Brent Safeguarding Adults Board

Annual report 2014-15

Brent

Chair's foreword

Welcome to Brent Safeguarding Adults Board Annual Report for 2014-15. You will see from the report that the picture of need has changed in Brent. This report also details how the Safeguarding Adults Board ['SAB' or Board'] in Brent responded to these changes and the impact of the SAB's work programme in pushing for continued improvements in safeguarding practice throughout the period.

Whilst I would thoroughly recommend reading the report in full I would like to take this opportunity to comment on a few key findings within the report which I believe demonstrates the effectiveness of the partnership. The continued impact of the 'Abuse: See it, Stop it campaign" in 2013 is demonstrated in a number of key indicators, not least the 47% increase in safeguarding concerns reported in 2014-15.

What is striking however is that 40% of all concerns reported were about individuals who were previously unknown to social care services. It is also striking that members of the public raised 48% of all concerns in 2014-15.

It is reassuring we can demonstrate improved public understanding of the risks posed to adults and that people in Brent confidently report safeguarding issues

Previously the SAB were concerned that abuse and neglect were not always recognised by those who did not work within social care so it is reassuring we can demonstrate improved public understanding of the risks posed to adults and that people in Brent confidently report safeguarding issues.

The report also highlights the need for partner agencies to remain alert to the profile of abuse in Brent and adapt our strategies to meet fresh challenges. In 2014-15 43% of enquiries allege that the harm occurred in the adult's own home, meaning that it isn't prudent to rely on emergency services, health or social care practitioners to identify and report abuse. The data both demonstrates the value of public awareness campaigns and provides a clear justification for maintaining the momentum of the 'See it: Stop it' campaign so that each of us can recognise signs of neglect and abuse and know how to report this.

The challenge for the Board going forward, however, will be to determine how we target resources so that campaigns more effectively address specific risks and inform adults at risk and carers of steps they can take to prevent harm to protect themselves against future risk.

The report also details how well partnership staff respond to allegations of abuse and neglect. The available data, especially when considered alongside local and national comparative data, demonstrates good, effective safeguarding practice within Brent. For example, 2% of cases in Brent recorded capacity as unknown, nationally this figure was 20%, signifying that Brent practitioners take seriously their duties to assess mental capacity and secure suitable representation to support

those who need support during a safeguarding investigation. The reported data for outcomes following safeguarding interventions also demonstrates how well Brent practitioners have embraced the 'Making Safeguarding Personal' principles as 86% of concluded enquiries in Brent either removed or reduced the risk (compared to 63% nationally). It is also a testament to the skills of the investigating teams across the agencies that they have responded to concerns raised by the SAB about the high level of inconclusive findings and not only turned around the upward trend but dramatically reduced the number of cases found to be inconclusive to 16.5%.

The positive impact of measures taken last year to improve the quality of care given in residential care setting has seen a small reduction in allegations of neglect and/or abuse arising in those settings. Whilst this suggests we are moving in the right direction, there is still significant work to be done to ensure that people in receipt of care services are, and perceive themselves to be, cared for in a way that meets their needs safely and with dignity.

During 2014-15, in preparation for the implementation of the Care Act, the Board reviewed its governance arrangements, structure and membership in order that partners were well positioned to undertake the Board's new statutory duties. It is now formally recognised within Brent Council's and Brent Clinical Commissioning Group's constitution and has secured appropriate representation and financial contributions from the key statutory agencies so we have resources to monitor, analyse and improve on safeguarding practises within the partnership.

Given the high level of public awareness, dedication of frontline staff and commitment by the strategic partnership I am confident that we are in a strong position to build on the successes of last year. There is no room for complacency however if the SAB is to provide the leadership needed to deliver continual improvements for adults at risk particularly at a time of unprecedented organisational change and financial pressures.

Fiona Bateman
Independent Chair
Brent Safeguarding Adults Board

What is safeguarding?

