

Redbridge Safeguarding Adult Board (RSAB) Annual Report 2024 – 2025



Safeguarding Adults – Working to Keep People Safe

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1. Foreword from the Independent Chair & CIIr Mark Santos

I am very pleased to introduce the Annual Report of the Redbridge Safeguarding Adults Board 2024/25, development and publication of which is a key statutory duty.

As the Independent Chair of the Board, I am extremely grateful to all partners for their continued engagement and support to safeguard people living in the Borough, in the context of ongoing challenges in responding to changing safeguarding risks and needs; and the demands on their individual services.

This Annual Report describes what the Board has been doing as well as what individual Board partners have achieved during the year. This helps to inform the strategic plan and annual priorities for 2025/26.



There continues to be learning from Safeguarding Adults Reviews that provide a focus for improvements in safeguarding practice and processes, which is reflected in the strategic plan and our priorities.

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

Warmest regards

Eileen Mills

Independent Chair



This Annual Report sets out the year's achievements and challenges of Redbridge's Safeguarding Adults Board. It is a demonstration that for safeguarding to be successfully addressed it requires all of the key stakeholders to play their part.

The Report highlights the key challenge of resourcing and the impact that this may have on the effectiveness of the work. Despite this challenge much has been achieved against the Board's priorities. Amongst those developments has been the creation of the safeguarding hub within the Local Authority which is making a significant difference.

The work of the Board is a continuous journey and the Report describes its next set of priorities, key amongst this being learning from Safeguarding Adults Reviews that have been undertaken, ensuring that the necessary change is embedded in practice, systems and processes.

This work would not be possible without all of the Board members who I pay tribute too and in particular the work of Lesley Perry our Safeguarding Adults Board Manager and our Independent Chair Eileen Mills.

With best wishes

Councillor Mark Santos

Cabinet Member for Adult Social Care and Health

2. What is the Redbridge Safeguarding Adults Board?

The Redbridge Safeguarding Adult Board (RSAB) is a partnership of statutory and non-statutory organisations, representing health, social care and support providers and the people who use those services across the Borough.

The three key statutory duties for Safeguarding Adults Boards in the Care Act are:

- publish a strategic plan for each financial year that sets out its objectives and what members will do to achieve this;
- publish an annual report detailing what the SAB has done in the year and what each member has done to implement the strategy; and
- conduct any Safeguarding Adult Reviews in accordance with section 44 of the Act.

Membership comprises of the senior leaders across organisations, who under the leadership of the Independent Chair, work collaboratively to develop and improve safeguarding across the Borough. The partnership includes:

- o London Borough of Redbridge (adult health and social care, children's services, community safety, housing, public health, and commissioning)
- o Metropolitan Police Service (MPS) East Area (EA) Basic Command Unit (BCU)
- o Barking, Havering, and Redbridge University Hospital Trust (BHRUT)
- o Barts Health NHS Trust (BHNT)
- o Partnership East London Cooperatives (PELC)
- Department for Work & Pensions (DWP)
- o Healthwatch Redbridge
- o London Fire Brigade (LFB)
- o National Probation Service (NPS)
- NELFT NHS Foundation Trust
- o North East London (NEL) NHS Integrated Care System (ICS)
- o Age UK Redbridge, Barking & Havering (RBH)
- Voiceability
- o One Place East
- Redbridge Carers Support Service (RCSS)
- o Apasen
- Sanctuary Housing
- o Jewish Care
- Redbridge Community Action
- o Cabinet Member for Adult Social Care & Health, LB Redbridge
- o Lay Members
- o Care Quality Commission (CQC) Observer

The work of the RSAB is supported by the following Subgroups and linked forums:

- Policy and Practice Subgroup a forum to develop and review multi-agency safeguarding policies and procedures and take forward the development of multi-agency practice.
- Safeguarding Adults Network Forum enables the contribution of a user perspective to the development of safeguarding adults work across Redbridge and influence change in policies, procedures, and practice through the RSAB.
- Redbridge 'One Panel' a forum to bring together referrals for cases to be considered for review. These include Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), and Child Safeguarding Practice Reviews (CSPRs). The Panel will also undertake the role of monitoring recommendations of completed reviews and ensuring that learning is shared across Redbridge.
- Learning and Improvement Subgroup which has been developed to lead on the development and implementation of Action Plans from any Safeguarding Adult Reviews (SARs). Disseminating learning and oversee multi-agency audit programme.
- Joint Data Subgroup this remains in the developmental stage but aspires to bring together multiagency data across children and adult services to inform priorities and provide assurance on multiagency performance.

