

# Camden safeguarding Adults Partnership Board

ANNUAL REPORT 2023- 2024



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### **1. Message from the Independent Chair, Christabel Shawcross Christabel image to be inserted**

I am pleased to introduce the Camden SAPB Annual report outlining the SAPB priorities, outcomes and multi-agency learning , identifying safeguarding priorities for the current year 2024-2025.

A significant achievement was the producing of a new 5 year Strategy 2023-2028 that was well consulted on and engaged with diverse groups and people with lived experience for views. This strategy, on the SAPB webpages lays out the multi-agency SAPBs ambitions for the next 5 years.

We are a wide partnership with the 3 statutory partners, (the local authority, health, police) alongside fire and rescue service, housing, homelessness support, commissioned care providers, voluntary and community sector partners. All have contributed to this strategy, which focuses on how we work to reduce the abuse of adults at risk across our partnership in the borough of Camden.

A key outcome from consultation was for more involvement and engagement with resident groups and service users in co-production and influencing priorities. Following the successful work by the Community Engagement group in 2022 in producing a short video explaining safeguarding at home and where to seek help. The SAPB funded this to be translated in all the languages spoken in Camden for accessibility.

Whilst the Community engagement group has extended its engagement with a wider number of community groups, it is still work in progress to provide support to individuals who might be able to participate in a reference group on safeguarding.

The SAPB agreed the first year of the strategy plan for 2023-2024 would be to focus on abuse prevention and raising awareness. The extended engagement group is an example of this. We improved links across strategic partnerships such as Community Safety and Children's partnership. Sharing common concerns about raising awareness of domestic abuse and where to seek help and support.

The outcome to provide a SAB newsletter to promote what the board is working on and provide information, unfortunately had to be delayed due to resource issues and is in development.

The strategy has been devised with the use of a range of performance information. We recognised that we needed to have a more effective Multi agency Performance dashboard to assist the SAPB in identifying changes trends and this work progresses in 2024 as there is a significant amount of data analysis needed and provided by the 3 statutory partners. A multi-agency audit on how well Making safeguarding personal was being implemented showed good examples but also identified learning points within the system for involving individuals. Analysis also showed that the SAPB needed more effective engagement with social care providers, we then promoted the work and learning from SARs at a workshop for providers across residential, nursing and homecare and supported living providers.

We saw increased numbers of concerns especially on self-neglect and neglect, similar to national data and looked at how to raise awareness of earlier intervention. A key issue was the London wide rise in homelessness and rough sleeping for which assurance was given to SAPB by homeless partners on understanding the safeguarding issues. This also led to a housing partner from the wider social housing provider forum on the SAPB, and following engagement to promote the work of the SAP a representative has joined to have a more integrated approach across all housing providers.

The analysis of the people who died rough sleeping, again a wider London concern was reported to SAPB in order to ensure any learning was shared, such as encouraging individuals with substance misuse to seek appropriate help and involving mental health services.

Another key achievement was, following concerns raised by an increase in financial abuse and scams it organised the first Annual SAPB Conference to look at how partners could better tackle the issues raised, providing information through Trading Standards, working with the voluntary sector to provide support and with the Police when investigating allegations.

The SAPB is responsible for commissioning independent safeguarding reviews when it seems multi agency work could have prevented safeguarding abuse and the subgroup decided that “Matthew” met the mandatory SAR criteria. We published this SAR which identified multi-agency lessons to be learnt and made recommendations to improve practice and collaboration. This included updating the Camden SAPB “Multi-agency Cuckooing” guidance and is now on the webpage. This will help agencies and staff become more aware of cuckooing, when individuals may be at risk of coercion, what signs to look out for and the multi-agency safeguarding reporting process. The SAPB has promoted multi agency training and implementation of the action plan. More details on the learning are in the annual report.

As Chair I participate in the local North Central London Chairs group, identifying shared priorities, the London network as vice chair and National network to ensure wider issues are brought locally and local issues are raised for joint approaches and learning across the systems such as the Cuckooing guidance, self-neglect and fire safety.

The SAPB strategy delivery plan is reviewed each year. To make sure we are doing what we said we would do, we adapt and change as new priorities emerge. This will be based on our vision to work closely with diverse communities and people with lived experience, develop a model of co-production. We have also been involved in understanding the new CQC Assurance of local authority adult social care which will look at leadership and safety and involve safeguarding board representatives.

