



Redbridge Safeguarding Adults Board

Redbridge Safeguarding Adult Board (RSAB)

Annual Report 2025 – 2026



Safeguarding Adults – Working to Keep People Safe

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1. Foreword from the Independent Chair & Cllr Daniel Morgan Thomas

The RSAB is an independent statutory body with a strategic responsibility to work with its members and partners to protect and support adults with care and support needs from abuse, neglect and self-neglect in Redbridge.

In December 2025, the CQC rated the London Borough of Redbridge as 'Requires Improvement', identifying significant shortfalls.

Of particular concern, safeguarding and governance were both scored 1 (significant shortfalls), indicating systemic weaknesses in protecting adults at risk.



The inspection identified significant areas requiring improvement within Adult Social Care and the wider system and highlighted opportunities to further strengthen safeguarding arrangements, governance, quality assurance and partnership working across the wider system. These findings provide an important focus for collective improvement activity across all partner agencies.

As Chair, it has saddened me that Previous annual reports have highlighted limitations in the Board's access to comprehensive multi-agency assurance information and quality assurance capacity. These constraints reduced the Board's ability to develop a fuller understanding of safeguarding effectiveness across the partnership and reinforce the importance of strengthening assurance arrangements going forward. The inspection findings reflect serious failings across the system. At times, adults in Redbridge have experienced delays in receiving support and inconsistent safeguarding responses.

This report sets out not only what has happened, but how the system is responding with recommendations to improve oversight and assurance.

In response to the findings an Adult Improvement Board has been established with oversight from the Secretary of State, to oversee the required improvements. I am a member of the Board to ensure that governance crosses over with the Redbridge Safeguarding Adult Board (RSAB) and its priorities.

The RSAB is an independent statutory body with a strategic responsibility to work with its members and partners to protect and support adults with care and support needs from abuse, neglect and self-neglect in Redbridge.

At the beginning of the year the Board reviewed their vision and values, as part of the updating of the RSAB Strategic Plan 2025 - 2028. The RSAB believe that people in Redbridge have the right to live a life free from harm, where communities:

- have a culture that does not tolerate abuse
- work together to prevent abuse
- know what to do when abuse happen

The values of this Plan are based on understanding and promoting peoples' right to make decisions, the importance of maintaining dignity and respect and the celebration of diversity. The Board believes in:

- Personalisation - person-centred and person-led practice that embraces genuine coproduction with adults at risk so that interventions are meaningful
- Equalities-Understand and counteract inequalities in safeguarding practice
- Openness - Accountable for what we do. Confident to work alongside residents with lived experience of abuse or neglect. Transparent in our journey of continuous improvement of safeguarding practice
- Pro-active-Support positive culture change within our institutions so that our workforce is proud to make positive contributions to a safe, fair Redbridge
- Learn-Learn from each other to prevent future harm. Set expectations for good safeguarding practice, having reflected together on what enables good practice
- Empower-Empower individuals and staff to challenge unsafe or harmful practices.
- Engage with advocacy to support adults who have experienced abuse secure better access to justice

The RSAB must now ensure that its vision is delivered across agencies as part of the improvement journey.

Eileen Mills

Independent Chair



Joining the Cabinet with responsibility for Adult Safeguarding at the start of a new corporate year, it has been valuable to look back in this Annual Report at the work that has been undertaken by Redbridge Council and its partners in the previous one.

As Eileen has noted, the extremely disappointing outcomes of the 2025 CQC inspection highlighted concerns especially around safeguarding, which the Council now rightly sees as an organisation-wide priority. These failings were unacceptable for the most vulnerable residents of this Borough, their families, neighbours and friends and the findings of that inspection serve in turn to reinforce the importance of learning from SARs such as the case of 'Munir' published towards the end of last year.

It is however encouraging that despite a very limited resource baseline, the RSAB has been able to produce resources of real value to practitioners across our Local Area. I hope colleagues will take note of the recommendations contained in this annual report and will look forward to seeing many more statutory partners engaging with us in this important work going forward. My thanks go to all Board Members who have actively shaped the work highlighted in the annual report and especially the Independent Chair, Eileen Mills and Partnerships Manager, Lesley Perry, without whose conscientious efforts all impact would be much diminished.

