

**Barking and Dagenham
Safeguarding Adults Board
Annual Report
2025 – 26**



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1. Independent Chair's Foreword and Overview



Anju Harmit Ahluwalia BEM
Independent Chair
Barking and Dagenham Safeguarding Adults Board

I have had the pleasure of being the Safeguarding Adult Board Independent Chair for four years now and have seen the growth and changes across the borough and the partnership in the current climate of uncertainty. Much positive work has been achieved across the SAB and jointly with the Safeguarding Children's Partnership and the Community Safety Partnership.

Going forward it important to build on this work and to align priorities across all the three boards so that resources and responsibilities are shared, to ensure that safeguarding is everybody business and to achieve tangible outcomes.

The joint safeguarding conference was delivered in November across the SAB, the Children's Partnership and Community Safety and was attended by nearly 100 professionals and service users from local agencies, organisations and the community and voluntary sector. There were high profile speakers who shared their knowledge and experiences around transitional safeguarding, lived experiences of the care system, housing and homelessness and cuckooing. Attendees were able take part, share their views and network with others. Positive feedback was received and there was appetite for this to take place annually.

The Care Quality Commission (CQC) inspection rated Adult Social Care as OUTSTANDING. This is an amazing achievement for Barking & Dagenham. It was possible because of all the hard work across the council and with partners working together to achieve the best outcomes for the local community. As part of the process the inspectors wanted to discuss the work that I do as chair. I shared the board's achievements, some of the challenges and the importance of meeting local people who use services to ensure their voices are heard at board level. I explained that it is important for me to be a critical friend to partners and provide challenge to address the issues and gaps.

The key takeaway for me from the inspection process is that a lot of hard work is undertaken to deliver support with the limited resources and increasing needs.

This is my last year as the chair for the board and I am looking forward to seeing and hearing about the amazing work that will continue, building on the work that has taken place over the last year.

2. What is Safeguarding Adults?

The Care Act 2014 statutory guidance defines adult safeguarding as:

‘Protecting an adult’s right to live in safety, free from abuse and neglect. It is important that people and organisations work together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.’

The Care Act 2014 came into force on 1st April 2015. The Act introduced new requirements for safeguarding adults and the arrangements that each locality must have in place to ensure that vulnerable people are protected from risk, abuse or neglect. The Local Authority, the NHS Integrated Care Board and the Police are all statutory partners of the Safeguarding Adults Board (SAB) and other important local partners are also key players in the work of the partnership. The Care Act identifies six key principles that should underpin all safeguarding work. These can be seen in the diagram on the right.



3. The SAB's Vision

Every adult living in the London Borough of Barking and Dagenham has the right to live in safety, free from fear of abuse or neglect. The Safeguarding Adults Board exists to make sure that organisations, people and local communities work together to prevent and stop the risk of abuse or neglect.

In the London Borough Barking and Dagenham we want to embed a stronger and safer culture that supports adults who are at risk of harm. We know that to achieve this we have to work in partnership with the people who use local services and with the wider local community. All agencies working with adults at risk have an essential role in recognising when these people may be in need of protection. Agencies also have a responsibility to work in partnership with adults at risk, their families, their carers and each other. The Safeguarding Adults Board has a statutory duty to ensure it uses its powers to develop responsibility within the community for adults who need care and protection.

The main focus of the work of the Safeguarding Adults Board is to ensure that safeguarding is consistently understood by anyone engaging with adults who may be at risk of or experiencing abuse or neglect, and that there is a common commitment to improving outcomes for them. This means ensuring the community has an understanding of how to support, protect and empower people at risk of harm. We want to develop and facilitate practice which puts individuals in control and generates a more person-centred approach and outcomes.

The Safeguarding Adults Board has a three year Strategic Plan in place with priorities, objectives and annual actions which set out how partners will work together to safeguard adults at risk. The current Strategic Plan can be viewed here

<https://www.lbld.gov.uk/barking-and-dagenham-safeguarding-adults-board#tabs-3> and is referred to again in section 9. The Strategic Plan and priorities are currently being revised and agreed for 2026 – 2029.

The Safeguarding Adults Board has a responsibility to:

**Prevent abuse
occurring**

**Protect adults
at risk**

**Respond to
concerns**

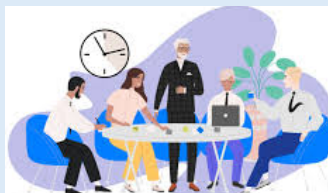
It may be suspected that someone is at risk of harm because:

- there is a general concern about someone's **well being**
- a person sees or hears something which could put **someone at risk**
- a person tells you or someone else that something has happened or is happening to them which could put **themselves or others at risk.**

4. The Board and Committees

The Barking and Dagenham Safeguarding Adults Board is made up of the following statutory partners:

- The Local Authority
- The Borough Police
- The NHS Integrated Care System



Other members of the board include the Council Cabinet Member for Housing, Adult Social Care & Health, representatives from North East London Foundation Trust (NELFT), Barking, Havering, Redbridge University Hospitals (BHRUT), the London Fire Brigade, the London Probation Service, the Department of Work and Pensions, Barking and Dagenham Healthwatch, Care Provider Voice and chairs of the committees.

The SAB has four committees, which are chaired by different partner organisations:

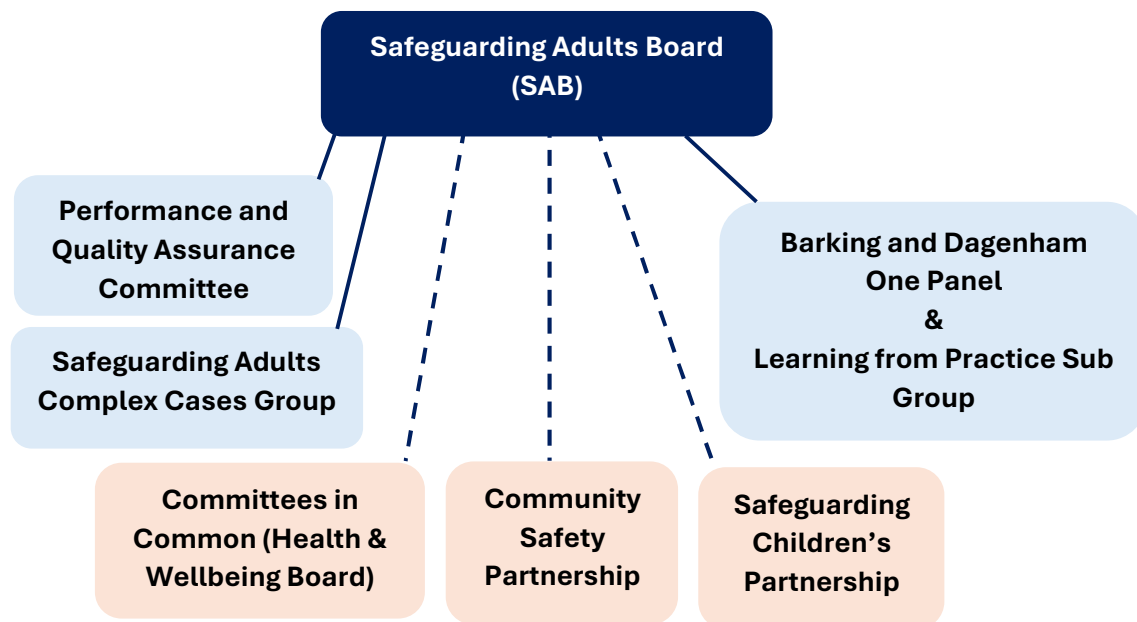
- The Performance and Quality Assurance Committee (chaired by Care Provider Voice)
- BD One Panel (chairing is shared across partners and rotates)
- The Safeguarding Adults Complex Cases Group (chaired by the London Borough of Barking and Dagenham)
- The Learning from Practice Group (chaired by NHS Integrated Care System)

The Barking and Dagenham One Panel has been in place since 2024 and brings together referrals for cases to be considered for review including Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs) and Child Safeguarding Practice Reviews (CSPRs). The Panel also undertakes the role of agreeing and monitoring reviews taking place. Guidance documents and the referral form can be found [here](#)

There is a joint Learning from Practice group that implements the learning and development arising from reviews from across all the local partnerships as well as other local, regional and national learning.

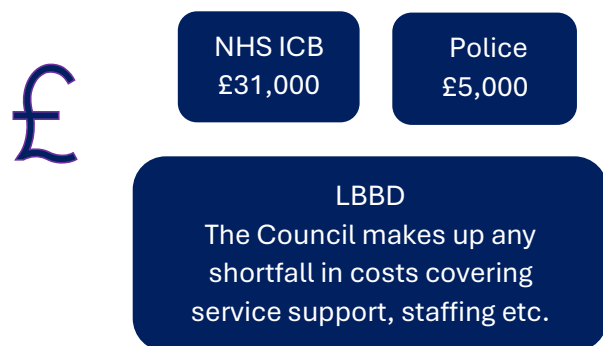
The Independent Chair meets regularly with LBBD Council's Strategic Director of Adults and Children's Service and the Adult Social Care Operational Director as well as with the committee chairs and other key SAB partners.

The board is supported by the Council Cabinet Member for Housing, Adult Social Care & Health as a participant observer. This enables Councillor colleagues to be kept up to date with safeguarding adult matters. In addition, the committee chairs and officer advisors also attend board meetings.



Financial Contributions

Statutory partners make financial contributions to the SAB. This supports the running of the board including the cost of the Independent Chair, Safeguarding Adult Reviews and any multi agency learning and development activity undertaken across the partnership.



The SAB's Statutory Responsibilities

The SAB must publish an annual report each year as well as having strategic plan. This annual report reviews the work undertaken by the SAB and its committees throughout 2025-26 and provides an account of the work of the partnership including achievements, challenges and priorities for the coming year.

In addition, the SAB has a statutory duty to carry out Safeguarding Adult Reviews (SARs) where an adult in the Local Authority area:

- has died as a result of abuse or risk (either known or suspected) and there are concerns that partner organisations could have worked together more effectively to protect that adult.
- has not died but the SAB knows or suspects that an adult has experienced serious abuse or neglect.

The implementation of recommendations and action plans from SARs must be reported in the annual report. Three SARs were undertaken in 2025-26. More information on these can be found in chapter 6.



5. Safeguarding Data

This section provides an overview of adult safeguarding performance in Barking and Dagenham during 2025–26, using Safeguarding Adults Collection (SAC) data and benchmarking against previous years and average performance in England. The Safeguarding Adults Collection (SAC) is the principal national dataset on adult safeguarding. Local authorities submit data annually to the Department for Health and Social Care, providing information about how statutory safeguarding duties under the Care Act are delivered. This collection is a key source of data for the Safeguarding Adults Board.