The SAPB partners agreed to have a self-assurance and challenge workshop, using a London Safeguarding Adults partners audit tool, to reflect on delivery, how to improve outcomes and the priorities for 2023-2024 delivery plan. Whilst this was delayed until May 2024 it confirms following this our 3 key priorities for 2024-2025 will be Partnership and Collaboration, Workforce Development and Quality assurance/ continuous development.

Christabel Shawcross

Independent Chair Camden Safeguarding Adults Partnership Board.

## **2.Introduction**

Welcome to the Camden Adult safeguarding Partnership Board (SAPB) Annual Report 2023- 2024.

The Safeguarding Adults partnership board is comprised of local authority, health, the police, and other key partners. It is a statutory body required by the Care Act 2014, to develop and publish a strategy plan, commission Safeguarding Adult Reviews (SARs) and produce an annual report detailing its effectiveness in safeguarding adults within the community it serves.

This report outlines the aims, objectives and progress made by the partnership in safeguarding adults within the London Borough of Camden, it reflects on the challenges faced and lessons learned over the past year and looks ahead into the next 12 months.

This report provides a comprehensive overview of the priorities and activities the board, and its partners committed to in the Annual Report 2022- 2023 and in the 5 year strategy and provides insight into the steps we plan to take in the future to create a safer environment for all adults in the Borough.

## Consultation

This annual report has been developed using a consultation process aimed at ensuring that it is extensive and reflected the needs of the community within London borough of Camden.

Engagement took place with stakeholders across disciplines, community groups and partners to gain feedback that was insightful and pragmatic. This engagement process used multiple methods including face to face interviews, workshops, internal audit reports and a devised strategy survey.

However, it is necessary to highlight that during the consultation process there was an observed lack of engagement to fully utilise all these consultation methods and maximise their potential. Despite these challenges the input received has allowed for specific concerns and achievements to be discussed and has shaped the findings and recommendations of this report.

## **3.Which Organisations are on the Board?**

The Camden Adult Safeguarding Partnership Board is comprised of statutory partners which include:

## Local Authority

- Adult Social Care
- Housing
- Community Safety
- Integrated Commissioning
- Camden Learning Disabilities Service (CLDS)

## Health Services

- National Health Service North Central London integrated Care Board (NHS NCL, form NCL CCG)
- London Ambulance Service NHS Trust
- Camden and Islington Mental health NHS Foundation Trust
- Great Ormond Street Hospital NHS Foundation Trust
- Royal Free London NHS Trust
- University College London Hospitals NHS Foundation Trust
- Tavistock and Portman NHS Foundation Trust

## Law Enforcement and Public Safety

- Metropolitan Police (Camden)
- Camden and Islington Cluster Probation Service
- London Fire Brigade (Camden)

## Voluntary Sector Organisations

- Age UK Camden
- Hopscotch Women's Centre
- Camden carers
- Rethink
- Voluntary Action Camden

