough.

The Transitional Safeguarding Task and Finish Group will develop a comprehensive framework to ensure effective safeguarding for individuals transitioning from adolescence (14–25 years) to adulthood, addressing risks, gaps, and service integration.

This group aims to:

1. identify key transitional risks, including violence, exploitation, mental health, and criminal justice involvement.
2. Build capacity within services to support young people during their transition from youth services to adult services, such as YJS to probation, CAMHS to adult mental health, children's social care to adult social care, and education to employment.
3. Ensure that individuals falling outside statutory eligibility are not left unsupported and that there are adequate community resources for this group.
4. Establish a clear, coordinated pathway for supporting young people during transitions and mitigating risks, including crime, victimisation, and exploitation.

The work of the subgroup is informed by knowledge of local needs and services, and through the application of learning and recommendations within relevant reviews, inspection reports and knowledge of best practice.

This group met for the first time in January 2025, therefore it is in infancy and will continue into the new year.

15. Learning from Practice

Learning from Practice Framework

The SAB Learning from Practice Task and Finish Group coordinates the identification, consideration, and dissemination of learning from practice with adults, their families and carers. The Task and Finish Group considers learning from a range of sources as outlined below:

Discussion at Learning from Practice is not an alternative route for escalation, the focus is on practice development and wider system learning. In 2024-2025 the Task & Finish Group concluded one reflective learning review, and progressed with actions arising from multiagency quality assurance.

SAR Panel

The Safeguarding Adults Review (SAR) Panel is a multi-agency senior officer group with delegated responsibility from the Hillingdon SAB. The SAR Panel reviews serious incidents notified to the Safeguarding Partnership where there is a belief that the criteria of section 44 of the Care Act may be met. The core membership of the SAR Panel is made up of representatives of the Metropolitan Police Service, Adult Social Care, Housing, The Hillingdon Hospital, North West London Integrated Care Partnership and Central and North West London NHS Foundation Trust.

In 2024-2025 the SAR Panel reviewed and refreshed the SAB Learning from Practice Framework. The purpose of this was to increase efficiency and effectiveness.

The Panel considered the circumstances of 5 adults, with one meeting the criteria for a Safeguarding Adults Review. The findings of this SAR, along with two others concluded in the reporting period are discussed in detail in the next section.

Learning from Practice - Safeguarding Adults Reviews

We have concluded three Safeguarding Adults Reviews (SARs) in 2024-2025 all meeting the criteria for a mandatory SAR under of the s.44 Care Act 2014.

As a Partnership we offer our sincere condolences to the families of Rachel and Mairead, and thank them for their participation in the SAR processes. We also acknowledge the bravery and generosity of Ms Stitch in engaging directly with the SAR, and in the development of training and resources for frontline practitioners. Each of the SARs has been assigned a pseudonym, where possible in conjunction with the adult or their family.

The purpose of SARs is to identify learning to improve how well services work together in the future to safeguard adults with care and support needs. These SARs have been conducted in a way consistent with our commitment to a learning culture that is; open and honest; proportionate and avoids hindsight bias; identifies and addresses systemic issues; and supports and challenges safeguarding partners to make continuous improvements to practice.

Each SAR has it's own action plan developed and monitored within the SAB Learning from Practice task and Finish Group.

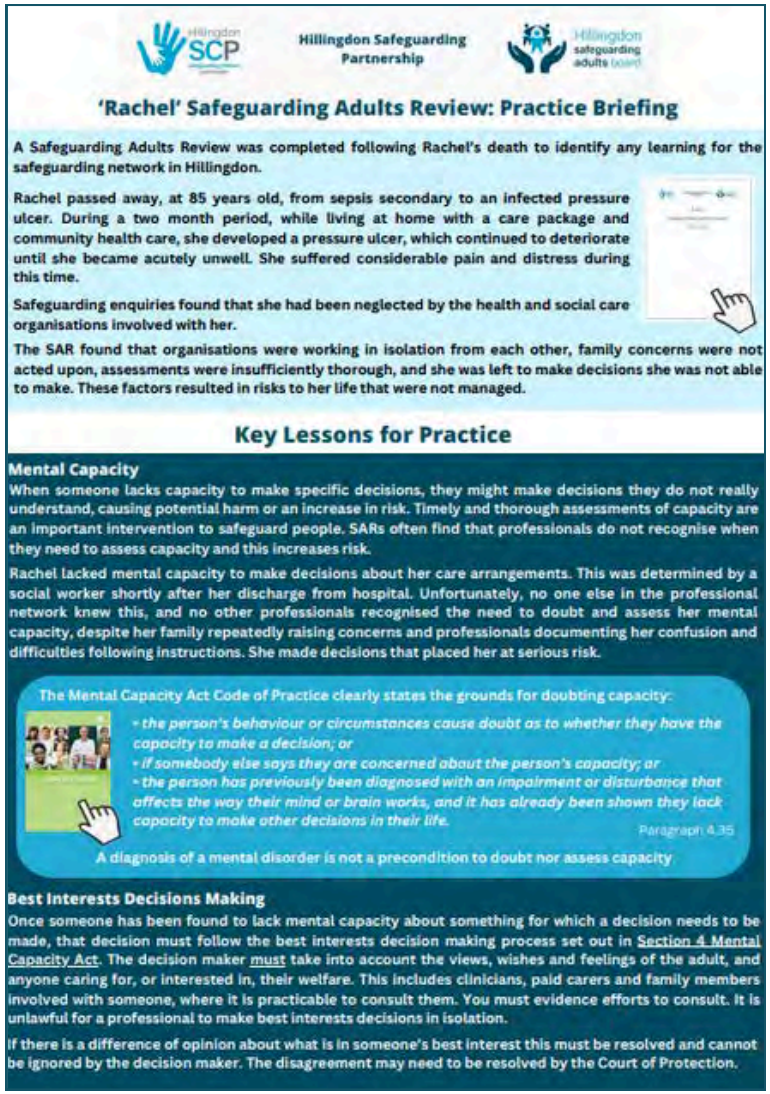
In 2023-24 the Carol SAR was published. The dedicated action plan for Carol was concluded in 2024-25 and an impact report submitted to the SAB.