The data included for Barking and Dagenham covers the period from 1st April 2025 to 31st March 2026. Comparative information on safeguarding activity is also available showing performance for England in 2024-25 and allows for a more detailed evaluation of our own performance.

Key figures for Safeguarding in Barking and Dagenham in 2025-26



1,653

safeguarding concerns raised

(19% increase since 2024-25)



89%

**of enquiries resulted in risk removed
or reduced**

(95% in 2024-25)



77%

**of enquiries involved risk in the
individual's own home**

(England average: 49%)



22%

**conversion rate from safeguarding
concerns to Section 42 enquiries**

(17% in 2024-25)



98%

**of individuals stated that their
desired outcome had been achieved**



15%

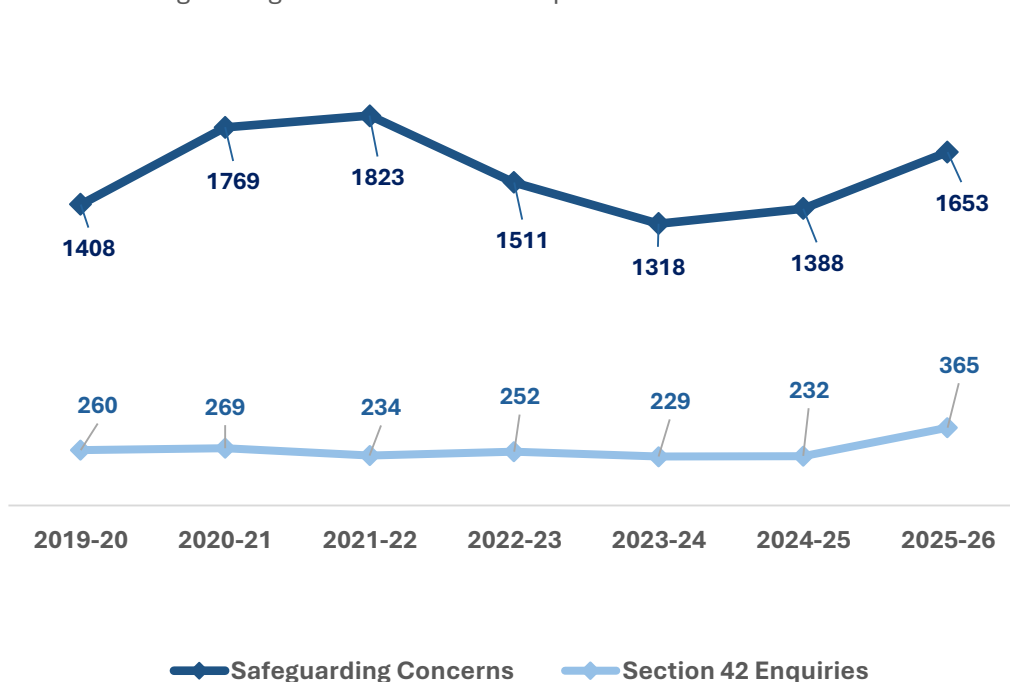
of risk type recorded as Self-neglect

(England average: 10%)

Safeguarding Activity is Increasing

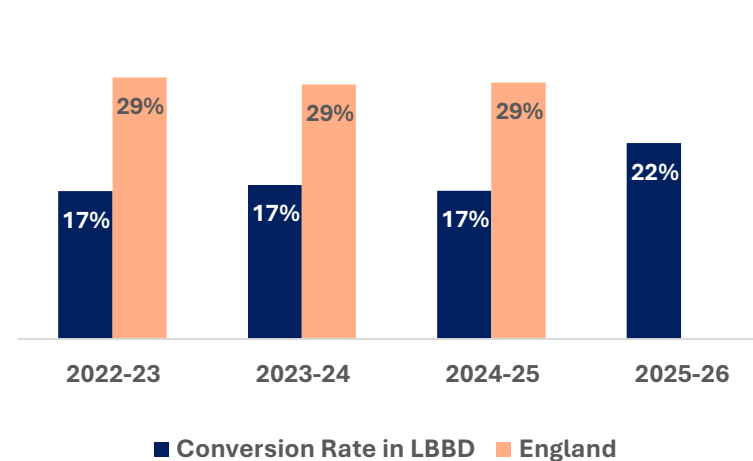
Safeguarding activity increased significantly during 2025-26. A total of 1,653 safeguarding concerns were raised, and 365 Section 42 enquiries were initiated. This represented a 19% increase in safeguarding concerns and a 59% increase in Section 42 enquiries compared with the previous year.

Safeguarding Concerns and S42 enquiries: 2019-20 to 2025-26



As a result, the conversion rate, the number of Section 42 enquiries that started for every 100 concerns raised, increased from 17% to 22% for the borough. However, it remained below the England average of 29%.

Section 42 conversion rate: 2022-23 to 2025-26

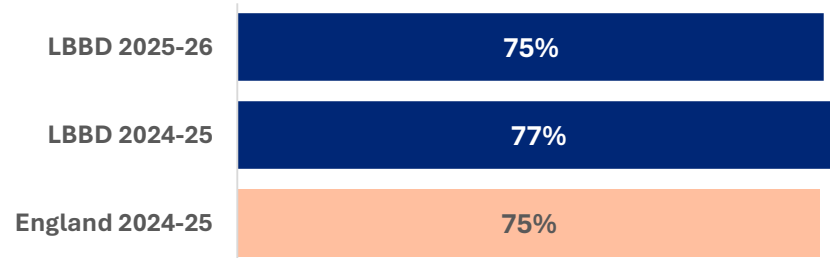


Managing Risk and Making Safeguarding Personal in Concluded Section 42 enquiries

This section examines the 365 Section 42 enquiries concluded during 2025-26. It considers both professional assessments of how effectively risks were identified and managed, and feedback from adults about whether safeguarding interventions achieved their desired outcomes.

Risk identified and action taken

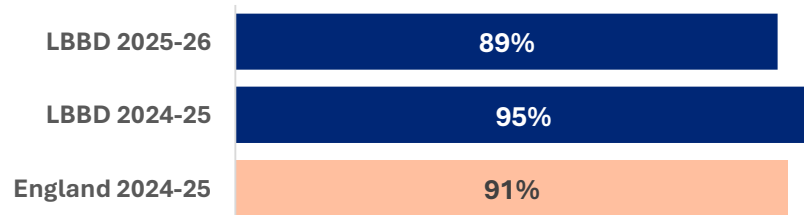
% of concluded S42 enquiries with risk identified and action taken



Risk was identified and action taken in 75% of concluded Section 42 enquiries in Barking and Dagenham in 2025-26. In 14% of cases risk was either not identified, or the risk assessment was inconclusive, while in 3% of cases risk was identified but no action was taken. A further 8% of enquiries ceased at the individual's request.

Risk Removed or Reduced

% S42 enquiries where risk was removed or reduced (of those where risk was identified and action taken)

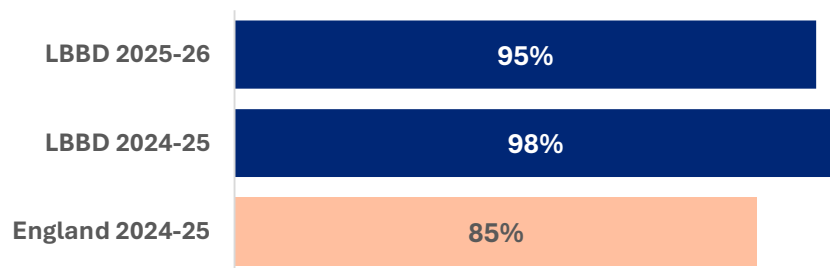


In 2025-26, risk was either removed or reduced in 89% of Section 42 enquiries where risk was identified. Performance was lower than in 2024-25 (95%) and the England average in 2024-25 (91%).

In 25% of concluded enquiries, risk was recorded as being removed and a further 64% were recorded as risk reduced.

Desired Outcomes Asked

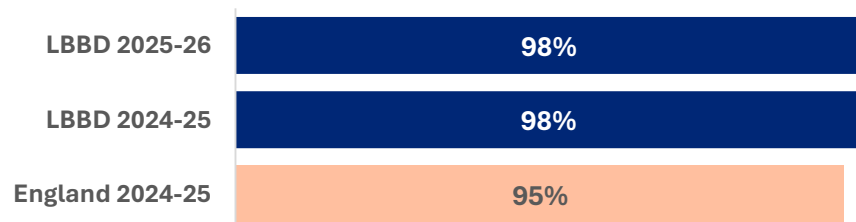
% of individuals asked about their desired outcome



Almost all adults involved in concluded Section 42 enquiries were asked about their desired outcomes (95%). This remained well above the England average (85%).

Desired Outcomes Achieved

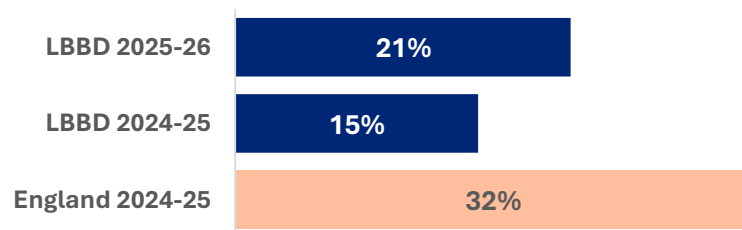
% of individuals achieved their desired outcome (of those where asked and expressed outcomes)



Of those who expressed a desired outcome, 98% reported that it had been fully or partly achieved. Performance remained unchanged from the previous year and exceeded the England average of 95%.

Mental Capacity Assessment

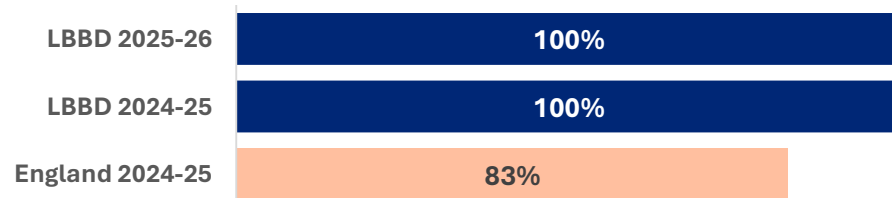
% Of individuals in concluded S42 enquiries where the adult at risk lacked capacity to make decisions



In 2025-26, 21% of adults involved in concluded Section 42 enquiries (75 of 357) were assessed as lacking capacity to make decisions relating to their own protection. This represented an increase from 15% in 2024-25, although the proportion remained below the England average of 32%.