The RSAB and RSCP (Redbridge Safeguarding Children Partnership) come together as a joint Executive Group to provide multi-agency strategic leadership to the both the RSCP and RSAB, overseeing the strategic aims of the RSAB and RSCP within the context of wider system reform and national developments. The Executive Group also ensures development and maintenance of strong links with other strategic boards, with a focus on joint working and a holistic approach to safeguarding. These include, but are not limited, to the Community Safety Partnership and the Health and Wellbeing Board.

3. Funding the Redbridge Safeguarding Adults Board

The work programme for the Board, Subgroups and that of the Independent Chair are funded through SAB contributions. A well-resourced Board is essential to enable it to deliver its statutory duties and supports the Board to fund Safeguarding Adult Reviews (SARs) and learning events and other Board activities. The current and previous Independent Chairs have raised that the RSAB is unable to effectively deliver some of its statutory duties because of lack of resources, particularly in relation to use of data, quality assurance and delivery of multi-agency training.



This last year has seen an increase in the number of SARs being undertaken, which has increased the burden on the small existing resource.

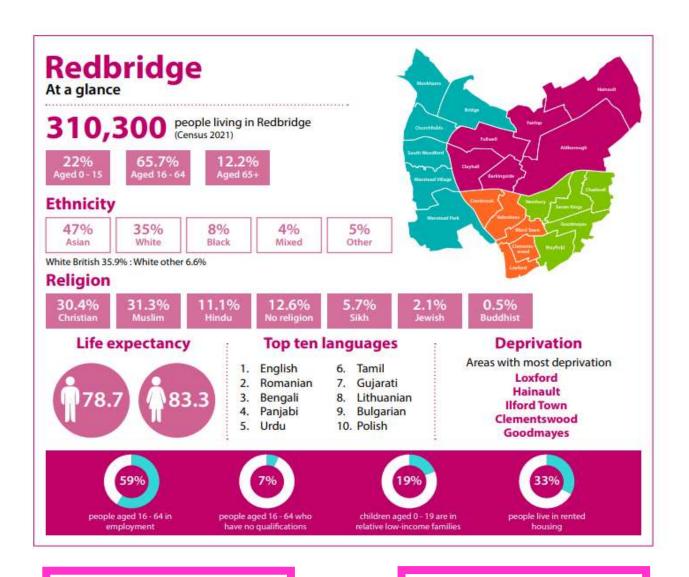
The current resource for the RSAB is 0.5 (Full Time Equivalent (FTE)) Board Manager and three days a month for the Independent Chair. There is no administrative support to organise and provide secretariat for the SAR Panels. The main RSAB and Subgroup meetings are supported by the Local Authority Safeguarding Hub and the Redbridge 'One Panel' by the ICB.

The extra demands created by the additional SAR activity this year has served to highlight the gap. A recent survey of SABs in London identified that only one other SAB had no administrative support.

The RSAB members need to consider the resource allocated to the support the functioning of the RSAB or the activities it wishes to undertake.

