Brent	**Health and Well Being Board** **3 July 2013** **Report from Acting Director of Adult Social Services**

Safeguarding Adults in Brent

Introduction

1. This is the first Safeguarding Adults report to be presented to the Health and Well Being Board, therefore, it provides:
   - An overview of Safeguarding Adults
   - A summary of operational arrangements in Brent
   - An overview of the Brent Safeguarding Adults Board (BSAB) and its work, and
   - High level activity analysis for 2013/14.

2. The Board is asked to comment on the contents and provide a steer on the Board's role in Safeguarding Adults, in particular driving improvements in the health and social care sector to reduce abuse.

Overview of Safeguarding Adults

3. There are 4 terms that define Safeguarding Adults:
   i. *Adult at risk / Vulnerable adult* – an adult (18 years or older) who needs community care services because of mental or other disability, age or illness and who are, or may be unable, to take care of themselves against significant harm or exploitation.
   ii. *Abuse* - includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.
   iii. *Significant harm* - is not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development
   iv. *Mental Capacity* - If you have mental capacity, it means that you are able to make your own decisions – that you are able to understand and think through information and make a choice based on that information. The Safeguarding Adults process assumes Mental Capacity, ensures that adults are supported to make their own decisions (even if they are unwise) and makes sure that anything done for or on behalf of people without capacity should be an option that is less restrictive of their basic

4. In 2000 the Government published 'No Secrets', which prioritised the need to safeguard vulnerable adults from abuse. It also set out a framework for action within which local agencies work together to prevent and reduce the risk of harm to vulnerable adults and respond to abuse of vulnerable adults. The focal point for this action is local multi-agency Safeguarding Adults board and the local codes of practice which underpin multi-agency practice.

5. 'No Secrets' remains the defining document for Safeguarding Adults, but it is only statutory guidance. The Care and Support Bill, which is going through Parliament at the moment, recognises the need for a clear legal framework for Safeguarding Adults, similar to Children's Safeguarding. These changes are likely to be implemented in April 2015 and will reinforce the work already happening in Brent. The Local Authority will be required to:
   - establish and run a Safeguarding Adults Board and require key organisations to take an active role - Brent already has a Board, details set out below, and representation and engagement from partner organisations is good
   - publish a Safeguarding Annual report – Brent has written, but not published annual reports over the last 3 years. A summary of the Annual Report was included in last year's Local Account, but there are already have plans to publish the 2012/13 report at a conference in October
   - investigate when allegations of abuse are raised - Brent has a dedicated Safeguarding Adults team (SGA team) which responds to all allegations of abuse and an overview of the team and an analysis of their work is set out below
   - to carry out Safeguarding Adults Reviews (Serious Case Reviews) when there are serious concerns about operational practice – the Brent Safeguarding Adults Board already has a process for escalating serious concerns and an Independent Management Review (IMR) was undertaken, in line with this policy, in 2012 in relation to a number of sexual assaults where the perpetrator lacked Mental Capacity.

Operational arrangements in Brent

6. The core of the Safeguarding Adults process in Brent is the Adult Social Care Safeguarding Adults (SGA) team. The SGA team receives and screens all Safeguarding Alerts. It signposts where the alert does not require a full investigation and co-ordinates the response when a full investigation is required.

7. The SGA team works to the Pan London Safeguarding procedures, an overview of these procedures is attached at Appendix 1. The Safeguarding Adults Manager (SAM) is the key accountable role when responding. Their first priority is to ensure the victim and any other victims are safe, and then to co-ordinate a multi-agency response to ensure that the incident is robustly investigated and the relevant actions are agreed and implemented.

8. The fact that there is a single team with responsibility for this work has facilitated strong working relationships with police and health and other partners. However, there is on-going work to ensure that all partners understand the range of

Safeguarding Adults activity they should be undertaking, including improving core practice to prevent abuse, raising good quality SGA alerts on time, delivering actions in the SGA protection plan to ensure people are safe, undertaking investigative actions within Pan London timescales and challenging the SGA team when they do not think things are being done correctly.

9. The SGA team was reviewed and restructured at the start of this year. The review and restructure was driven by:
   - the findings of the multi-agency audits and the Independent Management Review, which highlighted the need for SAMs to be focused on decision making and challenging partner agencies to deliver, rather than chasing actions and other detailed operational activity
   - activity data that highlighted the different types of investigations that need to be undertaken and how by closer working with partners, the team could reduce its investigative capacity and focus resources on chasing actions and detailed operational activity. For example, approximately 20% of all investigations relate to Serious Incidents in health (e.g. Grade 3 and 4 pressure sores). There is a robust and independent process for investigating these incidents in health, therefore, these investigation reports now contribute to the SGA process, rather than the SGA team duplicating the investigation.