Advocacy in Section 42 Enquiries

% of adults who lacked capacity to have had support provided by an advocate, family member or friend



All adults assessed as lacking capacity received support from an advocate, family member or friend during the safeguarding process. Performance remained at 100% in 2025-26 and exceeded the England average of 83%.

Type and Location of Risk in Concluded Section 42 Enquiries

Understanding the type, location and source of risk helps the Safeguarding Adults Board identify emerging trends and target preventative action. The analysis below is based on 357 Section 42 enquiries concluded during 2025-26. As individuals may experience more than one form of abuse or neglect, multiple risk types can be recorded within a single enquiry.

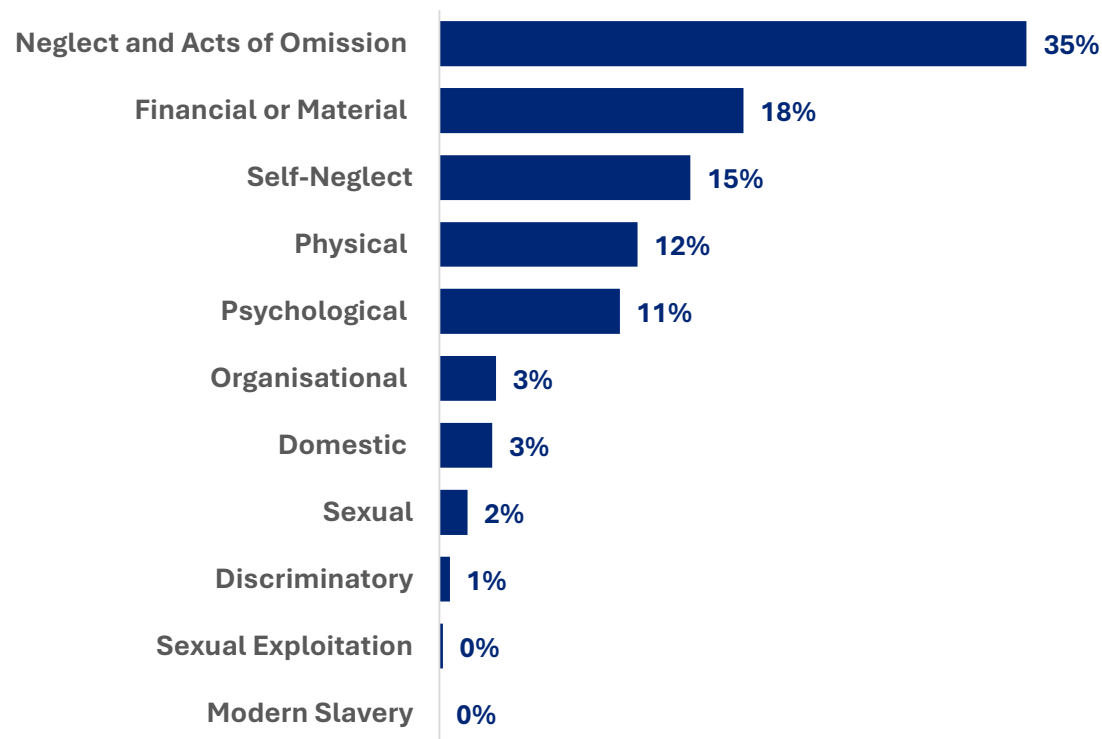
Type of risk: what was the risk?

Neglect and Acts of Omission remained the most common risk type (35%). While it dropped from 40% in the previous year, it remained above the England average of 30%.

Financial or Material risk the second most common issue at 18%. This includes things like theft, fraud, and financial scams. It was followed by Physical Abuse (12%) and Psychological Abuse (11%).

Self-neglect, currently at 15%, has risen steadily since 2022-23 and is now higher than the England average of 10%. Self-neglect remains an important area of focus for partnership working.

Type of Risk in Section 42 enquiries in LBBB - 2025-26



Location of risk: where does risk happen?

Over three-quarters of all risks occurred in the adult's own home (77%). While this is slightly down from 80% in the previous year, it remains significantly higher than the England average (49%).

Risks in residential care homes accounted for 7% of enquiries, while nursing homes accounted for 4%. This total of 11% is lower than the England average of 29%.

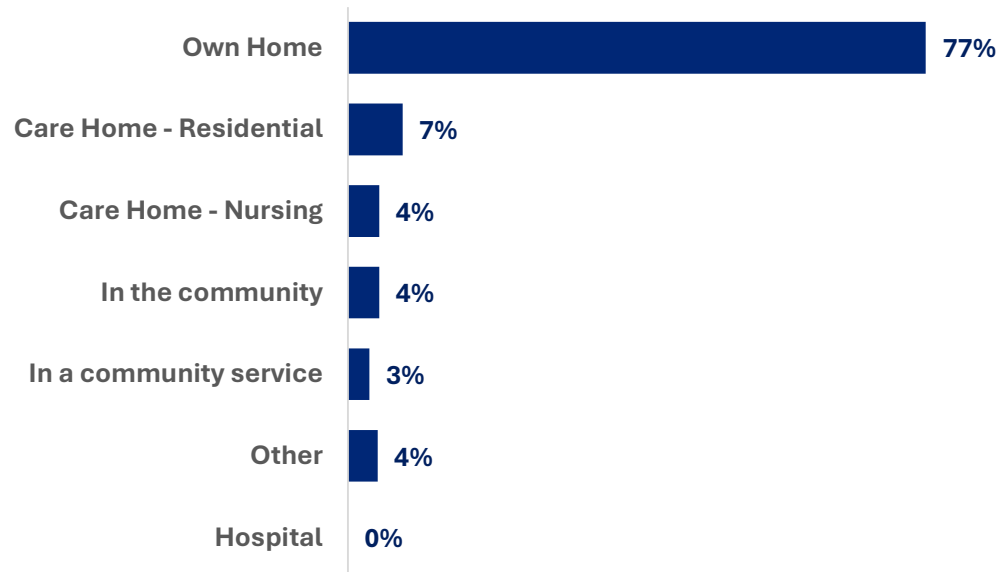
Risk in other/ unspecified locations (4%) has fallen steadily from 13 % in 2021-22, as our recording of locations has improved.

Source of risk: who is alleged to have caused harm?

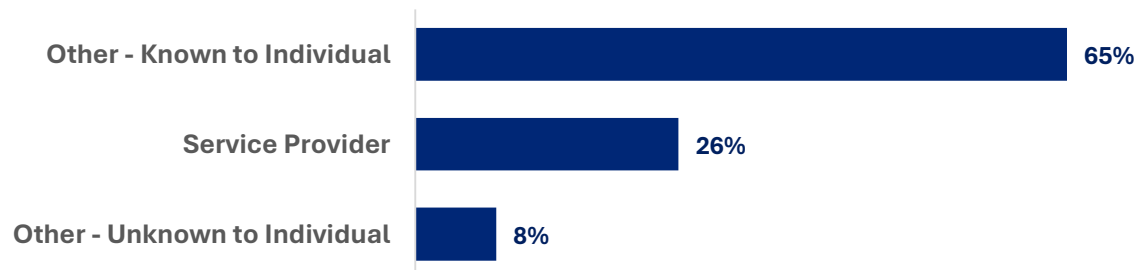
In nearly two-thirds of all cases the source of risk was an individual known to the adult (such as a family member, partner, neighbour or friend). About one in four cases involved a professional service provider. This decreased from 31% and sits below the England average of 32%.

The proportion of enquiries where the source of risk was unknown to the individual accounted for 8% - a significant decrease from 29% in 2021-22 and well below the England average of 14%.

Location of Risk in LBBD - 2025-26



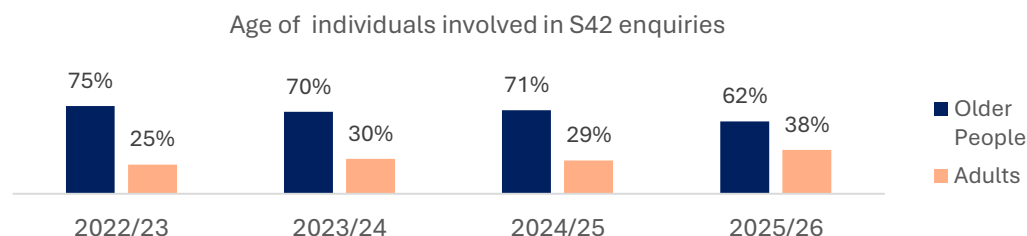
Source of Risk in LBBD - 2025-26



People involved in Section 42 enquiries

A focus on Section 42 safeguarding enquiries starting in LBBD in 2025-26 shows that women are more likely to have been involved in safeguarding enquiries than men while older people are much more likely to have been than adults aged 18-64. Demographic profiling also shows that people from a White ethnic background are more likely to have had a Section 42 enquiry. The data also profiles the primary support reason of individuals involved.

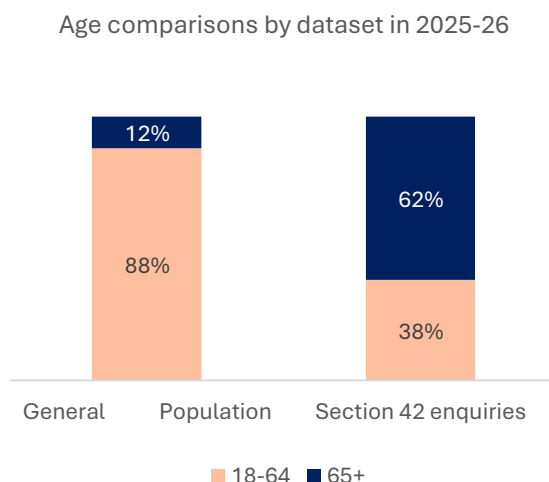
Age



Older adults (aged 65 and over) remain the largest group involved in Section 42 enquiries (62%). Whilst this is down from 2024-25, it remains a disproportionate need.

People aged 65 and over made up 12% of the population but accounted for 62% of Section 42 enquiries.

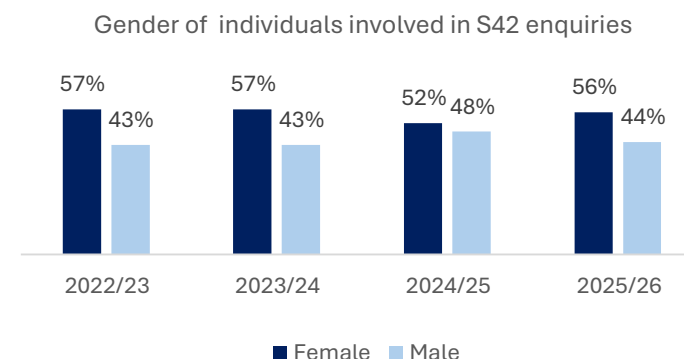
Looking at rates per 10,000 highlights this difference. In LBBD there were 99.4 enquiries per 10,000 people aged 65 and over, compared to 8.4 enquiries per 10,000 people aged 18-64. This means an older resident was nearly 12 times more likely to be involved in Section 42 enquiries than a working age adult.