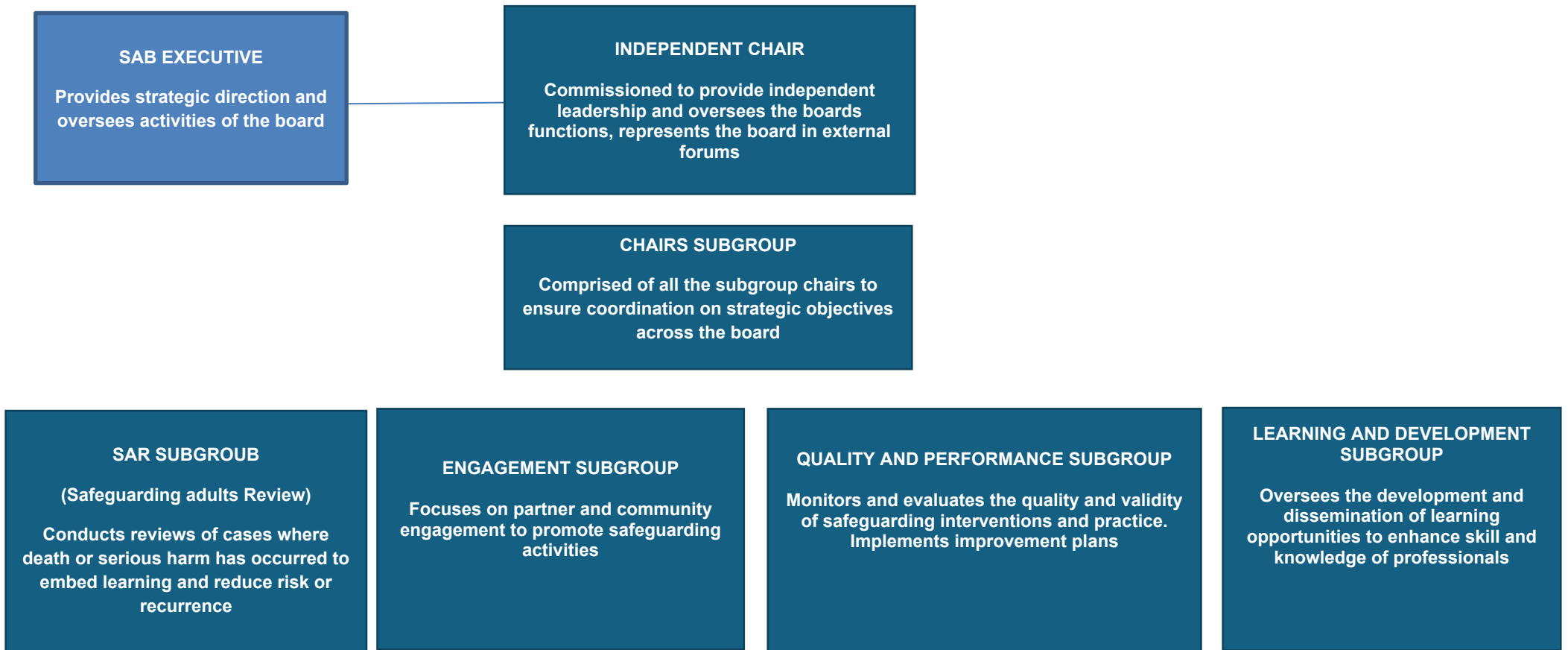
# 4. Governance and Structure of the Board

## Governance

The Camden Adult Safeguarding Partnership Board has the strategic lead for safeguarding adults in Camden. The board is not itself responsible for the delivery of services but aims to promote and maintain collaborative partnership working to mitigate the risk of harm to adults within the Camden community.

## Structure

The Board includes the Safeguarding Adults Board (SAB) Executive, the Independent Chair and several subgroups focusing on specific areas.



## 5. Legislation underpinning the Boards work

### The Care Act 2014

The Care Act 2014 section 43(5) and Schedule 2 (4) requires the Safeguarding Adults Board to publish an annual report as soon as feasible after the end of each financial year to cover:

- (a) what it has done during that year to achieve its objective,
- (b) what it has done during that year to implement its strategy,
- (c) what each member has done during that year to implement the strategy,
- (d) the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
- (e) the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),
- (f) what it has done during that year to implement the findings of reviews arranged by it under that section, and
- (g) where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.



The Care Act 2014 embeds the six principles of safeguarding.

**Empowerment** - People being supported and encouraged to make their own decisions and give informed consent.

1. **Prevention** - It is better to act before harm occurs.
2. **Proportionality** - The least intrusive response appropriate to the risk presented.
3. **Protection** -Support and representation for those in greatest need
4. **Partnership** -Local solutions through services working with their communities.
5. **Accountability- Accountability** and transparency in safeguarding practice

### The Human Rights Act 1998

The Human Rights Act 1998 ensures everyone's rights are protected, underpinning the right to live free from abuse and neglect.

### Equality Act 2010

The Equality Act 2010 provides the legal framework to protect the rights of individuals and advance opportunity for all. It ensures that individuals are not discriminated against on the basis of protected characteristics which is essential in safeguarding practices.

### Safeguarding Vulnerable Groups Act 2006

The safeguarding Vulnerable Groups Act 2006 establishes a framework for vetting individuals working with vulnerable adults and children.

## **6.Board 2023- 24 Priorities and Actions**

In the 2023- 24 Annual Report the board committed to six core priorities we felt were essential in our pursuit of safeguarding and protecting those vulnerable adults within the London Borough of Camden.

Each partner organisation on the board has committed to its own priorities, using their individual strengths to contribute to these overarching goals.

Integrating these individual partner priorities into the boards collective strategy aims to ensure a more comprehensive and holistic approach to safeguarding and promotes the boards shared goal.