10. The team's new structure is set out at Appendix 2. The recruitment campaign has been relatively successful, but there will still be 3 vacancies in a team of 11 staff. These vacancies will be offered as secondments, through the Safeguarding Board, as it is important that the team gains health experience and knowledge. The key transition period, from old to new structure, will be July and August this year and a transition plan is in place. The Board has contributed to and signed off the transition plan and there will be updates at upcoming Boards on the implementation of the new structure.

Brent Safeguarding Adults Board

11. Brent Safeguarding Adults Board meets every two months and is made up of the key statutory agencies and a range of other key partners – the full membership is set out at Appendix 3. BSAB's primary objective is to ensure that Safeguarding Adults is everyone's responsibility and ensure the protection of adults at risk of significant harm. They do this by:
    - working together to promote safer communities to prevent harm and abuse, and
    - identifying, investigating and responding effectively to allegations of abuse.

12. The BSAB has maintained a close focus on improving performance and practice in relation to identifying, investigating and responding effectively to allegations over the last 2 years after the implementation of the Safeguarding Adults team in April 2011. Therefore, the Board's agenda has been driven by two core items: performance reports (an overview of core data is set out in the High Level Analysis section), and multi-agency audits.

13. The multi-agency audits are carried out every two months. The aim is to audit 10% of all the alerts that go on to a full Safeguarding Adults investigation. The

Board chooses the focus for each Audit and the conclusions are presented to the next Board. There have been 8 audits (40 cases) and these audits have involved 32 people from 12 organisations. The focus for the audits is listed below:

- Financial Abuse, where the outcome of the investigation was inconclusive - high numbers reported
- Learning Disability, where the outcome of the investigation was inconclusive – high numbers reports
- Repeat Referrals – issues raised about the impact of the wider impact of SGA process from the Learning Disability audit
- Investigations – quality of investigations was questioned in previous audits, so more detailed analysis carried out
- Mental Health alerts – identified to assure the Board after the transfer of Mental health Safeguarding Adults work to the Adult Social Care SGA team
- Screened alerts – percentage of alerts being screened out of the process had increased significantly in 2012/13 and the Board wanted assurance that this process was safe
- Nursing Home alerts – SGA team identified the high number of pressure care alerts coming from nursing homes and so requested further analysis
- Alerts where the Home Carer was the alleged perpetrator – following on nursing home SGA alerts, home care alerts are the second biggest sectoral source of alerts.