Gender

Women were more likely to become involved in Section 42 enquiries than men in 2025-26. 56% of enquiries involved women which was an increase since 2024-25 when 52% were female.

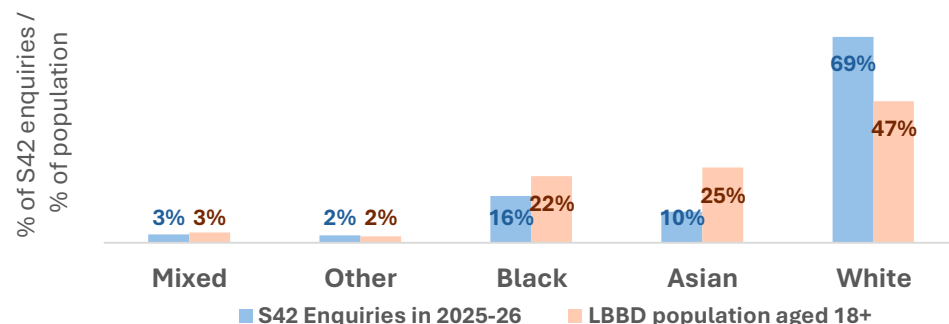
Across England 57% of Section 42 enquiries involved women in 2024-25.



Ethnic group

Differences in enquiry rates may partly reflect variations in age profiles across local communities, with Black and Asian populations generally having younger age distributions than the borough average.

Ethnicity of individuals in LBBB involved in S42 enquiries in 2025-26



People from a White ethnic background were involved in 69% of enquiries. This represents the majority of enquiries and is higher than the percentage of the ethnic group in the borough (47%).

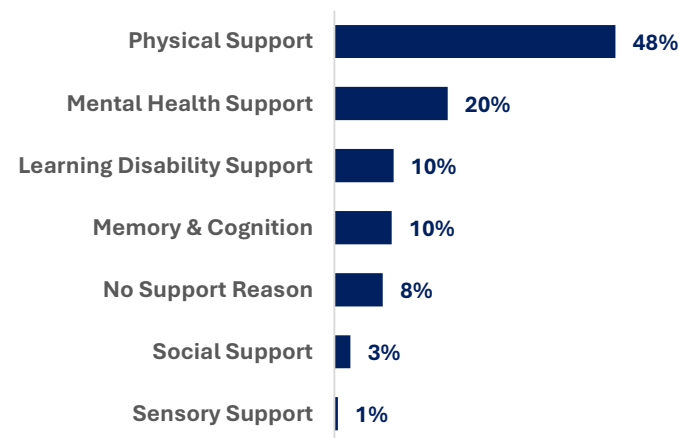
16% of S42 enquiries involved individuals from a Black background and 10% involved Asian individuals. These proportions are lower than the percentages in the borough's adult population (Black ethnic group 22% and Asian ethnic group 25% in LBBB).

Note: Relative to population size there were 26 enquiries per 10,000 White residents, 12 per 10,000 Black residents and 7 per 10,000 Asian residents. Lower rates in the Black and Asian community may be affected by a younger age profile.

Data quality note: Unrecorded or 'Not known' ethnicity data has been removed from the calculations for the chart above. However recording has improved and ethnicity 'Not Known' reduced from 18% in 2021-22 to 10% in 2025-26.

Primary Support Reason: why people need support

Section 42 Enquiries in 2025-26 by PSR



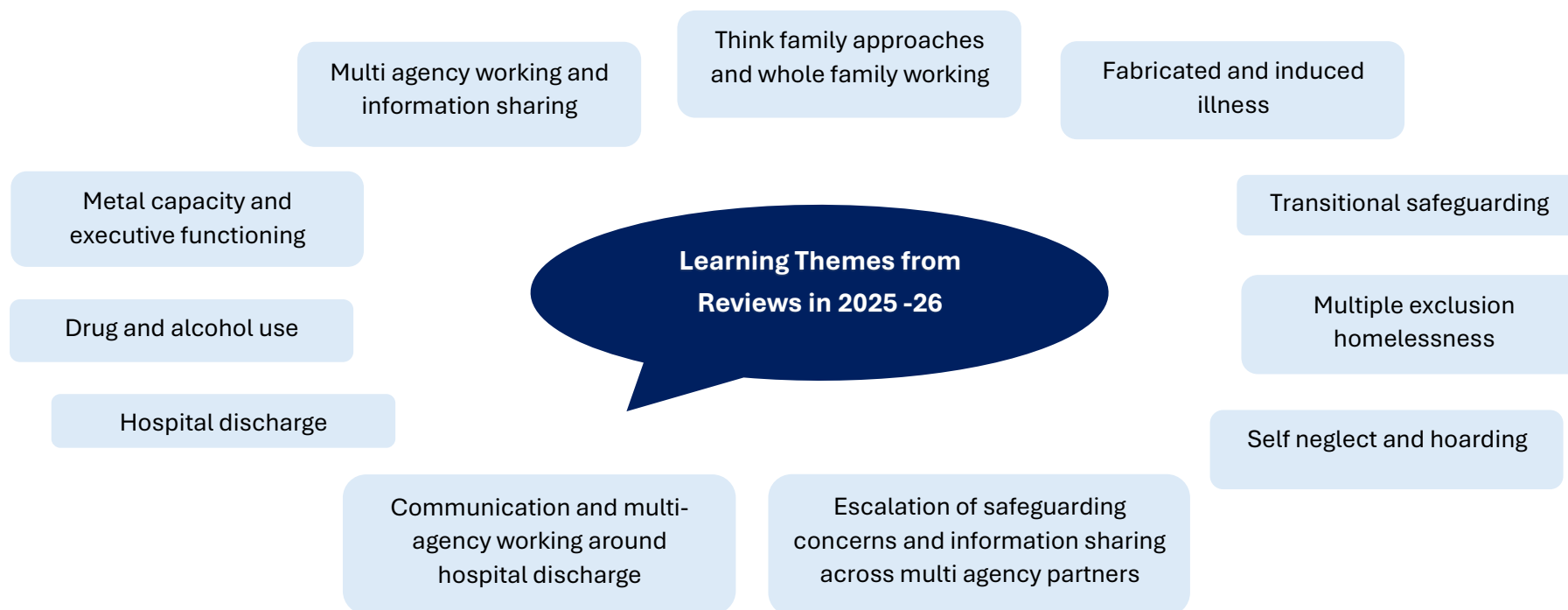
Nearly half of all enquiries in 2025-26 concerned an adult with physical support needs. While still the main primary support reason, this decreased from 53% in 2024-25.

20% of Section 42 enquiries in 2025-26 involved individuals receiving support for mental health conditions.

In 8% of cases, the adult at risk had no identified care or support needs.

6. Safeguarding Adult Reviews (SARs)

In 2025-26 the Barking and Dagenham Safeguarding Adult Board completed and published one Safeguarding Adult Review (SAR) 'Michelle', commissioned and continues to undertake one joint Safeguarding Adult Review (SAR) and Children's Safeguarding Practice Review (CSPR) taking a think family approach to the learning and one SAR. The partnership has also contributed to a SAR undertaken by Redbridge SAB called SAR 'Christopher'. Throughout these reviews learning and themes have been identified and reviewed with professionals across the partnership. Some of the learning and themes from the reviews are set out below. Once the reviews have been completed and agreed they will be published and the recommendations will be implemented across the partnership. All the Safeguarding Adult Review reports are published here [Safeguarding Adult Reviews \(SARs\) | London Borough of Barking and Dagenham \(lbbd.gov.uk\)](https://lbbd.gov.uk/safeguarding-adult-reviews-sars/)



7. The SAB's Partners

The London Borough of Barking and Dagenham

Developments and improvements in safeguarding adults' practice

Over the past year, adult safeguarding practice has continued to strengthen, underpinned by a clear focus on person-centred, preventative and outcome-based approaches. The service has aligned its improvement activity to core principles of safety, independence and wellbeing, ensuring that safeguarding is embedded within wider care and support delivery rather than operating as a standalone function.

There has been a sustained emphasis on improving the quality of practice through enhanced audit activity, learning from Safeguarding Adult Reviews (SARs) and more consistent application of Making Safeguarding Personal.

Practice improvements have also been supported by stronger oversight arrangements and workshops, including regular performance monitoring and quality assurance forums. These have contributed to improved timeliness in key processes and a clearer focus on risk management and desired outcomes.

The ongoing work has resulted in an 'Outstanding' CQC rating following an inspection in June 2025, with safe pathways, systems and transitions rated as 'Outstanding' and Safeguarding as 'Good'.

However, gaps remain. Variability in practice quality persists, particularly in complex areas such as self-neglect and cases that fall below Section 42 thresholds but still present significant risk. There is also an ongoing need to strengthen the translation of learning into frontline practice and to ensure consistent recording of outcomes. Workforce development, particularly advanced safeguarding skills and reflective practice, continues to be a priority to sustain improvement.



Contribution to multi-agency safeguarding practice and partnership working arrangements

Adults Social Care and Support has made notable progress in strengthening multi-agency safeguarding arrangements through active engagement with the Safeguarding Adults Board and wider partnership structures. Ongoing collaboration across statutory and voluntary sectors has supported the delivery of shared priorities, including improved community engagement, prevention and co-production with residents and the wider workforce.

Partnership working has been enhanced through regular forums and governance structures such as the One Panel, the Safeguarding Adults Complex Cases Group, the SAB, Persons in a Position of Trust (PIPOT) procedures and the Learning from Practice Subgroup, which has provided strategic leadership and oversight. This has included a focus on embedding learning from SARs (for example, during Safeguarding week) as well as updating our Complex Cases Group and PIPOT procedures. This has resulted in strengthened engagement around improving access to joint policies and strengthening performance reporting and data sharing across agencies.

Despite these improvements, challenges remain in achieving consistent engagement across all partners. Attendance and contribution from some agencies has been variable, impacting the effectiveness of multi-agency initiatives such as the Complex Cases Group. There is also a need to further clarify roles, responsibilities, and escalation pathways to ensure timely and coordinated responses to risk. Continued focus is required to embed a shared understanding of thresholds and to strengthen operational collaboration, particularly with primary care and housing partners.