Dissemination of Learning

A SAR focused newsletter was published to to dissemnate learning from SARs and bring practice briefings, other learning resources and thematic learning to the attention of practitioners across the partnership.

A SAR focused webinar was delivered to an audience of over 140 practitioners sharing thematic learning from the three SARs published 2024-25. This received excellent feedback. It was recorded and is available to watch online.

Rachel SAR



Hillingdon Safeguarding Partnership

'Rachel' Safeguarding Adults Review: Practice Briefing

A Safeguarding Adults Review was completed following Rachel's death to identify any learning for the safeguarding network in Hillingdon.

Rachel passed away, at 85 years old, from sepsis secondary to an infected pressure ulcer. During a two month period, while living at home with a care package and community health care, she developed a pressure ulcer, which continued to deteriorate until she became acutely unwell. She suffered considerable pain and distress during this time.

Safeguarding enquiries found that she had been neglected by the health and social care organisations involved with her.

The SAR found that organisations were working in isolation from each other, family concerns were not acted upon, assessments were insufficiently thorough, and she was left to make decisions she was not able to make. These factors resulted in risks to her life that were not managed.

Key Lessons for Practice

Mental Capacity

When someone lacks capacity to make specific decisions, they might make decisions they do not really understand, causing potential harm or an increase in risk. Timely and thorough assessments of capacity are an important intervention to safeguard people. SARs often find that professionals do not recognise when they need to assess capacity and this increases risk.

Rachel lacked mental capacity to make decisions about her care arrangements. This was determined by a social worker shortly after her discharge from hospital. Unfortunately, no one else in the professional network knew this, and no other professionals recognised the need to doubt and assess her mental capacity, despite her family repeatedly raising concerns and professionals documenting her confusion and difficulties following instructions. She made decisions that placed her at serious risk.

The Mental Capacity Act Code of Practice clearly states the grounds for doubting capacity:

- *the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision; or*
- *if somebody else says they are concerned about the person's capacity; or*
- *the person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been shown they lack capacity to make other decisions in their life.*

Paragraph 4.35

A diagnosis of a mental disorder is not a precondition to doubt nor assess capacity

Best Interests Decisions Making

Once someone has been found to lack mental capacity about something for which a decision needs to be made, that decision must follow the best interests decision making process set out in Section 4 Mental Capacity Act. The decision maker must take into account the views, wishes and feelings of the adult, and anyone caring for, or interested in, their welfare. This includes clinicians, paid carers and family members involved with someone, where it is practicable to consult them. You must evidence efforts to consult. It is unlawful for a professional to make best interests decisions in isolation.

If there is a difference of opinion about what is in someone's best interest this must be resolved and cannot be ignored by the decision maker. The disagreement may need to be resolved by the Court of Protection.