Agency	Contribution 2024 - 2025
London Borough of Redbridge	£45,000
NHS North East London ICB	£30,000
MOPAC	£ 5,000
Barts Health NHS Trust	£ 4,000

4. About Redbridge



Total number of safeguarding concerns raised in 2024-2025: 2089

Year-on-year change from 2023–2024: 1021

Individuals involved in safeguarding enquiries: 1069

Progression to further s.42 enquiries and completed:

Section 42 Enquiries: 72

Other Enquiries (non-S42): 11

Performance Observations

Trends in abuse types and enquiry rates



- Increased number of referrals year on year
- Abuse in care setting most prevalent
- Significant number of AARs know the persons causing harm

Making Safeguarding Personal practice improvements



- Evidence of promoting the MSP principles

Quality and timeliness of responses

- Improvements in timeliness for completing s.42 (2) enquiries desired
 - Better application and adherence to MCA 2025 required
 - Improvement in reporting on mental health safeguarding activities required

Comparison with previous years and regional averages

Higher volume of safeguarding referrals annually



- Higher volume of ineligible referrals

5. The Contribution of the RSAB Partners to Safeguarding Adults

All agencies represented on the Board were requested to submit a completed template answering a series of questions to demonstrate how their organisations are committed to safeguarding and the contribution they have made towards the RSABs priorities over the reporting period, including key achievements and challenges. Following Board member agencies submitted a return, which is only nine out of twenty-three requests.

Barts NHS Health Trust NFLFT

BHRUT VIA

EA BCU MPS Age UK

Jewish Care LB Redbridge Safeguarding

NHS NEL ICB Adult Service

As the main quality assurance process across partners, it is of concern that the responses were so few. The RSAB needs to consider a different approach in how it seeks assurance from partners going forward in the next reporting period. From those that respond were able to demonstrate the governance and framework which supports adult safeguarding. How Making Safeguarding Personal is supported and how they priority areas of work for the RSAB have been addressed on a single agency basis. The returns also provided insight into the areas of development for the RSAB going forward.

Key highlights of achievements by Partners

Age UK

"We ensure that we support our clients when a safeguarding concern has been identified and ensure that we provide support to them in a person-centred way ensuring that we respect their wishes and tailor any support to meet their individual needs"

Jewish Care

Introduction of safeguarding newsletter

BHRUT

"Introduction of a hospital based IDVA,"

"newly designed Domestic Abuse posters were distributed across both hospital sites, placed in all patient and staff toilets"

Barts

"Improved communication regarding the outcomes of safeguarding concerns that have been raised by the hospital."

MPS

Improved data "Allows for continued assessment on trends around the impact we are having on Adult safeguarding"

The Adult Decision-Making guide for referrals to ASC went live in Feb and we have seen a 15% drop in referrals to ASC MPS-wide since then which enables ASC to focus on those most at risk and reduces inappropriate reports coming into them.

LB Redbridge Safeguarding Adult Service

the establishment of the Safeguarding Adults Hub, which centralises the triaging and oversight of all safeguarding concerns

To support professional judgement and prioritisation, the 'BRAG Tool' (Blue, Red, Amber, Green) was introduced and embedded into practice. The tool provides a structured method for assessing risk and urgency at the point of referral and during the life of the enquiry.

NEL ICB

A set of comprehensive safeguarding standards was ratified to ensure safeguarding arrangements are in place and robust for new services being commissioned.

Establishment of a Violence Reduction /Serious Violence Duty Steering Group to develop a Trauma-Informed Care (TIC) and Serious Violence Duty Strategy

NELFT

"The NELFT Specialist Safeguarding Advisor for Redbridge now has an increased presence at pressure ulcer review meetings and complex case discussion meetings within Redbridge Community Health. This enables the identification and support of safeguarding concerns while ensuring that NELFT policies and procedures are followed as part of the Trust's governance framework"

VIA

Reframing 'Challenging Behaviour' as 'Distressed Behaviour' – including policy and training updates. This has helped us adopt a more trauma informed approach to incidents of violence and aggression (V&A) exhibited by service users, to look for themes and patterns, and to be more professionally curious about what activated the behaviour. This has led to a more nuanced and less punitive approach to our response to incidents of V&A and includes us scrutinising our own impact.