The impact of partnership work on the delivery of services for service users

Partnership working has had a positive impact on the delivery of services, particularly in promoting more holistic, preventative and person-centred approaches. Collaborative initiatives with Health and Housing, Neighbourhood, Police and Community Safety services have supported improved identification of risk and earlier intervention, enabling residents to access support before issues escalate.

There is evidence that joint working has enhanced service responsiveness and accessibility, including the development of integrated approaches at the 'front door' and improved pathways for residents with complex needs. Programmes focused on co-production and resident engagement have begun to strengthen trust and ensured that services are better aligned to individual needs and lived experience.

In addition, partnership work has contributed to improved outcomes in areas such as reablement and community-based support, helping individuals to maintain independence and reduce reliance on long-term care.

However, the impact of partnership working is not yet fully realised. Inconsistencies in joint working, particularly between housing and adult social care as well as Health and Social Care, have led to delays and gaps in service delivery in some cases. Partnership data sharing remains a challenge, limiting the ability to fully evaluate outcomes. Further work is needed to strengthen integrated working at an operational level and to ensure that partnership activity consistently translates into improved outcomes for all residents.

What are the main themes and concerns that are arising in adult safeguarding and what impact have these had on practice development?

Key safeguarding themes over the past year have included self-neglect, hoarding, mental health and substance misuse, often presenting in combination and requiring complex, multi-agency responses. There has also been an increase in safeguarding concerns overall, alongside a lower conversion rate to Section 42 enquiries, highlighting the need for clearer thresholds and more proportionate responses.

These themes have driven practice development, including a greater emphasis on prevention, early intervention and contextual safeguarding approaches. They have also informed the redesign of pathways such as the Complex Cases Group, with a focus on clearer referral criteria, stronger governance and improved tracking of impact over time.

Another emerging theme is the impact of social and economic factors, including housing instability and cost of living pressures, which are contributing to increased vulnerability and demand for services. This has reinforced the need for stronger partnership working and community-based responses.

Despite progress, challenges remain in embedding learning consistently across the system and in ensuring that services are equipped to respond to increasing complexity. Ongoing development is required in workforce capability, data use, and system-wide coordination to respond effectively to emerging risks.

The Metropolitan Police

Developments and improvements in safeguarding adults' practice

The Metropolitan Police have continued to roll out training for frontline officers around adult safeguarding to improve the quality of reporting. The Adult Decision Making document sets out how the Police and Adult Social Care will work together to support the community and this has been well received. The development of the Standard Operating Procedure sets out clear standards, principles and guidelines on how the Metropolitan Police Service will identify and protect the vulnerable adults and ensure that they are allowed to live free from abuse and neglect. The Met police has also committed to an increase in funding of £25,000 per partnership up from £5,000 last year. This is significant in these financially challenging times.

Contribution to multi-agency safeguarding practice and partnership working arrangements

The Police have contributed to multi agency practice via the continued use of joint working protocols across the Police and Adult Social Care and the wider partnership. Work is being undertaken to support prevention, the Multi-Agency Risk Assessment Conference (MARAC) and the Safeguarding Adults Complex Cases Group.



The impact of partnership work on the delivery of services for service users

The Police track trends in data and use this to measure the impact that work is having. Since the implementation of the Adult Decision Making Protocol we have seen a 15% drop in referrals to Adult Social Care which enables them to focus on people at most risk. We are also using data to look at repeat people coming to notice and how we reduce harm and demand to vulnerable adults.

What are the main themes / concerns that are arising in adult safeguarding and what impact have these had on practice development

The Police have had involvement as a statutory partner in Safeguarding Adult Reviews (SAR), the One Panel and oversight of reviews across Adults and Children's Services and Community Safety. Learning from the recent SARs that have been commissioned have highlighted themes of domestic abuse, trauma, communication, mental capacity and executive functioning for partners to consider and implement. The Multi Agency Safeguarding Hub (MASH) teams review referrals made, undertake research and share information. Crime trends around vulnerable adults have not increased, however circumstances surrounding missing persons continue to generate wider learning and discussion amongst partners.

Barking Havering Redbridge University Trust (BHRUT)

Developments and Improvements in Safeguarding Adults Practice

This is the final year of the BHRUT's Safeguarding Strategy 2021-2025, and the set priorities have continued to be delivered, underpinned by the safeguarding annual work plans, which are reviewed quarterly and on an annual basis at the Trust's Safeguarding Assurance Group. The Safeguarding Strategy priorities align with key local and national agendas. Building on these strategic priorities, the Trust has continued to strengthen its governance, shared learning, and quality assurance frameworks over the past year:

- **Mental Health Governance and Safeguarding Assurance:** To ensure robust oversight of all mental health workstreams across the Trust, a dedicated Mental Health Steering Group has been established. As a key stakeholder, the Safeguarding Team collaborates closely within this forum to ensure effective mechanisms are in place to support both patients detained under the Mental Health Act and those presenting in acute mental health crisis. This collaborative governance framework ensures that any areas requiring improvement are systematically identified and addressed through targeted action plans.
- **Shared Learning and Case Reviews:** To continuously enhance staff knowledge and practice, safeguarding cases are actively presented and discussed at the Trust's Patient Safety Summit. This commitment to shared learning was further strengthened during 2025/26 by the re-introduction of quarterly safeguarding case studies, providing a regular, structured forum for multi-disciplinary review.
- **Ward Accreditation Framework (WAF):** The Trust maintained its active participation in the Ward Accreditation Framework (WAF) scheme throughout 2025/26. The WAF programme establishes clear standards and benchmarks, helping frontline staff celebrate where they are delivering high-quality patient care while clearly identifying areas for development. To ensure immediate impact, 'on-the-spot' supervision and responsive training are delivered dynamically during assessments whenever a knowledge gap is identified.

What are the main themes / concerns that are arising in adult safeguarding and what impact have these had on practice development

There continues to be a high number of patients who are presenting with mental health concerns or in mental health crisis. BHRUT has recruited a Mental Health Lead (RMN) and established a Trust wide Mental Health Group.

A large number of patients present with perplexing presentations which may include neglect and self-neglect which has resulted in closer working with community teams to ensure safe discharge planning. In addition, BHRUT is actively involved in North East London (NEL) wide projects to support the development of pathways and guidance and to standardise training in order to support professional development.

Domestic abuse continues to be a concerning theme, which solidifies the need for hospital based Independent Domestic Violence Advocates, which continues to be a gap in BHRUT.

Contribution to multi-agency safeguarding practice and partnership working arrangements

The Trust has successfully maintained multi-agency attendance at the following meetings:

- Safeguarding Adult Board (SAB) meetings
- Safeguarding Adult Review (SAR) meetings
- BD One Panel
- Working Groups (BHR)
- Quality and Effectiveness working group
- Safeguarding Adults Complex Cases Group
- MARAC

Throughout 2025/26, BHRUT demonstrated a steadfast commitment to multi-agency safeguarding excellence and statutory review processes:

- Statutory Reviews (SARs & DARDs): Maintained active partnership by delivering timely chronologies and comprehensive reports, while ensuring frontline clinical staff were directly involved in the review process.
- Learning and Governance: Embedded learning from reviews across the Trust by updating internal policies, executing robust action plans, and promoting learning events to support wider professional development.
- Information Sharing and Collaboration: Facilitated proactive intelligence sharing with Social Care and the Police, routinely contributing individual case information and data from targeted deep-dive audits.
- Real-Time Decision Making: Engaged actively in multi-disciplinary forums to drive immediate, collaborative risk-resolution alongside external partners.
- The ICB Designated Professionals/Nurses are members of the Trust's Safeguarding Assurance Group.
- BHRUTs Director of Safeguarding meets quarterly with ICB Designated Professionals and Nurses, so ideas and joint working can be shared.

The impact of partnership work on the delivery of services for service users

Throughout 2025/26, BHRUTs active collaboration with Social Care, the Police, and local mental health workstreams has directly enhanced service delivery for our most vulnerable patients. By breaking down organisational silos, we have shifted from a reactive response to proactive, holistic care. For service users, this integrated approach ensures faster, safer decision-making during crises and eliminates fragmented care. Furthermore, our active participation in statutory reviews ensures community-wide learning is directly translated into improved frontline practice, delivering a safer, more coordinated environment for our patients.

The Trust has well established Learning Disability and Dementia Working Groups, which are attended by users of the service and Trust staff.



North East London Foundation Trust (NELFT)

Developments and Improvements in Safeguarding Adults Practice

NELFT has continued to strengthen safeguarding governance and assurance through established internal structures, including the Safeguarding Operational Group and the Safeguarding Strategic and Assurance Group. These forums provide effective strategic oversight and assurance, with representation from safeguarding senior leaders, Integrated Care Directors, locality service leads, and Integrated Care Board (ICB) colleagues.

These groups oversee learning from safeguarding reviews and incidents, supported by robust action plans and tracking arrangements to ensure learning is implemented, monitored and sustained. The safeguarding workplan is reviewed regularly and remains responsive to emerging risks, regulatory expectations and learning from audits, reviews and incidents.

A revised organisational learning approach is being piloted to better align Safeguarding Adult Reviews (SARs) with the Patient Safety Incident (PSI) Framework. This alignment strengthens governance, improves triangulation of learning and ensures that safeguarding learning is embedded within wider patient safety systems in line with the Trust's updated organisational learning framework.

NELFT is also improving its use of safeguarding data through the development of a Power BI safeguarding dashboard. Although still in its early stages, the dashboard will provide borough-specific visibility of safeguarding activity, enabling improved trend analysis, earlier identification of risk and more targeted interventions. This will support proactive safeguarding responses, strengthen multi-agency oversight and contribute to improved outcomes for adults at risk.

The visibility and integration of the NELFT safeguarding team members across community services has continued to improve. Increased presence within localities has enhanced access to timely safeguarding advice, supported staff with escalation and decision-making and strengthened consistency in practice. This increased engagement has contributed to improved identification of safeguarding concerns, more effective risk management, and a strengthened culture of professional curiosity, vigilance and accountability.



Contribution to multi-agency safeguarding practice and partnership working arrangements

Relationships with the ICB and wider statutory and voluntary sector partners have continued to strengthen, supporting shared system leadership and safeguarding assurance. Regular safeguarding supervision and case discussion sessions with ICB Designated Safeguarding Leads for both adults and children have enhanced professional challenge, supported appropriate escalation, and improved consistency in decision-making for complex safeguarding situations.