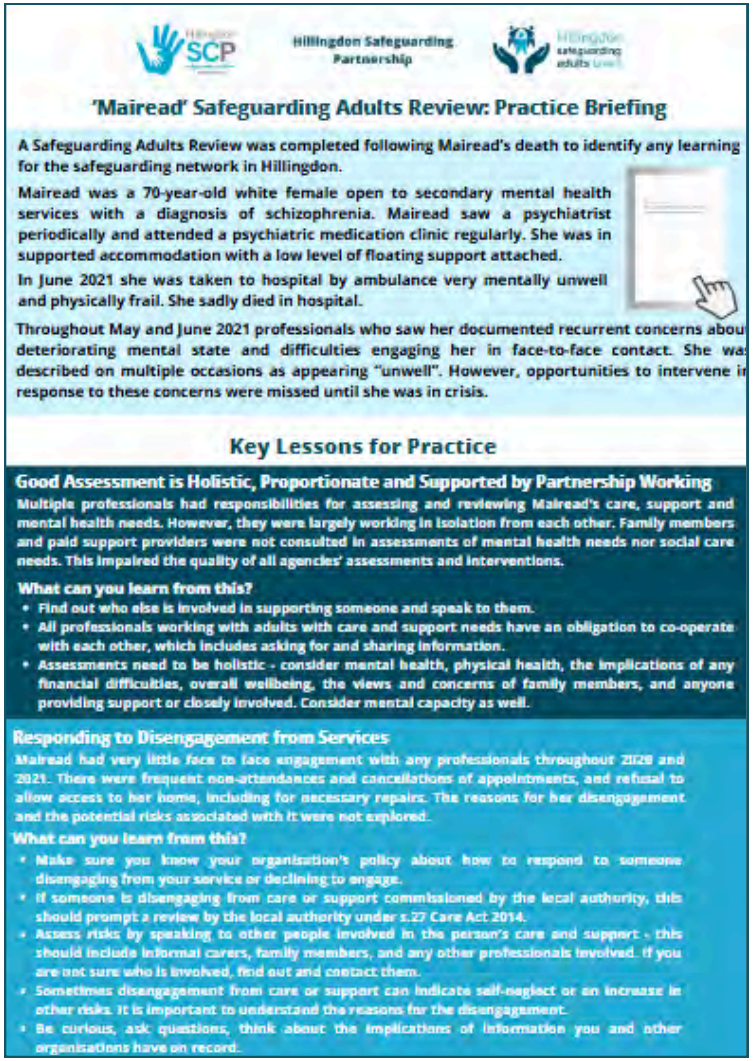
Rachel sadly died, at 85 years old, from sepsis secondary to an infected pressure ulcer. During a two month period, while living at home with a care package and community health care, she developed a pressure ulcer, which continued to deteriorate until she became acutely unwell. She suffered considerable pain and distress during this time. Thematic learning was identified across the following areas:

- Skin integrity preservation and management of skin integrity risks
- Partnership working and information sharing
- Lived experience and the voice of the person and their representatives
- Legal Literacy - Care Act 2014 and Mental Capacity Act 2005

The findings from this SAR have influenced a number of activities across the partnership:

- The North West London ICB have changed hospital transport commissioning arrangements to reduce risk to others.
- A webinar *Safeguarding Adults from Pressure Ulcers* was delivered to the multiagency network to increase awareness and understanding of best practice around skin integrity risk management.
- Community health and adult social care services have reviewed and improved their Mental Capacity Act training offer.
- Best practice in information seeking and sharing between health and social care services has been promoted through a published briefing and clearer communication pathways established.
- There has also been improved communications between hospital and community health staff related to tissue viability issues.

Mairead SAR



Hillingdon Safeguarding Partnership

'Mairead' Safeguarding Adults Review: Practice Briefing

A Safeguarding Adults Review was completed following Mairead's death to identify any learning for the safeguarding network in Hillingdon.

Mairead was a 70-year-old white female open to secondary mental health services with a diagnosis of schizophrenia. Mairead saw a psychiatrist periodically and attended a psychiatric medication clinic regularly. She was in supported accommodation with a low level of floating support attached.

In June 2021 she was taken to hospital by ambulance very mentally unwell and physically frail. She sadly died in hospital.

Throughout May and June 2021 professionals who saw her documented recurrent concerns abou deteriorating mental state and difficulties engaging her in face-to-face contact. She wa described on multiple occasions as appearing "unwell". However, opportunities to intervene i response to these concerns were missed until she was in crisis.

Key Lessons for Practice

Good Assessment is Holistic, Proportionate and Supported by Partnership Working

Multiple professionals had responsibilities for assessing and reviewing Mairead's care, support and mental health needs. However, they were largely working in isolation from each other. Family members and paid support providers were not consulted in assessments of mental health needs nor social care needs. This impaired the quality of all agencies' assessments and interventions.

What can you learn from this?

- Find out who else is involved in supporting someone and speak to them.
- All professionals working with adults with care and support needs have an obligation to co-operate with each other, which includes asking for and sharing information.
- Assessments need to be holistic - consider mental health, physical health, the implications of any financial difficulties, overall wellbeing, the views and concerns of family members, and anyone providing support or closely involved. Consider mental capacity as well.

Responding to Disengagement from Services

Mairead had very little face to face engagement with any professionals throughout 2020 and 2021. There were frequent non-attendances and cancellations of appointments, and refusal to allow access to her home, including for necessary repairs. The reasons for her disengagement and the potential risks associated with it were not explored.

What can you learn from this?