Cllr Daniel Morgan-Thomas

Cabinet Member for Adult Social Care and Health

2. About the Board

Safeguarding Adults Boards were established under the [Care Act 2014 Section 43](#) with a role that is distinct from its member organisations. Whilst member organisations provide safeguarding services and will support individuals in need of help and protection, the Board itself works strategically across its membership and with wider organisations to ensure there are safe arrangements in the borough. This role is set out in legislation: “The way in which an SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does”.

The Board’s coordination role includes:

- ❖ Provision of multi-agency safeguarding adults’ policy and procedures to ensure we are
- ❖ working together and with the person at risk
- ❖ Quality assurance processes around multi-agency working
- ❖ Identifying and sharing learning,
- ❖ Promoting awareness of safeguarding amongst the communities of Redbridge
- ❖ Learning from lived experiences
- ❖ Learning from best practice as well as situations where it could have been better

The Board’s role also involves gaining assurances from its members about effective arrangements being in place, this may involve:

- Multi-agency and single agency audits
- Assurances about learning from reviews
- Assurances about embedding board priorities and learning



As previous [Annual Reports](#) and [Appendix 1](#) have outlined the resourcing and the capacity of the RSAB to undertake all its functions and support members is not sufficient to meet all its functions.

Recommendation

The Board should consider whether additional capacity and resources would further strengthen its ability to undertake its full programme of assurance, quality improvement, learning and development activity, particularly considering increasing demands arising from SAR activity and improvement priorities.

3. Our Membership

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:

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

Eileen Mills is the Independent Chair whose role involves providing leadership, challenge and support to the Board in achieving its ambitions.

The structures (see [Appendix 1](#)) exist in the RSAB to bring partners together, but commitment to attendance and participation has been lacking at times, due to service reorganisation and conflicting demands on senior leaders. This means that the structures have not been functioning effectively enough to support effective oversight and assurance. Consistent attendance and participation will be important in supporting the Board's assurance, learning and improvement functions moving forward. Given the findings of the CQC inspection it is of concern that as a system the concerns were not identified and raised.

Recommendation

The RSAB records and report in attendance at the Board and Subgroups and escalates gaps in participation.

The RSAB strengthens mechanisms for challenge, escalation, quality assurance and the sharing of intelligence across the partnership to support earlier identification of emerging risks.

4. About Redbridge

Redbridge has a population of 311,000–313,000 residents, it is a highly diverse urban borough with a high population density.

The Redbridge Annual Public Health Report 2025/26 The role of public health in preventing, reducing and delaying demand for social care identifying that there is a rising demand for adult social care driven by:

- ageing population; and
- increasing complexity (frailty, mental health, disability).

There are approximately 199 CQC-regulated adult social care services in Redbridge (75 residential, 124 community-based). Available data, indicates that around 80–85% are rated 'Good' or 'Outstanding', although very few are rated 'Outstanding'.



This means that a minority of services are not yet meeting required standards, reinforcing the need for continued focus on quality, safeguarding, and provider oversight across the system. In the context of increasing demand and complexity of needs can equate to increased safeguarding risk and system pressure.

Recommendation

As the RSAB introduces a data set it needs to include quality of provider services oversight of the system.

5. Progress against the Priorities for 2025-2026

The priorities agreed for the period 2025-2026 were as follows:

- ❖ Learning from Safeguarding Adult Reviews (SARs)
- ❖ Discriminatory Abuse
- ❖ Assurance of Effectiveness of Safeguarding Arrangements

Responses to the priorities:

Learning from Safeguarding Adult Reviews (SARs)

The actions outlined at the beginning of the year included:

- ❖ 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.
- ❖ 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. (This did not progress due to changes in leadership and direction).
- ❖ Development and implementation of a multi-agency risk management (MARM) framework. This work did not progress and remains a priority for 2026 - 2027
- ❖ Development of a briefing based on learning from recent SARs

What was achieved?

- ❖ The RSAB Multi-Agency Self Neglect and Hoarding Protocol has been reviewed and ready for publication in 2026-27
- ❖ The RSAB has published briefings on Professional Curiosity and Learning from SAR Christopher

Challenges to progress

The Board acknowledges that progress against its priorities has not been sufficient, especially in relation the development of a MARM, which has been a repeated finding of SARs in Redbridge. This is due in part to changes in senior leadership, which have affected consistency and momentum, alongside the system-wide impact of the recent CQC inspection and system reforms, which has required an urgent refocusing of effort. The Board recognises the commitment shown by partners during this period and is focused on supporting and maintaining momentum across agreed priorities, moving forward.