6. What has the RSAB done during the year to achieve its objectives?

The priorities agreed for the period 2023-2024 were as follows:

- ❖ To address the issues identified in the data provided to the RSAB that the number of safeguarding referrals is not representative of the local population.
- ❖ To improve multi-agency oversight and management of high-risk safeguarding cases.
- ❖ To ensure that the RSAB has assurance that local safeguarding arrangements are in place as defined in the Care Act.

Response to priorities:

To address the issues identified in the data provided to the RSAB that the number of safeguarding referrals is not representative of the local population.

to develop and deliver a multi-agency action plan to improve the understanding of safeguarding and how to make referrals in racialised communities by establishing trust in public bodies, addresses barriers to engagement.

Key Achievement	What difference has it made?	Next steps
Safeguarding Survey developed used across communities	the results from Survey Monkey show that there is lack of awareness around safeguarding.	Creating posters in different languages
The safeguarding survey continues to be made available to communities	There are culture barriers and people not wanting to talk about what is happening within the family due to reputation in disclosing safeguarding.	
We will be visiting community groups and from visits already done.	People will think about safeguarding if information is available in different languages and if posters are displayed in places of worship and in smaller community groups	

To improve multi-agency oversight and management of high-risk safeguarding cases.

- ❖ To develop a multi-agency approach for the understanding of what constitutes a highrisk, tiered approach to management.
- Establish a panel for multiagency oversight and management of high-risk safeguarding cases.

Key Achievement	What difference has it made?	Next steps
The HASS teams now	Allows for practitioners and health	To extend the work to
have case discussion	practitioners to engage in conversations and	a wider partnership
meetings that take place weekly.	escalate any risks	working and develop supportive guidance
Complex cases that are	Significantly reduced risks around self-neglect	for the multiagency
becoming severe and	and hoarding that can be challenging.	workforce.
there is significant		
concern are escalated	Practitioners are able to listen to a wide range	
through to high level risk reporting.	of discussions and learn from the cases to better manage cases appropriately.	
Hisk reporting.	better manage cases appropriately.	
NELFT have a section on	High Risk cases are being triangulated with	
their system Rio where	other Multiagency Panels – Community	
high level risk is	MARAC, MARAC and MAPPA	
documented.		

To ensure that the RSAB has assurance that local safeguarding arrangements are in place as defined in the Care Act.

Review current structure of the RSAB to:

- Enhance multi-agency learning and development from themes and reviews both locally and nationally.
- Provide quality assurance to the RSAB (including transition of into adulthood, voice of the service user); and
- ❖ Provide data and intelligence to inform future planning

Key Achievement	What difference has it made?	Next steps
Establishment of Learning & Improvement group	Improved oversight and monitoring to the findings of SARs to provide updates to the RSAB on progress. The development of briefings to support practice.	RSAB to develop a MA Quality Assurance Framework
Establishment of Data Subgroup and data set	Development of a multiagency data set across children and adults	RSAB to receive quarterly reporting of the data to inform future work of the
Development of a Local Safeguarding Adult Partnership Assurance Tool	A method of providing assurance to the RSAB on partnership	RSAB and provide assurance on safeguarding adults

7. Response to Findings of Safeguarding Adult Reviews (SARs)

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

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

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

During the 2024 -25 year, the RSAB have undertaken and published five Safeguarding Adult Reviews (SAR).

- <u>SAR Christopher, June 2025</u> action plan is in place with assurance activity planned for late 2025
- <u>Thematic SAR Self Neglect Deborah and David, May 2025</u> the findings are responded to in the Priority areas of work for 2025/6
- SAR Barbara, December 2024
- Family A SAR, August 2024
- SAR Caleb, May 2024

All SARs include recommendations and the RSAB Learning and Improvement Subgroup have reviewed the recommendations and created action plans in response to the findings of the report.

The RSAB held an Extraordinary Meeting in March 2025 to

- Gain assurance of progress against recommendations.
- ❖ Be clear in relation to any gaps that need to be addressed and by whom; and
- ❖ Progress forward via the development of an action plan to include outstanding actions and wider thematic responses to address the challenges identified.