## **Board Priority 1**

### Implementing the priorities from the published SAPB 5-year strategy plan through the annual delivery plan

The coordinated efforts of all of the board's priorities, both as a partnership and through the individual actions of its partners has contributed towards the overarching priority of implementing the published SAPB strategy. Each action taken and initiative launched has served to make this a central priority underlining our collaborative commitment to achieving success in this aim.

#### Partners:

- Acquired funding to support an increase in staffing, establishment levels and support the launch of initiatives.
- Developed and disseminated policies.
- Disseminated national guidelines as they became available/ were updated.
- Established platforms for information sharing.
- Created learning events to promote continued improvement and collaboration.

#### Challenges faced:

- Cost of living crisis continues to impact partners, agencies, and the community it supports.
- Increased strain on resources
- National strikes increased system pressure, affected coordination and the delivery of some services.
- Covid-19 pandemic aftereffect continued to impact demand for services with increased risk and demand.
- Information sharing requires further development to become more effective across the partnership.

## Board Priority 2

The types of abuse that we will focus on may vary over the 5 years, but the fundamental focus will be on preventing domestic violence and abuse, self-neglect and hoarding, cuckooing, and mental capacity processes.

The focus on these specific types of abuse aims to enhance the ability to identify and intervene earlier, this aims to manage risk more effectively. The review and improvement of systems support regarding the Mental Capacity Act, Liberty Protection safeguards and Deprivation of Liberty safeguards aims to ensure a collaborative approach to safeguarding across our partners.

### What our partners said:

- We will work collaboratively across the partnership.
- Coordinate and strengthen our relationships with partners to ensure multi agency responses, to streamline strategies and efforts in all areas of safeguarding.
- Review practices and examine safeguarding issues collaboratively to protect our residents and wider community from these abuses.
- Introduce staff across the workforce committed to safeguarding and specific areas such as domestic abuse, female genital mutilation, as well as those with protected characteristics such as learning disabilities and autism.
- Ensure robust documentation and record keeping practice is embedded and follow up on safeguarding issues raised.
- Improve literacy around the Mental capacity Act and its application.

### What our partners did:

- Created and shared a self-neglect and hoarding toolkit.
- Held virtual training sessions in these specific areas of concern, including targeted focus on mental capacity.
- Worked with partners and additional organisations outside of the partnership such as trading standards to enhance our collaborative efforts.
- Collated and disseminated information and learning across the partnership.
- Kept emerging risk areas as specified above high on the agenda across all bodies to prevent their occurrence.
- Recruited specific staff such as domestic violence coordinators, and champions as well as retraining staff within partner organisations.
- Embraced new technologies such as the Blue-Sky app on telephones.
- Increased awareness of health inequalities for marginalised groups such as those with learning disabilities and autism, thus improving outcomes for these groups
- Promotion of the White Ribbon UK campaign

- Continued to monitor themes and trends in our efforts to remain proactive in addressing and preventing abuse.
- Connected with the DRIVE Partnership to explore ways to mitigate risk with perpetrators of abuse.
- Developed standalone domestic abuse policies.

#### **Additional Challenges faced:**

- Covid-19 pandemic and its continued impact on increased self-neglect, isolation, mental wellbeing.
- Self-neglect continues to be the highest risk area in safeguarding issues referred.
- Crime data has shown a year-on-year increase in cuckooing including home invasion and the London Borough of Camden has seen this trend matched.
- Increased mental health issues amongst 18- 25-year-olds directly impacting children and families.
- Domestic abuse reporting continues to rise.
- The suspension of Liberty Protection Safeguards implementation and its impact on MCA and DOLs
- Changes across partner organisations have impacted attendance at some learning and development events.

### **Board Priority 3**

#### Improve engagement with diverse communities by producing safeguarding materials in other languages.

Broadening our partners engagement with diverse communities, by providing safeguarding materials in multiple languages has been critical our aim to improve prevention of abuse. These multimedia materials will support ensuring that hard to reach groups know where to get help, people who draw on care and support feel empowered and able to influence service delivery through these coproduction efforts. Producing a more inclusive and effective safeguarding community supports the boards partners in meeting their core safeguarding requirements.

#### **Insert data visualisation for LBC population, and ethnicities**

#### **What our partners said:**

- Do more for black and ethnic minority and LGBTQ+ groups and those with protected characteristics.
- Develop strategies and review policies that disproportionately affect these protected groups.
- Engage more within communities to rebuild trust.