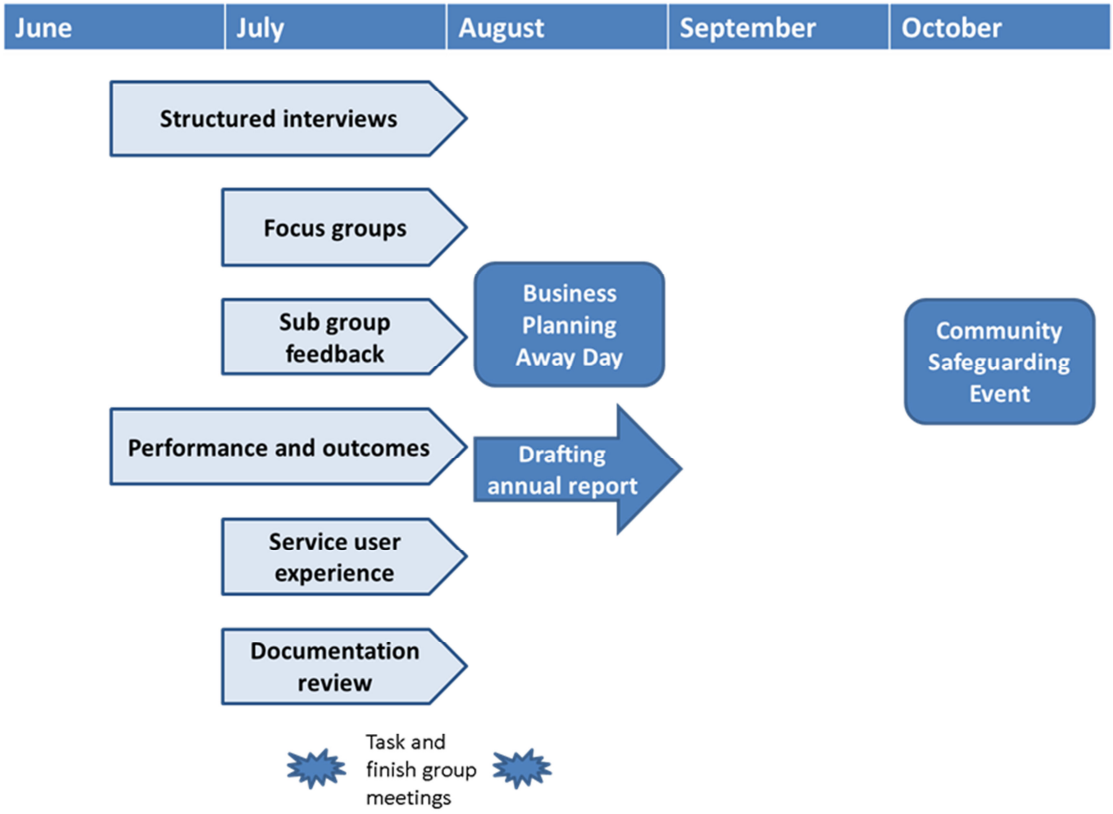
14. The multi-agency audits service a number of purposes. They:
    - provide the Board with assurance about the quality of practice in Brent
    - create a clear focus on outcomes for people. The audit tool is set up to look at: the person, the nature of the alert, the SGA process and the outcomes for the individual – how did the SGA process improve the person's life
    - are an excellent tool for engaging and promoting Safeguarding Adults across all agencies
    - drive operational change. In addition to the review of the SGA team, the following improvements have all been delivered as a result of the multi-agency audit process: the secondment of an Investigator from Audit and Investigation into the SGA team to lead on improving practice in relation to financial abuse cases; implementation of a new screening process for all alerts, roll out of investigation training (led by Audit and Investigation); alignment of Serious Incident and SGA processes to remove duplication; formal mechanisms for recording provider issues and communicating them to commissioners; operational guidance on suspension of home carers when there is an SGA alert.

15. The Board is creating a stronger focus on prevention and communication though as well. For example, over the last six months:
    - GP training has been rolled out across Brent – all GPs and their staff have been invited to attend
    - There is an on-going awareness raising campaign running across Brent. The new SGA leaflets have been designed and distributed, a bill board poster campaign has been run (attracting attention from national media outlets such as the Guardian and community Care) and this will be followed by a bus campaign and a Safeguarding Adults event in October

- Health partners have been working to improve pressure care although there is still more to do to see the impact of this work through a co-ordinated dataset
- Health and social care commissioners continue to work closely with the Care Quality Commission, providers and the Safeguarding Adults team to identify institutional problems and tackle them, but again there is more to do to ensure that all of this work is robustly evidenced and the impact is shown.

16. As the last section suggests, while the SGA team and the Board continue to deliver a range of improvements, there is still more to achieve. Therefore, the Board agreed, at its most recent meeting, to:
    - Review the work undertaken over the last 12 months
    - Review and confirm the Board's priorities
    - Ensure the governance and resources of the Board are set up to deliver those priorities.

17. The diagram below provides an overview of this work and the proposed timetable:



High level activity analysis for 2013/14

18. The approach to performance and activity analysis has been to focus on a core set of data (alerts, referrals, outcomes of investigations and types of abuse) and then to analyse specific issues in line with multi-agency audit topic (for example, there was a detailed analysis of data relating to home care alerts at the last Board).

19. The core dataset is only added to where the specific analysis highlights the need for on-going monitoring, for example, at its last meeting the Board agreed to include Pressure Care data (number, source (hospital, care home etc.)) from now.

20. Additional work is also required on setting the baseline for Safeguarding Adults (the context, how many vulnerable adults are there in Brent), so that the Board can better understand how the level of activity relates to the population of vulnerable adults in Brent. This will be undertaken as part of the 'Performance and Ouctomes' work stream as illustrated in the diagram above.