NELFT maintains active and consistent engagement with the Barking and Dagenham Safeguarding Adults Board, with attendance at Board-level subgroups by the local leadership team and Named Professionals. This includes participation in the One Panel, Practice from Learning Subgroup, and the Performance and Quality Assurance Committee, supporting effective system oversight, performance monitoring and shared learning. We are also regular members of the Complex Cases Group, contributing to effective partnership oversight on those most complex and concerning cases held by practitioners and agencies.

The Trust remains committed to contributing to multi-agency safeguarding arrangements to ensure learning from SARs and Local Child Safeguarding Practice Reviews (LCSPRs) is fully embedded into frontline practice. This is achieved through clear action plans, briefings, targeted training and dissemination of learning across services, ensuring lessons learned translate into sustained improvements in care.

NELFT also contributed to the Barking and Dagenham's Annual Safeguarding Conference, with a clinical psychology-led presentation focused on psychological safety, reinforcing its importance in safeguarding practice and multi-agency working.

The impact of partnership work on the delivery of services for service user

Partnership working remains a core strategic priority for NELFT, reflected within the Trust's Best Care Strategy and reinforced through co-produced organisational values: we are kind, we are respectful and, we collaborate with our communities.

Safeguarding and operational teams continue to work closely with the Lead Patient Safety Specialist on improving collaboration between acute and community services, with a particular focus on safer hospital discharges.

Additionally, the Safeguarding team has provided awareness sessions on:

- Domestic abuse
- Self-Neglect
- Professional curiosity
- Mental capacity and its interface with safeguarding
- PIPOT and LADO processes.

The Safeguarding and Operational Teams continue to attend Section 42 enquiry meetings and multi-agency meetings for complex cases, including those not meeting Section 42 thresholds.

The Safeguarding Team has delivered tailored training to enhance staff capabilities in identifying and managing safeguarding concerns. They also attend the Incident Review Group (IRG) alongside operational colleagues, supporting robust responses to safety incidents. NELFT has also embedded the new Patient Safety Incident Response Framework (PSIRF), marking a significant shift toward system-based learning and improvement following safety incidents.

At a locality leadership team perspective, the weekly all age Safeguarding and Risk Meeting ensures that there is senior oversight on high level risk cases and support escalation actions as required as well as referral on to the SAB Complex Cases Group where referral criteria is met.

What are the main themes / concerns that are arising in adult safeguarding and what impact have these had on practice development?

The Did Not Attend (DNA) / Was Not Brought Policy has been developed and ratified in March 2026 ahead of its review date in August 2026 response to organisation-wide themes, strengthening oversight and management of missed appointments and associated risk.

Domestic Abuse: Domestic abuse continues to be a significant safeguarding theme. The Safeguarding Adults and Children Level 3 training has been strengthened to include legal frameworks, routine enquiry, DASH-Risk assessment, and scenario-based learning, including adult child-to-parent abuse. Awareness sessions have been delivered across the Trust, with further resources and briefings scheduled for 2026.

At this stage of development, comprehensive quantitative analysis is limited, as the Power BI safeguarding dashboard is still being established. However, qualitative intelligence gathered through attendance at locality-based meetings, including High-Level Risk (HLR) forums identifies any recurring safeguarding themes and provides valuable insight and discussion to inform professional judgement, prioritisation, and targeted safeguarding responses.

Patient Safety Incident (PSI) Framework, actions arising from incidents are reviewed and implemented at locality level to support learning and service improvement. Where safeguarding issues are identified, actions are appropriately allocated, monitored and supported to ensure effective oversight and assurance.

The new safeguarding operating model is being implemented, shifting from a centralised corporate function to a more place-based approach. While the impact of reduced safeguarding staffing capacity is being carefully considered, safeguarding escalation pathways and assurance arrangements at both locality and organisational levels remain robust. The integration of the safeguarding lead within place is expected to strengthen and support existing safeguarding pathways complementing the responsiveness and support for frontline services.

Support for staff attendance at multi-agency learning events, including safeguarding awareness weeks, strengthens cross-sector collaboration and assures a skilled workforce aligned with national standards and local safeguarding priorities.



Developments and Improvements in Safeguarding Adults Practice

The Designated Professional for Safeguarding Adults continues to engage with wider London and National safeguarding forums as well as mental capacity and DoLS forums, where information is then brought back to Barking and Dagenham and shared across the system as appropriate.

The Designated Professional has continued to develop relationships across the system which has enabled greater partnership working. The Designated Professional has supported Primary Care services by delivering safeguarding adults training and updates at the most recent Protected Time Initiative (PTI) for GPs. This year's session looked to forge greater links between Primary Care and the BHRUT Safeguarding Team as well as providing updates on safeguarding.

The Designated Professional has continued to co-chair the Learning from Practice subgroup alongside the Designated Nurse for Safeguarding Children. This subgroup takes an all-age approach to using learning from reviews to impact practice. The Designated Professional continues to attend and engage with the BD One Panel.

Contribution to Multi-agency Safeguarding Practice and Partnership Working Arrangements

The Designated Professional has continued to engage with the Local Quality Surveillance Group which is a group set up to support assurance and safeguarding work in relation to care homes, supported living schemes, homecare providers and Primary Care providers. This meeting is held bi-monthly and is an opportunity for ICB colleagues to come together with local authority colleagues to better understand where there may be concerns about care providers and the work underway to support them. The Designated Professional continues to work alongside the Local Authority's Provider and Quality Improvement Team when there have been concerns about specific care providers. The Designated Professional also works with other local authority areas in a similar way to ensure assurance is sought where Barking and Dagenham residents may have been placed.

The Community Safety Partnership (CSP) Board is also attended by the Designated Professional as well as workshops around the Serious Violence Duty. The Designated Professional has also supported the CSP with a new Domestic Abuse Related Death Review (DARDR) that commenced this year. As the chair of the B&D One Panel, the Designated Professional supported in the sharing of information between Police colleagues and the wider professional network in relation to this DARDR.

The Designated Professional has also supported the process for an all-age review of a family where there is thought to be significant learning for both the SAB and the SCP. This is the first time a review has been commissioned locally for a whole family, and the Designated Professional has supported in finding an appropriate reviewer and ensuring that the key lines of enquiry are agreed by the group.

The impact of partnership work on the delivery of services for service users

Part of the Designated Professional role is to gain assurances around how care is delivered and where there are adverse inspection results, support has been provided to services to improve in their safeguarding practice, for example, with several primary care services.

As a result of published SARs, action plans have been developed which partners have agreed to implement. This has led to organisations delivering safer services to service users and shows a willingness for organisations to learn from incidences.



What are the main themes/concerns that are arising in adult safeguarding and what impact have these had on practice development

A key theme that has been emerging from primary care is the prevalence of domestic abuse victim/survivors whom GPs engage with. Some practitioners have felt unsure as to protocols for referring a victim/survivor of domestic abuse and what services there are available to support them. The Designated Professional delivered training to GPs sharing the local support services available.

The Probation Service

Developments and Improvements in Safeguarding Adults Practice

The Probation service have continued to support staff by delivering a series of workshops and thematic training events designed to keep everyone informed and engaged with the latest best practice. Alongside these sessions, we have been working diligently to enhance the quality of safeguarding data for both children and adults. This work has included the development of a new management information system that allows us to track all safeguarding activity more effectively.

To ensure a consistent approach, all probation staff are required to take part in a rolling programme of safeguarding training, which is a key component of their mandatory training schedule. This training is closely tied to pay progression and aligns with the Civil Service's competency-based framework. As a result, our staff are well-versed in the core principles of safeguarding and fully understand the responsibilities that come with their roles.



Contribution to Multi-agency Safeguarding Practice and Partnership Working Arrangements

Probation continues to work collaboratively with key partners to both manage risk and support those subject to probation, as well as their potential victims. On a strategic level, Probation actively participates in the adult safeguarding boards, as well as the Violence Against Women and Girls (VAWG) Strategic Group, ensuring we're always aligned with wider safeguarding priorities.

Operationally, Probation's involvement is equally robust. We are an active contributor to the Multi Agency Risk Assessment Conference (MARAC), taking a leading role in Integrated Offender Management (IOM) and participating in Multi Agency Public Protection Arrangements (MAPPA) case management panels. Our commitment extends further, as we contribute to the broader community safety and safeguarding agenda through ongoing partnership engagement.

To enhance our collaborative efforts, Probation has also dedicated a representative to the Multi-Agency Safeguarding Hub (MASH), strengthening our co-ordination and response across agencies. Probation has been provided with a Local Authority laptop which enables us to conduct our own safeguarding checks in real time which enhances risk assessments and minimises pressure for the MASH team.

The impact of partnership work on the delivery of services for service users

It is challenging to quantify the impact of partnership work on the delivery of services for service users especially within the criminal justice focus of probation. However, via the work of the SAB we have managed to improve partnership attendance at key operational meetings including mental health attendance at both Multi Agency Public Protection Arrangement meetings and Integrated Offender Management meetings which helps ensure that relevant individuals can access the appropriate support services.

This is also reflected in improved assessments under the Care Act and access to appropriate accommodation services.



The London Fire Brigade

Developments and Improvements in Safeguarding Adults Practice

Safeguarding practice within the London Fire Brigade continues to develop through increased awareness, stronger partnership working and ongoing investment in staff training.

Safeguarding is now firmly embedded across both operational and prevention activity. Crews routinely consider vulnerability during Home Fire Safety Visits, using structured approaches such as the tools to measure vulnerability and Clutter Image Rating scale to identify risk and support consistent decision-making.

Approximately 80% of the Home Fire Safety Visits originate from partner referrals, demonstrating trust in the Fire Brigade's role in supporting vulnerable residents. These referrals enable early engagement with individuals who may not otherwise access services and allow us to identify wider safeguarding concerns at an early stage.

This work is supported by our data-led Assessment of Risk, helping ensure visits are targeted towards higher-risk households, including those linked to fire trends and vulnerability factors.

We have also introduced a new training course for all firefighters focused on recognising vulnerability and strengthening safeguarding confidence when conducting Home Fire Safety Visits. Alongside this, the use of the Person at Risk process has improved consistency in how concerns are recorded and escalated, ensuring timely referral to relevant agencies and a more structured safeguarding response.

Contribution to Multi-agency Safeguarding Practice and Partnership Working Arrangements

The Fire Brigade continues to play an active role in multi-agency safeguarding across Barking and Dagenham, contributing both strategically and operationally. Station Commanders and officers attend forums such as community MARAC meetings, ensuring fire risk is considered within wider safeguarding planning.

At an operational level, crews work closely with partners including Adult Social Care, housing and health services. Information sharing through systems such as the Person at Risk (PAR) process helps build a clearer picture of vulnerability and supports early intervention.