### **What our Partners did:**

- Included those with lived experience/ who draw on care and support in a safeguarding video produced for training purposes.
- Translated this video into our community languages and embedded it on partners sites.
- Provided tailored training for partners and the wider community.
- Held virtual training sessions to reach a broader audience.

### **Additional Challenges faced:**

- Gaining the involvement and how to increase coproduction with people with lived experience.
- Increasing the attendance and participation of voluntary and community sector partners and organisations
- Raising awareness of safeguarding within the wider community through these partnerships

### **Board Priority 4**

Create a forum for people with lived experience to have their voices heard and support the co production of materials, reports and future strategies. Support people with lived experience give feedback on safeguarding processes.

Creating a forum for their voices to be heard is essential for people with lived experience to be included and valued in the safeguarding process and across the board's partnership working. This initiative aims to help people to protect themselves and each other from harm and abuse. Staff continuing to have meaningful, engaging interaction with these groups contributes towards the objective of "Making Safeguarding Personal".

This approach means people feel and are included in the safeguarding process and are supported to make informed decisions about risk. Co production and consultation becomes routine leading to more effective safeguarding strategies.

### **What our partners said:**

- To keep them safe we will listen to and involve Londoners in how their areas are policed.
- Improve the outcomes for people with learning disabilities and autism.
- Provide support to older people going through the safeguarding process.
- Work closely with multi-agency partners to meet the person's desired outcomes.

### **What our partners did:**

- Provided support from the preadmission and inpatient pathways for patients with learning disabilities and autism to improve patient outcomes

- Acquired funding for “care bags” for patients with learning disabilities and autism to improve patient experience within A&E
- Created guidance to support staff in managing disclosures of domestic abuse.
- In collaboration with BEH, started a DA and Harmful Practices drop-in surgery once a week for live discussion of cases
- Reinstated two key board subgroups within the partnership: learning and development subgroup and safeguarding and engagement subgroup
- Held the 5<sup>th</sup> annual Domestic abuse Conference with over 600 attendees, including a network of people with lived experience to aid our service provision development.
- Included those with lived experience in a safeguarding training video for our community.
- Use family/ network led decision family group conferences to make safeguarding personal.
- Allocated Peer coaches (people with lived experiences of mental illness) to work with people who are experiencing mental ill health to help connect with services.
- Facilitated and attended patient engagement events for people with learning disabilities and autism.

#### **Additional challenges faced:**

- Delay in the board’s commitment to “making safeguarding personal”.
- Continued working from home for some statutory and voluntary services has resulted in the reduction of face-to-face interactions
- This included visiting the most isolated and vulnerable people at home who are at greater risk of key issues and identified abuses.

## **Board Priority 5**

### [Listen to the community to take on board concerns and trends to share with the SAPB.](#)

Listening to our community is vital in attempting to understand and address the reasons behind abuses and neglect. By identifying new forms of abuse at an early stage we can provide more appropriate support throughout the safeguarding process, including the provision of advocates. This ensures that staff are equipped to identify risk and prevent exploitative activity. Community engagement provides valuable insight and allows the sharing of relevant trends with the SAPB to improve safeguarding practices.

### **Insert data visualisation for s42 enquiries**

#### **What our partners said**

- Collaborate and map with partners to improve access to advocacy.
- Make communities at Met wide priority.
- Take a community first approach to tackling and reducing neighbourhood crime, anti-social behaviour, and serious violence.
- Focus on issues that matter to Londoners.
- Ensure that we are in buildings and locations that are visible and accessible to the public.
- Spend more time serving communities, out in the neighbourhoods, learning about them, and how to address issues in their area.

#### **What our partners did:**

- Strengthened relationships between statutory safeguarding agencies and the voluntary care sector.
- Linked residents with partners and wider organisations to discuss abuses and protections.
- Sought people with lived experience to share their views for safeguarding training material.
- Developed a new Qlik dashboard, focusing primarily on safeguarding enquiry closures and provider safeguarding issues.
- Acquired funding which we allocate directly to people who draw on care and support who are facing financial hardship/ crisis.

#### **Additional Challenges faced:**

- Ensuring consistent and meaningful engagement from community members, especially those who draw upon care.
- Resources to maintain continuous community engagement.