21. The table below sets out the alerts, referrals and completions of investigations, and in particular highlights a number of key trends:
    - The number of alerts has doubled in 2012/13
    - The number of alerts progressing to a referral (full investigation) has significantly reduced as a result of the new screening process
    - The percentage of referrals being completed in year has grown significantly, highlighting that the team is dealing with referrals in a more timely manner

	2011/12	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	2012/13
Alerts	435	211	229	223	216	879
Referrals	387 (89%)	55 (26%)	73 (32%)	88 (42%)	97 (45%)	313 (36%)
Completed referrals	210	53	67	69	66	255
% (CR to R)	54%	96%	92%	78%	68%	81%

22. The next table (overleaf) sets out the type of referral and the outcome of the investigations. This highlights that:
    - Financial, neglect and physical abuse are the 3 most common types of abuse (they make up 85% of referrals). This has not changed over the last 3 years
    - Fewer cases are ending in an inconclusive outcome (down from 30% in 2011/12) to 13% in 2012/13, this suggests that the investigations and the SGA process is now more robust, which is backed up by the multi-agency audits
    - Financial abuse no longer has the highest level of inconclusive outcomes, which reflects the focus on improving investigative activity and closer working with the police.

	Referrals	Substantiated	Not substantiated	Inconclusive	Not complete
Financial	95	32	41	10	12
Neglect	92	22	32	10	28
Physical	111	28	32	19	32
Emotional	31	9	9	4	9
Sexual	16	3	7	0	6
Discriminatory	1	0	0	1	0
Institutional	6	0	1	3	2
Total	352	94 (27%)	122 (35%)	47 (13%)	89 (25%)

Conclusions.

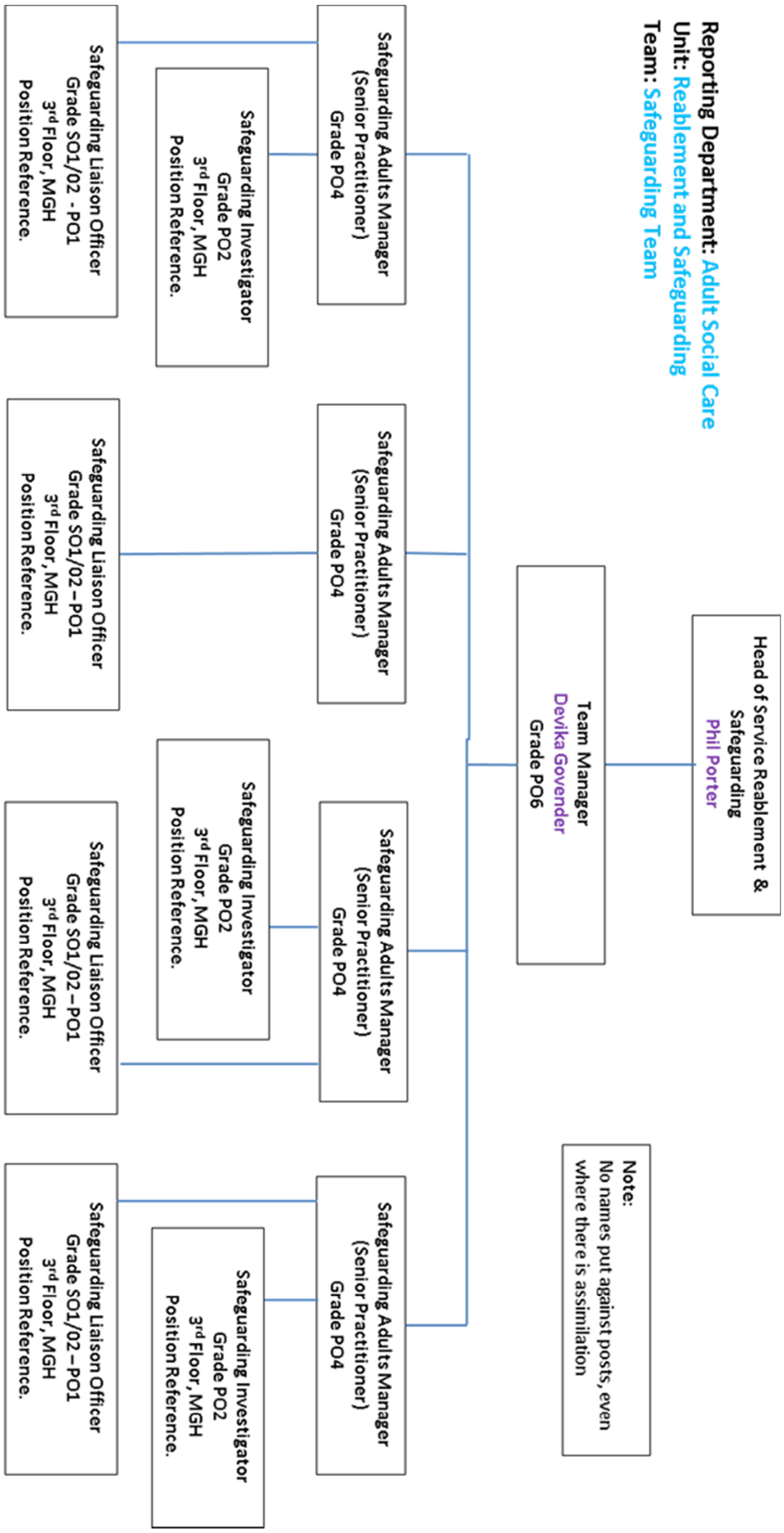
23. The Health and Well Being Board is asked to comment on the:

- contents of the report
- the Board's role in terms of Safeguarding Adults, and how it can support the preventative agenda through its leadership of the health and social care economy
- Governance arrangements: the Director of Adult Social Services currently chairs the BSAB and sits on the Health and Well Being Board, so there is a clear connection
- Future reports: the proposal is that the Board receives two reports a year, the Brent Safeguarding Annual Report to sign off and a 6 monthly update focused on performance, outcomes of the multi-agency audits and progress against actions.

Phil Porter
Acting Director of Adult Social Care

Appendix 1
Pan London Safeguarding Procedure

Appendix 2
Safeguarding Adults Team Structure



Membership of the Brent Safeguarding Adults Board

Phil Porter	Chair, Acting Director of Adult Social Care, Brent
Yolanda Dennehy	Acting Head of Reablement and Safeguarding, Brent Council
Steven Forbes	Head of Adult Social Care Commissioning, Brent Council
Anna Dias	Learning and Organisational Development Manager, Brent Council
Fiona Bateman	Senior Lawyer, Brent Council
David Murray	Acting Head of Community Safety, Brent Council
Laurence Coaker	Head of Housing Solutions, Brent Council
Sue Matthews	Safeguarding Children Co-ordinator
Ann O'Neill	Mencap
John Sclocco	Brent Carers Centre
Fiona Hill	Brent Mental Health User Group
Amanda Craig	Brent Clinical Commissioning Group (CCG) Director
Sarah Mansuralli	Deputy Borough Director, Brent CCG
Kim Rhymer	Operational Safeguarding Lead, CCG
Yvonne Leese	Director of Community Service, Ealing Hospital Trust
Bridget Jansen	Deputy Director of Nursing, North West London Hospital Trust
Natalie Fox	Borough Director, Central and North West London Trust
Mike West	Detective Inspector, Metropolitan police
Terry Harrington	Borough Commander, London Fire Brigade
Judith Brindle	Care Quality Commission
Hannah Storer	Brent Safeguarding Lead, London Ambulance Service
Deirdre Bryant	Probation Service

Appendix 4

Brent Safeguarding Adults Board Priorities

1. ***Effective Implementation of the Pan London Procedures*** - improving practice at each stage of the Pan London process itself. It is primarily focused on the ASC Safeguarding Team and how they manage each stage of the process, Strategy Meetings, Investigations, etc.

2. ***Excellent case recording and case communication*** - the Independent Management Review (IMR) was clear that all agencies should have recorded and communicated information more effectively. Therefore, this priority is to improve case specific recording and communication across all agencies in core practice and all stages of the Pan London procedure

3. ***Improved multi agency working*** – like the second theme, this theme is focused on individual cases and improving practice across all stages of the Pan London procedure, with a particular focus on key multi-agency interfaces

4. ***Core practice standards that prevent safeguarding*** – if core assessments (social care and clinical) are done well (and in particular mental capacity is clearly evidenced and support plans reflect this evidence), it will reduce abuse, therefore, this was agreed as a priority for prevention

5. ***Commissioning for quality*** – the IMR highlighted the need for the Board to ensure that the relationship between local authorities and providers is structured in such a way as to reduce abuse, so this becomes another key element of prevention

6. ***Cultural change*** - this is a broad and strategic theme, which looks beyond individual cases to how organisations and the public can think differently about safeguarding, for example, promoting dignity and respect for all including those with dementia

7. ***Board effectiveness*** – in this theme the Board is to be clear about its role and what it will take direct responsibility for and how its success will be measured.