Next Steps

The MARM is now part of the Adult Safeguarding Improvement Plan developed in response to the CQC Inspection findings.

Recommendation

The RSAB is fully briefed on the progress of the MARM development, and all newly published SARs are accompanied by a learning brief.

Discriminatory Abuse

The actions outlined at the beginning of the year included:

- ❖ Implementation of the Discriminatory Abuse Self-Assessment Tool
- ❖ Development of a 7-Minute Briefing,
- ❖ Development and promotion of safeguarding information for different communities

What was achieved?

- ❖ A 7-minute briefing on [Discriminatory Abuse](#) was published
- ❖ Multi-Agency Learning Event for professionals and volunteers took place
- ❖ Safeguarding information has been translated in six different community languages and published on the [RSAB website](#)
- ❖ Safeguarding Adults animation film is now available in different languages
- ❖ Engagement with Redbridge Community Voices Panel which lead to paid advertorials appearing in Redbridge Life to raise awareness of adult safeguarding across communities

Challenges to progress

The one area not completed was the self-assessment by agencies with only three returns.

Next Steps

The Safeguarding Adult network will continue to support engagement with communities which is now forming part of the Adult Improvement Plan in response to the CQC inspection.

Assurance of Effectiveness of Safeguarding Arrangement

The actions outlined at the beginning of the year included:

- ❖ Development of a multi-agency safeguarding dataset RSAB & RSCP
- ❖ Introduction of a multi-agency audit framework
- ❖ Receipt of a report on the findings of the SAPAT (Safeguarding Adult Partnership Audit Tool) to support future developments
- ❖ Support with CQC Local Authority Inspection and development of any resulting Action Plan
- ❖ Participate in the review of S75 arrangements

What was achieved?

- ❖ SAPAT (Safeguarding Adult Partnership Audit Tool) 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.
- ❖ Nine responses out of twenty-three request, were received
- ❖ From those that responded, we were able to demonstrate the governance and framework which supports adult safeguarding. How Making Safeguarding Personal is supported and how the priority areas of work for the RSAB had been addressed on a single agency basis.
- ❖ Feedback was incorporated into the development of priorities for 2026-7
- ❖ The RSAB Independent Chair and Partnership manager provided information for the preparation for CQC inspection in relation to RSAB activity and learning from SARs
- ❖ The RSAB Independent Chair is now a member of the Adult Improvement Board and the Partnership Manager a member of the Adult Social Care (ASC) Improvement & Assurance Programme Board

Challenges to progress

Despite establishing a subgroup to develop a data set, the RSAB still did not achieve its aim of having a multiagency data set. The absence of partner agencies providing timely, accurate and comprehensive safeguarding data prevents the Safeguarding Adults Board from identifying risks, monitoring performance, and providing assurance regarding the effectiveness of local safeguarding arrangements. This results in missed opportunities to prevent harm, weaker governance, and an increased risk of poor outcomes for adults with care and support needs. Achieving this ambition will require continued commitment, resource and shared ownership across partner agencies to ensure that meaningful assurance information can be collected, analysed and used to inform strategic oversight.

Recommendation

The RSAB must be provided with the capacity to develop a Multiagency data set and receive the support of partners to develop.

Current resource levels limit the extent of multi-agency audit and quality assurance activity that can be undertaken directly by the Board. Whilst SAPAT continues to provide a valuable source of assurance, increasing participation from partner agencies would strengthen the breadth and depth of intelligence available to support strategic oversight. Improved compliance is essential to achieve this.

Next Steps

The RSAB will continue to keep oversight of the progression of the LBR Adult Social Care Improvement Plan.

Recommendation

The RSAB needs to consider a different approach in how it seeks assurance from partners going forward in the next reporting period.

6. Contributions of Partners

Partner agency returns for the 2025 - 2026 Annual Report were only received from the Metropolitan Police Service (MPS), PELC and VIA, together with assurance information provided by the London Ambulance Service (LAS).