Whilst we should all seek to keep ourselves safe from abuse and neglect and have a duty to report any safeguarding concerns, statutory duties arise when an adult in need of care and support is experiencing, or at risk of experiencing, abuse or neglect and is unable to protect her/himself as a result of their needs. The Safeguarding Adults Team within Brent Council's Adult Social Care department coordinate the response to any allegation of abuse, neglect or exploitation and it is to this team that 'concerns' [previously known as 'alerts'] received by the Council are submitted.

The Safeguarding Adults Board ['SAB' or 'Board'] is a multi-agency partnership of agencies working with or on behalf of adults in need of care and support. The Board works to coordinate the strategic development of local safeguarding arrangements and to ensure partner agencies act to help and protect adults at risk of or experiencing abuse or neglect.

The first part of the report sets out a useful measure of the level, source and types of harm suffered by adults in Brent during the period. It is based on data from the Safeguarding Adults Team casework. This has been benchmarked locally against our area profile and nationally so that the Board are able to identify further ways to improve practises and safeguarding adults throughout Brent.

This report also provides a summary of safeguarding activity carried out by the partners across the social care, health and justice sectors in Brent. It details the work carried out to investigate allegations and resolve safeguarding concerns. Reports on the impact of partners' campaigns to raise awareness of the types of risk faced in Brent. Finally it reviews the impact that the SAB has had by seeking assurance that work undertaken by regulatory or commissioning bodies to prevent abuse and neglect before any concerns arise or from providers that they have met their responsibilities to provide care and have done so in a way that responds to actual or perceived

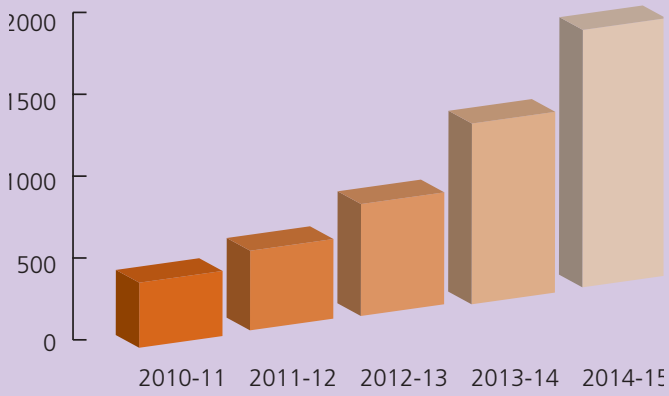
Who is an adult at risk in Brent?

safeguarding risk so that harm is averted.

The Safeguarding Adults Team received notification of 1720 safeguarding concerns in 2014-15, this is a rise of 47% from 2013-14 (see bar chart). This increase in demand corresponded to a similar increase in further investigations [referred to as 'enquiries'] 367 of which were concluded during the period and it is those 367 concluded enquiries that are analysed below. Almost 40% of safeguarding investigations in Brent are for individuals not already known to social care. Comparisons with national and local benchmarking figures (which are 19% in London and 18% nationally) demonstrate that people in Brent are better able to recognise safeguarding concerns and have the confidence to report these.

Our referral source data shows a percentage reduction in referrals from social care staff. Police and health care professional are now increasingly raising concerns, as are members of the public. Referrals from non-professionals, including self-referrals, account for 48% of all concerns raised in 2014-15.