Joint working is particularly important in cases involving self-neglect and hoarding. In these situations, fire risk is often linked with wider welfare issues. The London Fire Brigade works alongside partners to reduce risk while maintaining a person-centred approach, supporting independence where possible.

The use of shared tools, including the Clutter Image Rating for hoarding and tools for vulnerability, supports a common understanding of risk across agencies.

Additionally, risk information is recorded on systems such as the Operational Risk Database (ORD), ensuring that crews attending incidents have access to environmental risks, supporting both operational safety

Contribution to Multi-agency Safeguarding Practice and Partnership Working Arrangements

Partnership working has significantly enhanced the Fire Brigade's ability to deliver targeted and effective prevention activity. Strong relationships with local authorities, health services and housing providers ensure that we receive timely referrals for vulnerable residents.

These referrals allow crews to focus Home Fire Safety Visits on those most at risk, aligning activity with local risk data and the Assessment of Risk. This targeted approach improves efficiency and ensures resources are used where they have the greatest impact.

These visits often provide an opportunity to identify wider safeguarding concerns and connect residents with appropriate support services, making full use of each interaction with vulnerable individuals, crews can refer individuals to appropriate services using the Person at Risk process, helping address issues beyond fire safety.

Partnership working also improves operational preparedness. Information shared by partners is recorded on systems such as the Operational Risk Database, giving crews better awareness of risks such as hoarding or restricted access before attending incidents.

Overall, partnership working enables us to deliver a more informed, proactive and coordinated service, supporting safer outcomes for residents while improving how we target prevention activity.

Main themes and concerns arising in adult safeguarding and their impact on practice development

The main safeguarding concerns continue to involve self-neglect, hoarding and mental health. These issues often present together and can significantly increase fire risk, particularly where escape routes are blocked or fire loading is high. We are also increasingly encountering individuals who are socially isolated or disengaged from support services. These factors can make it more difficult to identify risk early and require a more proactive and persistent approach from crews.

These themes have influenced how the Fire Brigade operates. There is now a stronger emphasis on early identification during Home Fire Safety Visits, with crews using tools such as the Clutter Image Rating scale to assess both fire risk and broader vulnerability. Where concerns are identified, the Person at Risk process ensures issues are recorded and shared quickly with partner agencies. In higher-risk cases, information is also recorded on the Operational Risk Database to support ongoing risk management and firefighter safety.

Overall, these trends have driven a more data-led and preventative approach, helping us better target activity and respond effectively to increasingly complex safeguarding needs.



Developments and improvements in safeguarding adults practice

Improvement in safeguarding practice include feedback now being provided regarding safeguarding referrals raised by providers. This has increased provider confidence in this area. Safeguarding issues are highest in a person's own home care and providers are key in addressing this. We lead on the Home Care and Care Home Providers Forums that allow commissioned providers and Council, health and local service to share information and address concerns and issues.

The impact of partnership work on the delivery of services for service users

Partnership working has contributed to better living and safety for service users in the community. Safeguarding awareness and the Person in a Position of Trust PIPOT training has supported providers to improve safeguarding practice and collaborative working.



What are the main themes / concerns that re arising in adult safeguarding and what impact have these had on practice development

Some of the themes identified are around the reporting of abuse and awareness of safeguarding in the community and amongst providers. There is work to being undertaken to improve practice in these areas.



8. Quality of Care

Direct Payment Support for Residents

We have recently appointed a new provider to undertake our Direct Payment Support Service called Empower. Residents are supported to innovatively plan the best ways to use their personal budgets with personal assistants who have been vetted for employment checks. They are guided through the tasks and responsibilities involved when managing a Direct Payment and supported with undertaking all stages of recruitment. We also have in place a specialist provision to support residents who lack capacity in receiving their direct payment, ensuring that they too can benefit from the flexibilities offered by Direct Payments.

We are committed to conducting a fresh review of each resident in receipt of a Direct Payment. Our aim is to ensure that the essentials are so that residents continue to feel supported throughout their Direct Payment experience. This includes through our visiting officers who will make home visits to those considering a Direct Payment to support them to understand in particular what their likely care costs may be as per statutory requirements. This ensures residents are in an informed position before employing a personal assistant and agreeing to receive chargeable support.

Strengthening Our Technology Enabled Care Approach

We have continued to embed a technology first approach, supporting residents to remain safe, independent and connected within their own homes through the use of Technology Enabled Care (TEC). The service provides tailored solutions based on individual need, using a range of assistive technologies to support early identification of risk, improve monitoring and enable timely intervention. This forms a key part of our preventative offer, helping to reduce reliance on traditional care services while improving outcomes for residents and reassurance for carers. This sits alongside existing provision, including the falls pick-up service, which continues to provide a responsive and valued offer to residents.

Over the past year, we have also prepared for the introduction of a new, enhanced TEC service model, which will strengthen how technology is embedded across care and support. This includes a more structured approach to reviewing the suitability and effectiveness of technology within care packages, improved data and insight to identify risks such as non-use or changes in need, and a stronger focus on supporting practitioners to adopt technology as a routine part of care planning. These developments will enable earlier identification of safeguarding concerns, improve oversight of service delivery, and ensure that technology is used more effectively to support residents as their needs change.

Supporting Discharge

We continue to work in partnership to develop and commission innovative services to support discharge and reduce re-admission to hospital. We will be looking to develop a Barking and Dagenham transfer of care hub to improve responsiveness and support data collection and trend analysis.

In the hospital there are trusted assessors, who continue to support assessments to support people out of hospital more quickly and on to the right pathway to meet their needs.

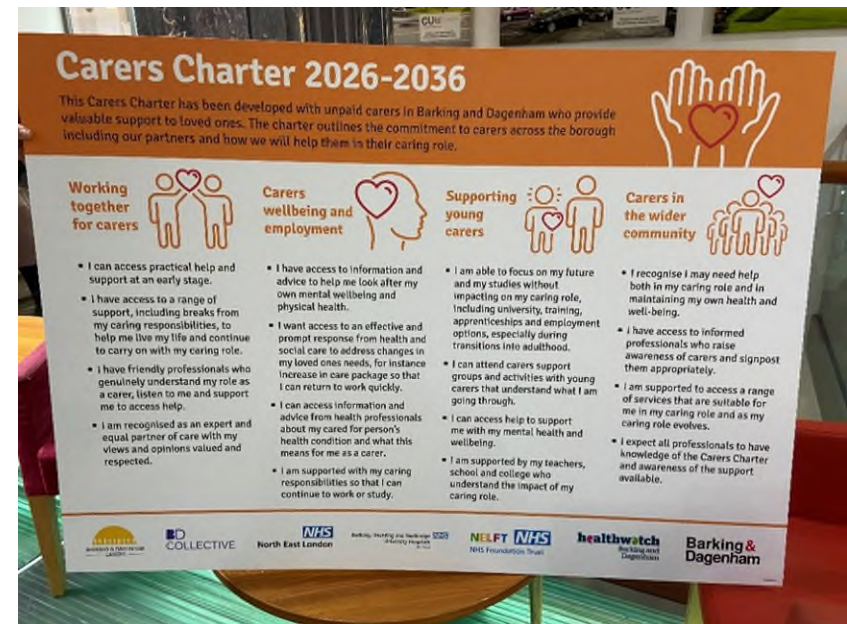
The Home, Settle and Support Service supports service users whose needs are below the threshold for social care. Here people are supported to settle back home after a hospital stay and put in steps to connect them back into the community including through supporting food deliveries, shopping, take up of welfare entitlements and positive community activities. Goals are co-produced with the resident. Particularly through the support at discharge, the service enables people to remain well within the community and reduce readmission into hospital.

Another initiative, helping people to get back home are our interim flats. These provide short term support at hospital discharge for people who cannot return home, for example, due to the condition of their home or access requirements. Interim flats are available to support discharge to a flat with care on site whilst remedial works take place or alternative long-term accommodation is secured.

The reablement service provided by Essex Cares Limited was commissioned to help people to regain and maintain their independence, reducing the need to rely on formal care. The service has now been established for 18 months and provides support to residents to aid in decreasing long term support requirements and getting people back to independence. Outcomes here are proving successful in keeping people living safely at home.

Carers Remain a Priority

The Carers Charter has been refreshed and will run from 2026-2036 and builds on the success of the previous Carers Charter. The charter has helped by setting our ambition and the accompanying action plan continues to help ensure we remain on track with our goals and priorities. This work is monitored through the Carers Strategic Group. Recently, we have been working on the hidden carer space including a dedicated resource to identify carers through hospital visits and appointments. Alongside this refresh, we have also recommissioned the Carers Support Service delivering to a new specification that builds on innovation and is reflective of the needs of local carers.



Provider Quality Assurance Update

The number of care providers who are based in the borough has increased. There are now twenty residential care providers and 166 homecare providers registered with CQC. One provider based in LBBD was successful in gaining a place on the Homecare Framework which became live in September 2025. The rest are all within the NEL footprint which will enable us to continue to develop close relationships. There continues to be a significant number of new providers setting up supported living and domiciliary services in the borough, who are keen to apply to join a framework to improve the chance of getting referrals from Barking and Dagenham. We are aware of 112 supported living providers in the borough.



Work of the Provider Quality and Improvement Team

There were 173 visits to adult providers in 2025. Throughout the year and as per the Borough's provider risk assessment process, seven providers were rated as 'red' and were subject to an intensive improvement plan and heightened level of inspection. Two of these providers were rated as red and then moved to blue which means a temporary suspension was imposed. The suspended providers consisted of one homecare and one supported living agency. This means that alongside an improvement plan and heightened level of inspection, these providers were suspended from taking on any new service users and any service users that were supported by the provider were reviewed by social work colleagues and other boroughs who also fund the placements. At the end of 2025 there were no suspended providers.

Primary Care Providers

There are currently 33 GP practices across the borough. Out of these 33 practices, 25 of them have been rated by the Care Quality Commission (CQC) as being 'good'. This means that the standard of practice from these practices is a good level for the general population across the borough. The CQC inspect various aspects of care and service provision, and this is broken down into five categories.

- Safe
- Effective
- Caring
- Responsive
- Well-led

Seven practices have been rated by the CQC as 'requiring improvement'. Practices rated as requiring improvement are supported by the NHS NEL ICB Primary Care Team to improve their practice so that residents receive a better and safer service. Common areas of development include safeguarding, education, training, practice policy updates and communication.