- ❖ MPS reported continued investment in adult safeguarding through enhanced frontline officer training, implementation of the Adult Decision-Making Protocol, development of a safeguarding Standard Operating Procedure and increased funding to local safeguarding partnerships. The impact identified included improved referral quality, a reduction in referrals to Adult Social Care following implementation of the Adult Decision-Making Protocol, and continued contribution to safeguarding reviews and multi-agency arrangements.
- ❖ PELC highlighted developments focused on improving outcomes for adults with neurodiversity and mental health needs. These included making Oliver McGowan training mandatory for clinicians and strengthening joint working arrangements with mental health services to provide 24/7 mental health professional support within urgent treatment settings. PELC reported increased practitioner awareness of neurodiversity, better use of disability passports and improved patient journeys through more timely mental health assessment and support.
- ❖ Via Redbridge has continued to strengthen safeguarding arrangements through a range of innovative developments focused on reducing health inequalities, improving outcomes for people with co-occurring mental health and substance use needs, and supporting vulnerable groups. Key achievements included enhanced partnership working with NELFT, the introduction of trauma-informed approaches, targeted outreach for women involved in survival sex, expansion of naloxone and overdose prevention initiatives, improved pathways for neurodivergent, LGBTQIA+ and other underrepresented communities, and increased involvement in multi-agency safeguarding forums. These developments have contributed to improved joint risk management, stronger safeguarding pathways, increased engagement with treatment services, rising hospital referral engagement, and improved treatment outcomes, with 258 planned treatment completions, 1,562 referrals received, and treatment uptake increasing from 67% to 84% during the year.

- ❖ The London Ambulance Service advised that safeguarding assurance is provided through the Brent Safeguarding Partnership as the lead commissioning area for London Ambulance Service safeguarding arrangements. Whilst it is not operationally feasible for LAS to complete individual annual assurance returns for all London safeguarding partnerships, LAS remains actively engaged in safeguarding across London and has shared key achievements from its annual report. During 2025-26 LAS raised 59,457 safeguarding referrals, representing approximately 2.5% of operational activity, and continued to embed its electronic safeguarding referral process. LAS also introduced a Child High Intensity Users Programme to identify children with repeated ambulance contacts, supporting earlier intervention and reducing safeguarding risks through partnership working with health and community services.

Unfortunately, returns were not received from all partner organisations, the information provided demonstrates continued commitment across those partners to improving safeguarding practice, strengthening multi-agency working, enhancing responses to vulnerability, and embedding learning from reviews and frontline practice.

Recommendation

The Board as part of the development of a Quality Assurance Framework requires comprehensive partner assurance to strengthen its understanding of safeguarding effectiveness across the partnership

7. Rough Sleeping and Homelessness

In May 2024, the Minister for Housing and Homelessness and the Minister for Social Care wrote jointly to Safeguarding Adults Boards highlighting the significant safeguarding risks associated with rough sleeping and homelessness and recommending stronger governance, leadership and oversight arrangements.



The RSAB has responded positively to these recommendations at the time and as such; the Director of Housing is a member of the Board and provides strategic leadership and assurance regarding homelessness and rough sleeping services. The Independent Chair has championed the importance of safeguarding adults experiencing homelessness through Board discussions and dedicated homelessness and rough sleeping workstreams in previous reporting periods.

The Board has also strengthened oversight of rough sleeper deaths, with all deaths notified to and reviewed through the Redbridge One Panel to identify learning opportunities, safeguarding concerns and system improvements.

Partnership working has been strengthened through established safeguarding protocols for hostel and outreach services, bi-weekly Rough Sleeping Task Force meetings and multidisciplinary meetings involving the local authority, voluntary sector and commissioned services. Approximately 15 complex cases are reviewed each month through the multidisciplinary process, with safeguarding leads contributing to coordinated risk management and intervention planning.

The Board has also supported the implementation of the Redbridge Homelessness and Rough Sleeping Strategy 2025-2030, which prioritises prevention, reducing rough sleeping, improving partnership working and strengthening pathways for vulnerable residents. Planned activity includes improved outreach arrangements, health and wellbeing events for rough sleepers, enhanced information sharing between partners, and development of accommodation pathways to support people away from the streets and into sustainable housing solutions. These arrangements provide stronger assurance that people experiencing homelessness and rough sleeping receive coordinated, person-centred support and safeguarding responses.