- Make sure you know your organisation's policy about how to respond to someone disengaging from your service or declining to engage.
- If someone is disengaging from care or support commissioned by the local authority, this should prompt a review by the local authority under s.27 Care Act 2014.
- Assess risks by speaking to other people involved in the person's care and support - this should include informal carers, family members, and any other professionals involved. If you are not sure who is involved, find out and contact them.
- Sometimes disengagement from care or support can indicate self-neglect or an increase in other risks. It is important to understand the reasons for the disengagement.
- Be curious, ask questions, think about the implications of information you and other organisations have on record.

Mairead was a 70-year-old white female open to secondary mental health services with a diagnosis of schizophrenia. Mairead saw a psychiatrist periodically and attended a psychiatric medication clinic regularly. She was in supported accommodation with a low level of floating support attached.

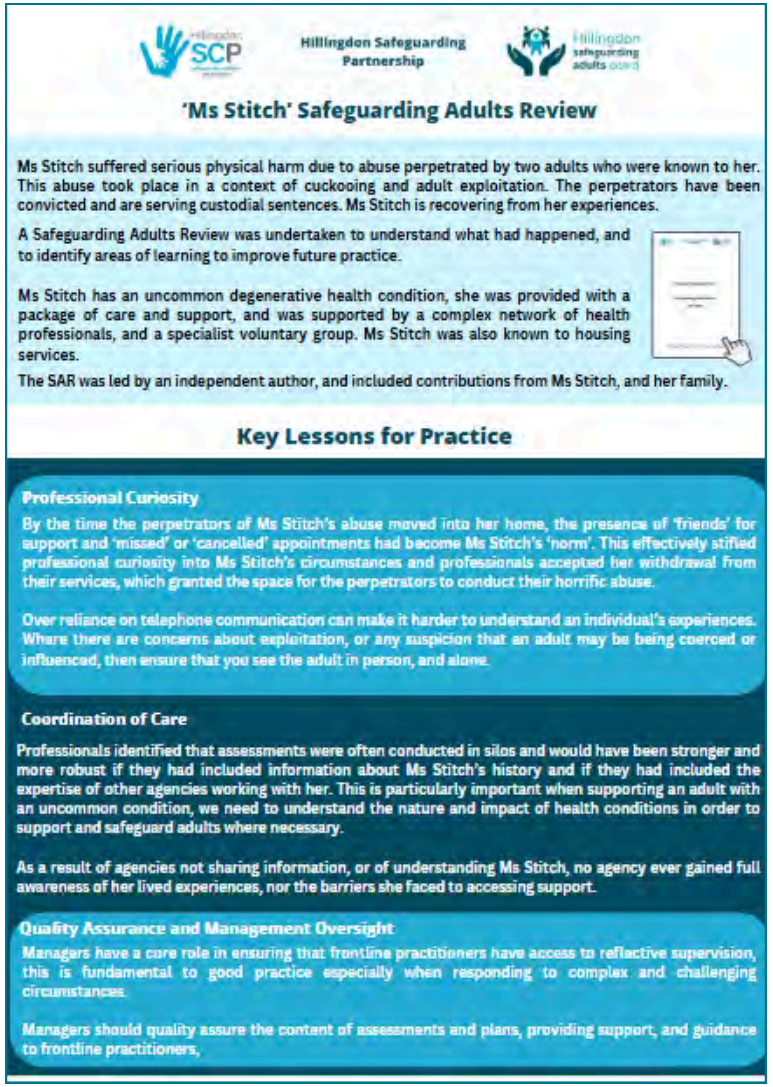
In June 2021 she was taken to hospital by ambulance very mentally unwell and physically frail. She sadly died in hospital. Thematic learning was identified across the following areas:

- Legal literacy - discharge of Care Act duties
- Quality of assessment – holistic, proportionate and supported by partnership working
- Responding to disengagement from services
- Application of section 42 Care Act 2014 when an adult at risk has died
- Impact of shared supported living arrangements

The findings from this SAR have influenced a number of activities across the partnership:

- CNWL has reviewed and updated their policy on patients who disengage from treatment; introduced a new care planning system Dialogue+, are implementing the Triangle of Care, and have launched an informal carer dashboard to support recognition and engagement with informal carers.
- Adult social care have provided assurance that all people in supported accommodation by the LA now have their care and support needs assessed and support reviewed.

Ms Stitch SAR



Hillingdon Safeguarding Partnership

'Ms Stitch' Safeguarding Adults Review

Ms Stitch suffered serious physical harm due to abuse perpetrated by two adults who were known to her. This abuse took place in a context of cuckooing and adult exploitation. The perpetrators have been convicted and are serving custodial sentences. Ms Stitch is recovering from her experiences.

A Safeguarding Adults Review was undertaken to understand what had happened, and to identify areas of learning to improve future practice.