All key RSAB partners were requested by to produce evidence of their single agency response to SARs. The meeting agreed to draw together thematic issues to concentrate the number of recommendations and key actions to be taken over the next 12 months as RSAB priorities.

What has changed in response to SAR Caleb, Family 'A' SAR and SAR 'Barbara'?

Firstly, a new electronic case management system has been introduced across Redbridge Health and Social Care. The new system is enabling Adult Social Care to achieve a streamlined recording, data collation and reporting process for managing safeguarding proceedings. This ensures that

records for safeguarding activities are centralised and accessible to practitioners, managers and partner services across Adult Social Care. The system has improved the reporting capability for the service and case management oversight.

Secondly, the Adult Safeguarding Service has been restructured following review. A new Strategic Lead for Safeguarding and Professional Practice post was created to oversee management of safeguarding activities across Adult Social Care. The restructure also included the development of the Safeguarding Adults Hub which became operational on July 2, 2024. From this date, a new system of triaging safeguarding referrals notified to Redbridge Adult Social Care was introduced.

The primary aim of the Safeguarding Adults Hub is to ensure that residents within the borough are safe and supported. As a service whose dedicated function is managing safeguarding adults 'proceedings at the front door of Redbridge Adult Social Care, the service will ensure that the safeguarding concerns are prioritised and processed in a timely manner. Through its primary functions, the Hub will ensure that adults at risk are supported to achieve their desired outcomes from safeguarding proceedings and support them to get best outcomes by developing and strengthening links with partner organisations and other agencies.

In addition to the triaging function, the Hub is also responsible for making initial enquiries and implementing immediate protection plans when the local authority is notified that adults who have care and support needs are at risk/experienced abuse, harm or neglect.

Another significant development in practice this year has been the development of the Adult Decision-Making document across London. The document is for Police MASH teams to decide what to refer to Adult Social Care and at what level of concern the information is. This aims to improve the quality and relevance of reports that the Metropolitan Police Service send through to Local Authorities.

The Learning and Improvement Subgroup have developed a <u>multi-agency 7 minute briefing on Professional Curiosity</u>.

A free briefing has been made available via the Redbridge SCP Safeguarding Training Programme 2024 – 2025 on 'Think Family': Safeguarding the Whole Family aimed at professionals and volunteers across both adult and children's services.

Additional work is ongoing to raise awareness raising undertaken Highlighting the link between Autism and Suicide.

The Leaning and Improvement Subgroup are taking forward work in 2025 – 2026 in relation to the findings from the later SARs (SAR 'Christopher' and the Self-Neglect Thematic SAR 'Deborah' and David').

8. Strategic Priorities - Looking ahead to 2025 - 2026

The priorities for 2025 – 2026, are developed from the <u>Strategic Plan 2025-28</u> and considering the learning identified from SAR and developed the <u>priority areas of work for 2025-26</u>.

Priority	Description	Reason
Learning from Safeguarding Adult Reviews (SARs)	Review and update of the RSAB Multi-Agency Self Neglect and Hoarding Protocol, to cover support with engaging with service users, understanding social isolation and trauma.	Responding to thematic learning
	Hold a roundtable event to review current multi- agency working informed by the findings and learning from SARs and the Families First for Children Pathfinder.	
	Development and implementation of a multi- agency risk management (MARM) framework. Development of a briefing based on learning from recent SARs	
Discriminatory Abuse	Implementation of the Discriminatory Abuse Self- Assessment Tool	To address issues of disproportionality
	Development of a 7 Minute Briefing	
	Development and promotion of safeguarding information for different communities	
Assurance of Effectiveness of Safeguarding	Development of a multi-agency safeguarding dataset RSAB & RSCP	To inform the work of the RSAB and its impact
Arrangements	Introduction of a multi-agency audit framework	The learning from
	Receipt of a report on the findings of the SAPAT to support future developments	SARs is reflected across the system
	Support with CQC Local Authority Inspection and development of any resulting Action Plan Participate in the review of S75 arrangements.	