### **Board Priority 6**

#### [Continue to share learning from past safeguarding adult reviews \(SARs\) and share information across the board partnerships.](#)

Partners learn lessons from Safeguarding Adult Reviews, Learning Disabilities Mortality Reviews, Domestic Homicide Reviews, audits and more. These lessons can only be learned by sharing evidence and performance, along with joint analysis to make continued improvement across the partnership. By effectively implementing multi-agency safeguarding procedures as an outcome of this learning, safeguarding practice is strengthened, and our partners are equipped with the knowledge and tools essential in the protection of vulnerable adults within our community.

#### **What our partners said**

- Review and extract key learning from Safeguarding Adult Reviews.
- Share these lessons across the board's partnerships to inform and improve safeguarding practices.

- Establish robust mechanisms for sharing information and insights gained from SARs.
- Ensure that all partners have access to and understand the implications of the findings from SARs.
- Continue the use of person at risk forms and subsequent referrals to local authority.
- Work in partnership with agencies to learn and implement improvements recommended from SARs, learning disabilities mortality reviews, domestic homicide reviews, and audits.
- Develop a safeguarding system learning plan to embed learning across the system.
- Reform the investigation process for officers and staff who have breached standards and remove those who fail to meet public expectations.
- Improve links between safeguarding guidance, clinical governance, and quality.

### **What our partners did**

- Delivered training online and face to face to respond directly to case reviews and arising themes such as MCA.
- Increased referrals for safeguarding adults and deprivation of liberty safeguard applications
- Delivered a transition programme for young adults transitioning from youth justice to adult criminal justice services.
- Shared relevant safeguarding information with all staff, volunteers, and trustees.
- Ensured consistent information and policy updates were disseminated across partner organisations.
- Provided learning and development opportunities for partners at the 2023 SAPB Summer conference.
- Directed timely community safety interventions to operational personnel.
- Reviewed cuckooing guidance, a key theme in SARs and incorporated learning from case reviews.
- Dedicated learning sessions to enhancing professional competencies in conducting risk and capacity assessments, including executive function and its relation to self-neglect
- Formed a homelessness steering group in direct response to an increase in deaths within the homeless/ hostel pathway.
- Revised access and workflows on case management systems to allow dual recording across multiple databases.
- Share information without consent where there is lawful basis and identified risk is significant.

### **Additional challenges faced:**

- Facilitating safe hospital discharge through effective multi-disciplinary joint working
- Reduced face to face contacts due to virtual ways of working
- Increased levels of repeat safeguarding themes appearing in SARs such as self-neglect
- Embedding SAR learning across our partners



## 7.Safeguarding Adult Reviews (SARs)

The second national analysis of Safeguarding Adults Reviews was published in May 2024, this provides crucial insight into the themes and areas for improvement in safeguarding practice. Findings in this report highlight the need for cross agency collaboration, early identification and management of risk such as self-neglect, domestic abuse, and disengagement.

The report emphasises the necessity of training and continued development of staff, as well as the integration of reflective practices to learn from past experiences including issues identified in SARs and their teachings are translated into meaningful changes in safeguarding policies and practices.

The Safeguarding Adult Partnership Board aligns well with the findings of the report by placing priority on multi-agency collaboration, focus on implementing training across the partnership and seeking to adopt continuous feedback mechanisms.

However, there is recognition that there are some areas in which the partnership falls short, whilst we have made progress in multi-agency collaboration, there is room for improvement in engagement from our partners. We continue to work on improving our response times in the completion and publication of SARs to support faster change in practice and processes.

The following SAR was published during the year 2023-24, this case involved some of the issues focused on in the 5-year strategy including cuckooing, self-neglect and mental capacity issues. Each SAR provides valuable insight and recommendations, these contributions help to shape the delivery plan and priorities within the annual review for the coming year ahead. These SARs are published as part of our statutory duty, promoting transparency and accountability.

### *“Matthew – M”*

*(note: this SAR appears in the 2022- 2023 Annual Report, this was incorrect as the publication of the SAR and its recommendations were made after April 2023 and so publication is duplicated in this report for the year 2023-24)*

The SAR detailed “Matthews” experience of home invasion and cuckooing dating back to 2018 and the concerns raised regarding the lack of safeguarding prior to his death. It has explored how agencies could have worked differently and together to better support and protect “Matthew” who had significant physical and mental health challenges. The SAR report and recommendations was published in May 2023.

The full report and 7 minute briefing is linked.