Ms Stitch has an uncommon degenerative health condition, she was provided with a package of care and support, and was supported by a complex network of health professionals, and a specialist voluntary group. Ms Stitch was also known to housing services.

The SAR was led by an independent author, and included contributions from Ms Stitch, and her family.

Key Lessons for Practice

Professional Curiosity

By the time the perpetrators of Ms Stitch's abuse moved into her home, the presence of 'friends' for support and 'missed' or 'cancelled' appointments had become Ms Stitch's 'norm'. This effectively stifled professional curiosity into Ms Stitch's circumstances and professionals accepted her withdrawal from their services, which granted the space for the perpetrators to conduct their horrific abuse.

Over reliance on telephone communication can make it harder to understand an individual's experiences. Where there are concerns about exploitation, or any suspicion that an adult may be being coerced or influenced, then ensure that you see the adult in person, and alone.

Coordination of Care

Professionals identified that assessments were often conducted in silos and would have been stronger and more robust if they had included information about Ms Stitch's history and if they had included the expertise of other agencies working with her. This is particularly important when supporting an adult with an uncommon condition, we need to understand the nature and impact of health conditions in order to support and safeguard adults where necessary.

As a result of agencies not sharing information, or of understanding Ms Stitch, no agency ever gained full awareness of her lived experiences, nor the barriers she faced to accessing support.

Quality Assurance and Management Oversight

Managers have a core role in ensuring that frontline practitioners have access to reflective supervision, this is fundamental to good practice especially when responding to complex and challenging circumstances.

Managers should quality assure the content of assessments and plans, providing support, and guidance to frontline practitioners.

Ms Stitch has a rare neurodegenerative health condition, she was provided with a package of care and support, and was supported by a complex network of health professionals, and a specialist voluntary group. Ms Stitch was also known to housing services.

Ms Stitch suffered serious physical abuse perpetrated by two adults who moved into her home. This abuse took place over several months in the context of cuckooing and exploitation. Thematic learning was identified across the following areas:

- application of professional curiosity
- coordination of an individual's care
- quality assurance of assessment
- consideration of Executive Function in Mental Capacity Assessment
- choice of language in case notes/records
- a professional's understanding of exploitation

The findings from this SAR have influenced a number of activities across the partnership:

- the development and implementation of a cuckooing and adult exploitation assessment tool, adopted by Adult Social Care, Central and North West London NHS Foundation Trust and the Probation Service
- The refresh and redevelopment of Adult Social Care Mental Capacity Act Training
- The development of a practice resource on Language in Adult Safeguarding Practice
- The development and delivery of adult exploitation and cuckooing training

16. Practice Development Activity

The focus of the Practice Development Forum (PDF) is to ensure that learning from practice is disseminated across the safeguarding partnership as required. The Practice Development Forum also considers learning from quality assurance audits and other statutory reviews, including Domestic Abuse Related Death Reviews. The group has a core membership across both the child and adult partnerships, in recognition that learning usually has applicability across both sectors.

During the year, to help disseminate and share information in different ways, we published the Safeguarding Partnership Newsletter which continues to provide practitioners with an accessible overview of key practice developments, resources and learning from practice. The Newsletter is sent to members of the Safeguarding Boards to cascade through their organisations, and to those individuals who sign up to a dedicated distribution list. It is also used by partners and relevant agencies to disseminate key information about services

Due to the complexity of the organisational structures that make up the Safeguarding Partnership it is difficult to measure the impact of practice briefings and newsletters. In the coming year we will be developing a mechanism that allows us to do this effectively and minimises any additional administrative burden on busy frontline practitioners and managers.

Quality Assurance - SAPAT

The Safeguarding Adult Partnership Audit Tool is regionally developed, and was amended slightly for local application to avoid duplication with other local audits.

The SAPAT aimed to gather information from local safeguarding partners on the effectiveness of local safeguarding adults arrangements, perceived achievements and challenges in the past year of both the SAB and individual safeguarding partners, and to identify barriers to effective adult safeguarding and effective partnership working within the Hillingdon SAB. This was intended to help identify risks for the partnership going forward and help to focus strategic priorities and business planning for the next financial year.

Participation in Self-Assessments: The self-assessment process is a valuable tool for understanding practice. However, its effectiveness depends on the level of participation. This year's engagement demonstrated a significant improvement against the 2022 SAPAT. This is a positive development.

A number of positives were identified by partners completing the SAPAT:

- Ongoing active work within and between safeguarding partners to develop and improve safeguarding practice.
- Benefits of the partnership's multiagency quality assurance schedule and independent scrutiny was acknowledged.
- Learning materials and events organised by the SAB recognised as valuable to support effective safeguarding practice.
- Positive feedback on the multiagency training offer.
- The SAB was described as having a spirit of collaboration, a lack of defensiveness and good internal rigour.
- Subgroup activity was well received and described as producing "effective outcomes", with "efficient management…including the necessary administrative processes".
- Voluntary sector partners acknowledge SAB achievements in community engagement including promoting safeguarding in the wider community, participation in National Adult Safeguarding Week, and World Suicide Prevention Day.