There is one GP practice that has been rated as 'inadequate', down from four practices the previous year. The NHS NEL ICB Primary Care Team are working with these practices to draw up robust improvement plans which are reviewed regularly to ensure the quality of service from these GP practices improves. NHS NEL ICB are working closely with the CQC, as well as the GP Federation, to ensure that whilst changes and improvements are made, patients continue to receive good quality, safe care. The GP practice in question changed provider in 2024 and has been awaiting a reinspection by the CQC since.



Learning from LeDeR Reviews

LeDeR is a service improvement programme and looks to learn from the deaths of people with learning disabilities and autistic people. LeDeR reviews are carried out for all deaths of people with learning disabilities and autistic people. These reviews make recommendations to improve practice and change processes so that the lives of people with learning disabilities and autistic people, are changed for the better. The Designated Professional currently holds the role of the Local Area Contact (LAC) for LeDeR reviews. This role essentially looks to quality assure LeDeR reviews that are completed for learning disabled and autistic people who are Barking and Dagenham residents who have sadly passed away.

NHS NEL ICB received a total of 116 LeDeR notifications for the year. A total of 15 LeDeR notifications were received for the year 2025/26 for local residents. Of these 15 notifications, 6 have so far been completed as reviews.

Locality	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Barking & Dagenham	0	6	7	12	16	18	16	16	12	15
City & Hackney	0	9	5	7	16	18	10	9	15	14
Havering	0	15	8	8	27	11	13	24	24	15
Newham	0	10	9	14	25	16	19	26	17	23
Redbridge	0	10	12	12	22	15	20	29	17	21
Tower Hamlets	5	14	8	5	14	10	8	9	16	12
Waltham Forest	0	9	8	10	10	8	5	11	18	16
Cumulative Totals	5	73	57	68	230	96	91	124	119	116

(Table 1 – comparison of notifications received by area since 2016 to present)

Generally, care was delivered to an appropriate level and there were no specific significant concerns about the care that service users received. From the completed reviews, the emerging themes were around the positive work between professionals and the appropriate referrals to onward services in some instances.

A full LeDeR Annual Report will be published in due course and will be available with further data and insights from across NEL.

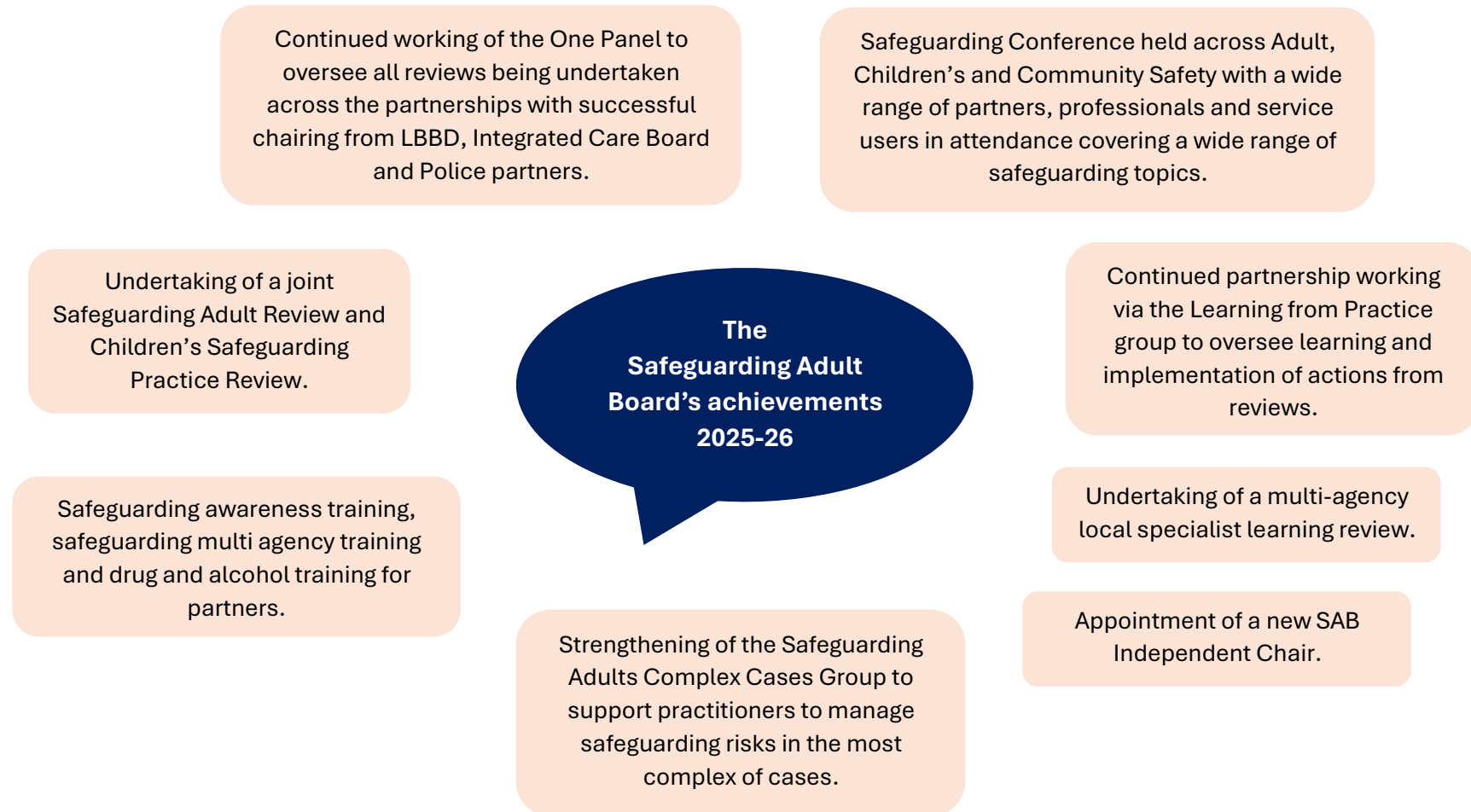
9. Partnership Priorities

The SAB's Strategic Plan is a three year plan for 2023-26 with overarching priorities and objectives. The plan is reviewed annually with actions set. A number of actions were agreed and completed in 2025-26 as set out below. The SAB has recently worked to review and develop new priorities for 2026 – 2029.

Priorities	Objectives	What will we do to implement this?	Update on Progress
1. The Voice of the Community	Hear the experiences of people with lived experience and use the feedback to develop the work of the SAB and its priorities.	Develop information, advice and guidance around safeguarding prevention with and for the wider community. Include people with lived experience in the SAB conference.	People with lived experience attended and presented at the joint Safeguarding conference and included in interview process for SAB Independent Chair.
2. The Cost of Living Crisis	Have a clearer understanding of impact of cost of living on safeguarding within the community.	Use data from SAB Performance Framework. Feedback from service users and community through community Hubs, BD Collective and health services.	Independent Chair visits undertaken within the community to gain feedback.
	Support the wellbeing of staff and professionals across the partnership.	Assurance from partner agencies that support is available to professionals. Ensure new SAB policies aimed at professionals include information about support for professionals' wellbeing.	Escalation Guidance published in response to SAR and review of Safeguarding Adults Complex Cases Group to strengthen process and support to professionals.
	Communicate across the partnership the support and resources available to our communities and service users.	Develop information and advice around safeguarding and how to access services and support.	Easy read leaflet complete and published. Area created on the website for shared multi agency documents. 7 minute learning briefings published and learning events undertaken across the partnership focussing on themes from Safeguarding Adult Reviews and other learning.

3. Address Inequalities within the Community	Identify the inequalities within our communities and address these.	Use data from SAB Performance Framework to inform work and decision making. Ensure information and services are accessible to all our communities and people with different needs.	Data analysis report presented to partners quarterly with a focus of communities over-represented and under-represented in safeguarding work.
	Ensure information and advice is accessible to all communities using different forms, social media etc.	Produce an accessible safeguarding leaflet and video to raise awareness of what safeguarding is and what to do in the event of a concern.	Safeguarding leaflet published on website and shared.
4. Effective Partnership Working	Use the current training and learning resources across the partnership to enhance learning from SARs and other reviews.	Sharing of the learning from reviews and serious incident investigations across the partnership and with other partnerships. Sharing of training resources and information e.g. 7 minute briefing etc. Assess the impact of the Right Care, Right Person model on safeguarding within the community.	Learning from reviews shared across the partnership via briefings and learning workshops/events. Joint safeguarding conference undertaken and positive feedback received. Partnership training implemented around multi agency responses to safeguarding. Right Care, Right Person Police Strategy implemented and feedback generally positive.
	Make links across the Adults, Children, Community Safety and Health and Wellbeing Partnership	Independent Chair to attend other partnership meetings where relevant. Work together to tackle domestic abuse including the sharing of learning from Domestic Homicide Reviews and SARs.	Joint partnership rapid review led by Community Safety Partnership including adults and children's services to identify early learning. Joint review commissioned for Family N. Learning shared via joint One Panel and Learning from Practice processes. One Panel process supports whole family approach working across agencies.
	Grow the SAB membership to include voluntary and faith sector.	Invite the voluntary and faith sector to the SAB workshops and conference.	Voluntary and faith sector attended and presented at the safeguarding conference.

10. Safeguarding Adult Board's Achievements



11. Managing Risks Across the Partnership

Provider Failure

This can happen when a care provider is unable to exercise its normal day-to-day duties.

Our Provider Quality and Improvement Team work closely with local providers to support them to provide good quality services. Information is shared with other boroughs and across the North East London area through the Integrated Care Board (ICB).

Service Demand

We are seeing an increase in need for services across the partnership e.g. mental health, social care and health. Partners continue to monitor service demand and share information and data across the partnership to respond appropriately.

Managing Risks Across the Partnership

Communication

Partners continue to communicate and are engaged in collaborative work so that the shared priorities in the SAB Strategic Plan can be achieved.

Learning from Safeguarding Adult Reviews and Other Reviews

The Learning from Practice Group lead on implementation of learning, ensuring it is disseminated across the partnership. Actions are monitored and outcomes are fed back to the SAB and other partnerships.

12. Further Information about Safeguarding

For further information about safeguarding and information about the Safeguarding Adults Board please use the following link

[Safeguarding adults at risk of abuse or neglect | London Borough of Barking and Dagenham \(lbbd.gov.uk\)](https://lbbd.gov.uk/safeguarding-adults-at-risk-of-abuse-or-neglect)

To report a safeguarding concern

Adult Social Care Intake Team

020 8227 2915

safeguardingadults@lbbd.gov.uk



In an emergency

Call 999 and ask for the Police

Call 101 if you are worried but it is not an emergency.

Out of Hours Emergency Social Work Duty Team

020 8594 8356

adult.edt@nhs.net