## Homelessness and Rough Sleeping deaths (in relation to SARs)

The Safeguarding Adults Board includes representation from housing and public safety on both the board and the high-risk panel. This allows the SAB to focus on improving coordination and service delivery. The board recognises the need for the better collaboration between these organisations. The SAB regularly receives and reviews updates from central and local government, as well as partners, analysing their impact on the local context and wider system. It has also implemented review methods for cases that don't meet the mandatory SAR criteria. Additionally, the SAB acknowledges the need to formalise connections with reviews of homeless deaths and incorporate the lessons learned.

**Insert data visualisation on sec 42 primary support groups and harms**

## **7.Looking forward: 2024 -2025 (and our 5-year strategy plan)**

Over the last 12 months we have laid the foundations for our 5-year strategy (2023-2028). This strategy, now publicly available on the SAPB webpage was developed through extensive consultation with diverse groups and individuals with lived experience.

In our first year we concentrated on preventing abuse and raising awareness. This focus has already shown significant results in achieving the following milestones.

- An increase in reported safeguarding concerns (Include stats) including financial abuse, scams, self-neglect.
- Welcomed a housing partner to the SAOB, enhancing our integrated approach.
- Analysed the needs of rough sleepers, facilitating shared learning including across partners including, substance misuse and mental health.
- Held the first annual SAPB conference providing a platform to share learning and awareness.
- Drafted and published multi agency cuckooing guidance ensuing cross partnership coordinated response.

These achievements demonstrate our commitment to proactive and collaborative safeguarding across the partnership and all of its partners.

Looking forward, to the next year of this 5 year plan , the SAPB commits to continuing our efforts with renewed determination to deliver the 6 key priorities:

- Empowerment
- Prevention
- Proportionality
- Partnership

- Protection
- Accountability

The delivery of the above priorities will not be without challenges, many of these anticipated challenges resemble those we have continuously worked on over the previous 12 months. However, our partners are starting to notice and report some emerging trends that will add new dimensions to safeguarding efforts across the partnership. The board and its partners are committed to constant review and adaptation of our practices to ensure the safety and well being of the individuals within the borough.

### Insert visualisation on asc referrals 2023

To deliver the above, the next 12 months will focus on:

## Partnership and collaboration

The partnership will continue to build on its relationships and strengthen them across its agencies, stakeholders, and community. Working towards shared goals and continuing to engage with these communities to develop a model of co- production means that our safeguarding work is truly cohesive. Community organisations and people with lived experience will continue to be critical in the coproduction of services and strategy.

### Specific aims

- Evidence sharing, joint performance analysis.
- Partnership boards work together to identify trends.
- People with lived experience influence services
- Successful implementation of multi-agency safeguarding procedures
- Consultation and co- production become routine.
- People who draw on care and support are empowered and influence service delivery.
- People are helped to protect themselves and each other from abuse.

### Future Challenges

- Increasing numbers of homeless individuals/ rough sleepers, specifically those who fall between the gaps of substance misuse and mental health services.
- Partners refocusing from silo working into a more organisational effort within the partnership.

- Partnership expansion to improve relationships with more organisations such as children’s boards and coroners’ courts.
- Transitional safeguarding for vulnerable young adults from children to adults’ services

## Workforce Development

Investment in our workforce by providing ongoing training and development for staff across the network is key to ensuring confidence in its that knowledge skills and ability to respond to new challenges and emerging areas of prevention.

### Specific aims:

- Identifying and reporting abuse
- Reasons behind abuse are tackled.
- New forms of abuse are identified early.
- Wider influences of wellbeing impacting safeguarding are addressed.
- Safeguarding practice is continually strengthened.
- Staff members can identify and manage risk.

### Future Challenges:

- Carers and people who draw on care and support feeling pressure due to the reduction of services.
- Recruitment and retention difficulties, particularly with the cost of London residency for staff against the cost of living
- Managing the increasing complexity of cases and the rising number of SARs indicating a need for more preventative measures
- The implementation of Liberty Protection safeguards when they are enacted.

## Quality Assurance and Continuous Development

Quality assurance and continuous development will be achieved through regular audits and strong feedback evaluation processes.

To ensure our partners practices remain responsive and impactful we will regularly review and update our strategies throughout the 5-year timeframe, using learnings from past experience and keeping an eye on new developments emerging to respond to the needs of our community.

### Specific aims

- Learn lessons from safeguarding adult reviews, learning disabilities morality reviews, domestic homicide reviews audits and mor e

- Share evidence and performance and analyse it together to learn and make continual improvements.
- Partnership boards and the structure in place to safeguard children, work together to identify safeguarded trends.