Quality Assurance - Equality Diversity & Inclusion

The purpose of this review was to explore the impact and application of Hillingdon Safeguarding Partnership's Equality, Diversity, and Inclusion Statement. The Statement was introduced in 2020, with renewed commitment to the values agreed in 2022.

Hillingdon Safeguarding Partnership will:

- Work in partnership with children, young people, adults, and carers who have protected characteristics to ensure that their views are represented.
- Acknowledge, promote, and celebrate the value of diversity.
- Ensure that issues of equality and diversity are considered across all functions of the Safeguarding Partnership, including Boards, subgroups, and Reviews.
- Foster a culture of high support/high challenge to counteract any discrimination and/or oppression.
- Be honest about areas/incidents we need challenge and develop to ensure that we are proactively counteracting discrimination and oppression and promoting equality.
- Ensure that equality and diversity is considered in quality assurance frameworks to identify strengths and areas for development.
- Ensure that we have impactful training in place to educate and inform professionals around their responsibilities and duties in relation to issues of equality and diversity.

The review achieved a response rate of 66%, with 8 out of 12 agencies completing the self-assessment.

The self-assessments indicate multi-agency partners are actively considering EDI in their operations, highlighting several strengths, including a strong commitment to EDI and the integration of EDI considerations into agency practices.

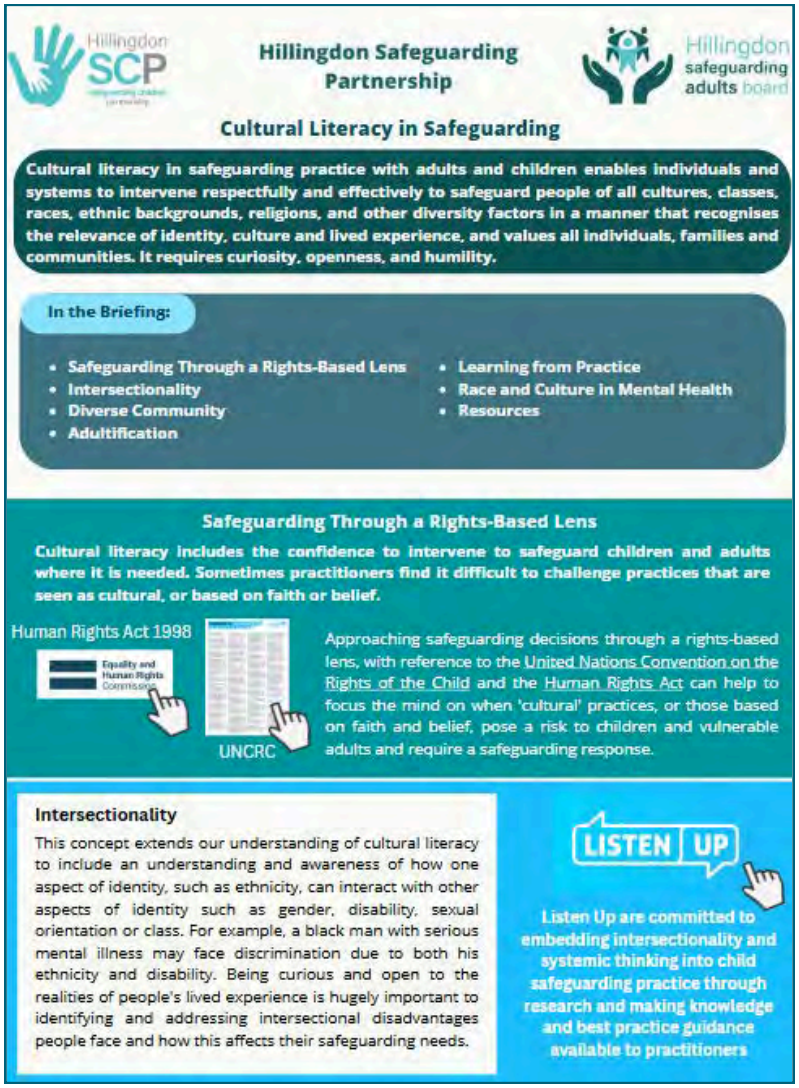
Partners also identified areas for development:

"To work collaboratively as a partnership to meet the needs and celebrate diversity. Ensuring we are included in all religious and cultural celebrations. The organisation's approach to acknowledging and valuing diversity in the workforce. Ensuring we are including all celebrations."

"Review and refine existing policies and practices to ensure they are inclusive and responsive to diverse needs, enhance the representations of children's views and how these are obtained, and have better transitions for YP especially those with additional needs."