8. Learning from experience how to improve our work

The Redbridge One Panel provides the forum to review cases of concern that may reach the threshold for Safeguarding Adult Reviews, Domestic Abuse Related Deaths and Child Safeguarding Practice Reviews.

In the reporting period, five referrals of cases for consideration of a SAR were received, with one progressing to a full SAR – SAR 'Munir' the Overview Report from which as published in June 2026. The Action Plan will be developed and progressed in the next reporting period.

Of the other cases, two did not meet the criteria and two led to single learning and actions.

The Learning and Improvement Subgroup have taking forward work in 2025 – 2026 in relation to the findings from the SARs

- ❖ SAR 'Christopher'
- ❖ Self-Neglect Thematic SAR 'Deborah' and David'

Key Achievement	What difference has it made?	Next steps
The RSAB Multi-Agency Self Neglect and Hoarding Protocol has been reviewed (published in August 2026).	The Protocol is update reflective of learning from SARs and recognised best practice	To embed the Protocol into practice and review its use.
Publication of Briefings RSAB 7 Minute Briefing: Professional Curiosity RSAB 7 Minute Briefing: SAR 'Christopher'	Professionals have resources to support practice and disseminate learning	To review the impact on any future SARs

9. Strategic Priorities – looking ahead to 2026 - 2027

The April 2026 RSAB meeting reviewed the progress on the priority areas for 2025-26 and the work of the subgroups alongside the drivers for priorities for 2026 – 2027 highlighted by the CQC Inspection and setting up how the RSAB establish clear pathways for assurance. The meeting also considered a recent presentation from the [Borough's Reach Out \(Domestic Abuse\) Service](#) which highlighted low numbers of referrals to the service for adults without children. From the discussion the following priorities were agreed for 2026 - 2027.

Priority	Description
Assurance of Effectiveness of Multi-Agency Safeguarding Arrangements	❖ Oversight progression of the LBR Adult Social Care Improvement Plan ❖ Develop and implement a Multi-Agency Risk Management (MARM) protocol setting out arrangements for managing risk where safeguarding concerns do not progress to a Section 42(2) enquiry ❖ Strengthen the Safeguarding Adults Board (RSAB) governance, accountability and assurance arrangements including assurance performance frameworks and improved oversight/risk tracking ❖ Mapping of the governance and accountability infrastructure and analysis of Terms of Reference (ToR) developmental and approval of revised RSAB ToR. ❖ Develop an appropriate escalation matrix and protocols to ensure risk is held at the right level and an appropriate level of aggregate reporting for effective risk governance is in place and linked to the MARM.
Domestic Abuse	❖ Promotion of awareness of domestic abuse in relation to cohorts with increased risk i.e. older people; those with learning disabilities; and those undertaking a family caring role. ❖ Development and monitoring of joint working between services working with adults at risk and joint working with the Reach Out Service. ❖ Auditing of cases of adults at risk impacted by Domestic Abuse for a baseline and re-auditing to identify improvements.
Learning from SARs	❖ Completion of the review of the RSAB Self-Neglect and Hoarding Protocol, 3rd Edition to reflect learning from SARs
Making Safeguarding Personal (MSP)	❖ Promotion of the voice of the adult service user and shared values across the partnership ❖ Oversight of any new multi-agency policies and procedures to ensure that they reflect the MSP principles of choice, control, and respect of individual's desired outcomes. ❖ Development of multi-agency guidance, briefings and learning resources for practitioners (in conjunction with area of the Adult Improvement Plan)

Structure and Resource of the RSAB

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

- Policy and Practice Subgroup which is a forum to develop and review multi-agency safeguarding policies and procedures and take forward the development of multi-agency practice.
- Safeguarding Adults Network Subgroup 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.

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.

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 Redbridge 'One Panel' has been supported by the ICB transition to the MPS and secretariat from the Local Authority.

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.



Partner Contributions 2025 – 2026

Agency	£
NHS NEL ICB	30,000
Barts Health NHS Trust	4,000
Local Authority	44,289
MPS (via MOPAC)	5,000
Total Expenditure/Budget	83,289