### **How we will do this**

- Regular audits and reviews, including multi agency safeguarding concern and pen audits. Auditing across all partner agencies to identify areas of improvement and ensure standards. Key areas will include self-neglect, cuckooing and transitional safeguarding consistencies.
- Establishing continuous feedback mechanisms to incorporate input from staff, partners, residents, and families – particularly those with lived experience. This includes forums, learning events, surveys.
- Regular supervision and appraisal of staff to ensure high standards of practice are maintained and identify areas in need of improvement.
- Reflective practices to ensure staff are continuing to learn from their experiences and improve decision making.
- Data interrogation and analysis, including a comprehensive data integration dashboard to allow the monitoring and analysis of safeguarding trends. This includes generation of insight reports and sharing this data to inform collaborative improvement efforts.
- Ensuring timely publication of materials including SARs to maintain transparency and keep partners and communities informed.
- Compliance with national guidelines and statutory review participation.

The 2023 – 2024 year has laid the foundation for our 5-year strategy, and the partnerships focus has shown significant results in achieving the milestones set out above.

These achievements show our commitment to collaborative working to safeguard our residents across the partnership and its agencies.

Looking forward to the next four years of our 5- year plan, the SAPB continues to be committed to deliver the on the 6 priorities of proportionality, empowerment, prevention, partnership, protection, and accountability.

We will continue to strengthen and build our relationships with all stakeholders across the London Borough of Camden community, sharing goals and developing a model of coproduction.

We will regularly review and update our activities and strategies throughout the 5-year timeframe, using lessons learned from reviews, audit and the sharing and analysis of information and data. These aims and strategies will steer our efforts during the upcoming year to ensure we continue to build on our successes and effectively address challenges.

The SAPB, its partners and wider agencies will commit to work together to make the London Borough of Camden community a safer place for everyone.

## 9. Links (in lieu of appendices)

### Camden Strategy 2023- 2028

<https://www.camden.gov.uk/documents/20142/25239190/SAPB+Board+strategy+2023-2028+%281%29.pdf/cb76b495-ccd2-6704-ae23-8e4981bc7880?t=1695311525028>

### Camden SAB Annual Report 2022 – 2023

<https://www.camden.gov.uk/documents/d/guest/sapb-annual-report-2022-2023-final-version>

### “Matthew” SAR and 7 min Briefing

<https://www.camden.gov.uk/documents/20142/25239158/Camden+SAR+Matthew+Final+Report+April+2023.pdf/3877de70-00f6-be85-87e5-70fb32245513?t=1686312958207>

<https://www.camden.gov.uk/documents/20142/0/Matthew+SAR+7+Minute+Briefing.pdf/7b59d118-45de-ab57-a2f0-825c4d75e441?t=1687526402713>

### Second National SAR Analysis

<https://www.bing.com/ck/a?!&&p=c08a2c95129657af49a25f1083c31bf0f19cc5cb3a007e4969606d57b9fb92e3JmItdHM9MTcyODk1MDQwMA&p;tn=3&ver=2&hsh=4&fclid=19dc13df-2133-6547-3fde-075a25336ef0&psq=second+national+sar+analysis&u=a1aHR0cHM6Ly93d3cyLmxvY2FsLmdvdi51ay9vdXlhc3VwcG9ydC9wYXJ0bmVycy1jYXJlLWFuZC1oZWVsdGgvc2FmZWd1YXJkaW5nLXJlc291cmNlcy9zZWVvbmQtbmF0aW9uYWwtYW5hbHlzaXMtc2FmZWd1YXJkaW5n&ntb=1>

### Camden Self Neglect Toolkit

<https://www.camden.gov.uk/documents/20142/0/Multi-Agency+Self-Neglect+Toolkit+2020+%281%29.pdf/47b4f4ef-eff5-09f9-8aac-f603a1c1ac40?t=1615993974005>

### **Camden Cuckooing guidance and toolkit**

<https://www.camden.gov.uk/documents/20142/0/SAPB+Cuckooing+guidance+June+2023.pdf/ca806e07-c6b4-35f9-fcf6-e2763be21a78?t=1689080227281>

<https://www.camden.gov.uk/documents/20142/0/Cuckooing+guidance+flow+chart+June+2023.pdf/b2688248-eb09-21eb-3df4-5dcda8795ecd?t=1689080324359>