Participation in Self-Assessments: The self-assessment process is a valuable tool for understanding practice. However, its effectiveness depends on the level of participation. It is therefore vital that moving forward, all partners engage in these processes to enable a comprehensive review.

Equality Diversity & Inclusion



We recognise that an Anti Racist and Anti-Discriminatory approach is fundamental to safeguarding practice. This is threaded through our practice development activity, the work of our Boards, Subgroups and in our practice with individual adults and children.

As a partnership we have marked Show Racism the Red Card since 2022, producing resources that highlight the critical importance of an active stance of anti-racism.

We know that our global majority children and adults are impacted by structural inequalities, and strive to proactively challenge this. We recognise that our global majority colleagues are also impacted by societal inequalities.

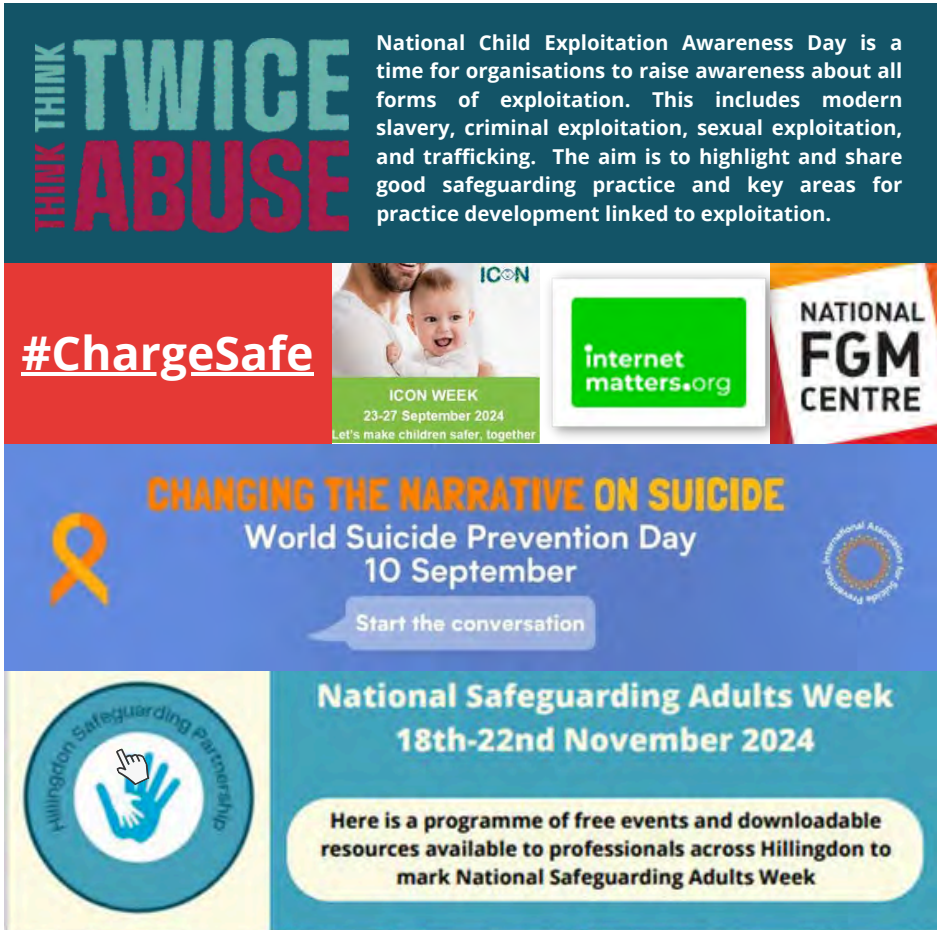
Awareness Raising & Prevention

Our Safeguarding Awareness Raising activity is designed to be suitable for practitioners working with both adults and children. This is to reinforce the principal of 'Think Family' and our endeavour to ensure that the needs of the entire family are considered, with any risks recognised, and action taken to mitigate these.

In the last year the Partnership has marked the following national and international awareness campaigns.

- Mental Health Awareness Week
- Child Exploitation Awareness Day
- International Day of the Girl Child
- Show Racism the Red Card
- Safeguarding Adults Week
- Internet Safety Day
- ICON Week
- World Suicide Prevention Day
- London Fire Brigade's ChargeSafe campaign

Each campaign is directly linked to one of our priorities, or to learning from local practice.



17. Training Offer

The purpose of the Safeguarding Partnership training programme is to ensure that practitioners have the most relevant and up to date opportunities for ongoing professional development. To promote accessibility training is delivered through a range of methods, including online, face to face and via webinar. Training by our children and young people is delivered in person.

Our training programme is accessed by a range of professionals

In total, 2047 sessions of professional development activity have been facilitated by the Safeguarding Partnership in 2024-2025. This includes commissioned training, conferences, and that delivered via the webinar programme.

In 2021-2022 the partnership delivered 1191 sessions of professional development activity. This is an increase of around 70% in the last 4 years and reflects the success of the webinar programme, and increased focus on commissioned training in response to specific learning or need.

Webinar Programme:

- Suicide Prevention
- An Introduction to CAMHS
- Fire Safety
- Safeguarding & Pressure Sores
- Learning from the Carol SAR
- Cuckooing & Adult Exploitation
- ICON
- The NSPCC PANTS Programme

17. Training: Reach & Feedback

Multiagency training is accessed by a range of practitioners across the partnership, representing the breadth and scope of the partnership arrangements. Each attendee is asked to complete a feedback form, designed to provoke thought about how they will apply the learning to their practice. In the year 24-25 we received 771 completed feedback forms.

The most responses were received from the following agencies:

- 239 Children and Young People's Services
- 181 Schools and Colleges
- 119 Adult Social Care
- 62 Central and North West London NHS Children's Health
- 52 Early Years Services

Safeguarding Partnership training is delivered using a hybrid approach, where possible ensuring that commissioned professional development activity is available in a range of approaches to try to meet individual learning styles.

We know that practitioners value the focus and accessibility of webinars, with attendance across services varying according to the topic being addressed. All webinars are subsequently made available to access online.

Training Feedback

98% of respondents rated the quality of training as 'Very Good or 'Excellent

99% of respondents rated the extent at which they had gained new skills and/or useful tools applicable to their practice as 'Good to Excellent'.

97% of attendees stated that they thought the training would be beneficial to colleagues

Thematic areas for development included where IT issues had disrupted the planned session, and where delegates would have preferred the particular session to be held online, or in person.

17. Training: Examples of Impact

Introduction to Domestic Abuse: 'I work with young people of age of 16 - 25 years old. Therefore, the training will help me to deal with situation of DV that young people might experience. the training was very informative and broaden my knowledge'.

Cuckooing & Adult Exploitation Workshop 'I work in compliance and our team manages the electrical and gas contractors along with others. We have issues where tenants will not allow our contractors access to properties to carry out the safety checks. This could be for a number of reasons but we ask that our contractors look out for safeguarding concerns, hoarding issues, mental health etc and I will be sharing my knowledge from today's session to them to look out for any potential cuckooing cases. We will work in partnership with Housing and Social Care colleagues to bring any potential issues to their attention to investigate'.

Adult LADO Webinar: 'The webinar was very informative, giving clear instructions on how to address issues relating to persons in positions of trust and some challenging situations that they can find themselves as well as the support that can be provided'.

Adult Safeguarding 'Understand how other agencies view safeguarding and have a better understanding of aspects of how a social care model of supporting an individual which are very important and contributes to holistic care planning' .

Child LADO: 'This has given me a greater understanding of the LADO process and of broader safeguarding issues. As a new Chair of Governors and Safeguarding Link Governor the greater familiarity I have with this area the more confident I feel. This was extremely useful in explaining some of the terms and processes that I have heard about'

FGM Workshop: 'Able to understand the context behind FGM in greater detail. Be able to consider how to manage and hold conversations and follow relevant protocol/legislation'.

Safeguarding Disabled Children: 'I will be more proactive and vigilant when there are concerns around any of the children that I work with' .

Traffic Light Tool: 'Will help me to identify appropriate and inappropriate behaviour and what actions to take.'

WTTSC: 'The next day I had a disclosure from a child, and was able to apply some of what I learnt...and getting in contact with the parents'.

Honour Based Violence: 'Sharing key messages with our family services and DSL team. Underline the impact of the one-chance rule. Better understanding of potential family power dynamics - to be shared with staff.'

18. Smarter Targets

To develop collaboration across strategic partnerships, with a particular focus on safeguarding adults affected by domestic abuse.

To ensure strategic focus is informed by the input and engagement of agencies across the breadth of the partnership through implementation of the SAB forward plan.

To continue to engage the Safeguarding Voices Group in active co-production in audits, strategies, and practice development intervention, with engagement across existing consultation and coproduction groups.

To consider learning from lived experience shared by carers to improve identification and partnership working with carers.

To assure ourselves that practitioners have effective training and support to effectively apply the Mental Capacity Act to prevent and respond to abuse and neglect.

To assure ourselves that partners are working together effectively to meet the needs of and manage risks to people affected by homelessness and rough sleeping, with a particular focus on the Target Priority Group.

To continue to develop, and seek assurance about, systemwide activity to prevent, identify and respond effectively to the exploitation and cuckooing of adults with care and support needs.

To develop a comprehensive framework to ensure effective safeguarding for individuals transitioning from adolescence (14–25 years) to adulthood, addressing risks, gaps, and service integration.

To continuously strive to improve and develop our collaborative multiagency response to prevent harm, to identify it where it occurs and to respond effectively to safeguard and support affected adults.