Safeguarding concerns between 2010-15

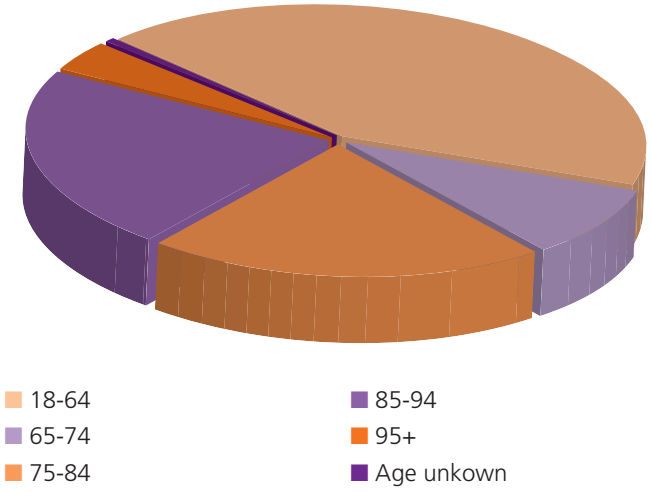


Although Brent has a comparatively young population, the number of people over 75 increased by 17% between 2001 and 2011. This group remains disproportionately represented in safeguarding interventions, in that over 47% of enquiries by the SAT in 2014-15 were for adults aged 75 or older (down from 50%, against national comparator of 52%). This group will therefore be a focus of an awareness campaign in 2015-16 so that we can support them to put in place protective measures to reduce the risk of abuse.

Brent is also a very diverse community. Black, Asian and minority ethnic (BAME) make up 65% of the population as a whole and approximately 40% for the population aged over 75. Our data confirms that 46% of safeguarding interventions involved adults at risk from BAME backgrounds. This has reduced from 50% in 2013-14 and against national comparator of 8%. Whilst it is reassuring that all parts of our community are receiving support when safeguarding risks occur and that we are reflecting the demographic in Brent, there is always more that needs to be achieved to reach out to our BAME communities and ensure all members of our communities know how to seek support when, or if, necessary.

46% of safeguarding interventions involved adults at risk from BAME backgrounds. This has reduced from 2013-14

Number of individuals by age

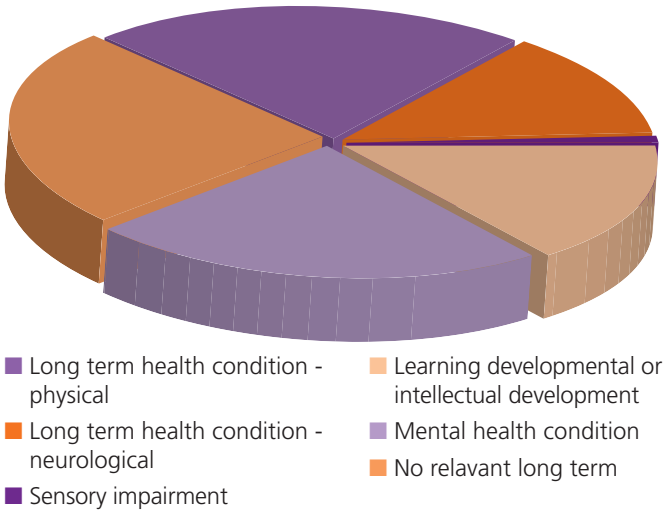


In addition, it is relevant to safeguarding that partners are working within an area with above national average levels of deprivation, unemployment, homelessness and children in poverty. The percentage of households estimated to be fuel-poor in 2012 in Brent (11.6%) was higher than both the London (8.9%) and England (10.7%). It is also relevant that partners take into account how people's own sense of well-being can impact on safeguarding.14.4% of residents report that their health limit day to day activates, with 7% indicating their activities were limited a lot as a result of health.

A key concern for many partners was the risk for older people of isolation as 27% of people over the age of 65 live alone in Brent, and 39% of adult social care users reported being lonely.

Of those subject to safeguarding enquiries in 2014-15 36% had a long term physical disability, neurological condition or sensory impairment (against a national comparator of 42%). 15% of enquiries related to individuals with a Learning Disability which is consistent with the national comparator. A further 6.5% of cases involved individuals with Dementia. This figure is consistent with last year's findings, but slightly lower than the national comparator of 9%. Previous successful campaigns directed towards this particularly vulnerable group has raised awareness and identified means of ensuring access to support which might account for this higher figure.

Number of individuals by reported health conditions



Mental health was recorded as the primary support need for 17% of investigations (against national comparator of 12%). The figure, though higher than national comparators, reflects a high level of awareness of safeguarding matters within local mental health services. The Board also understand that the 17% figure likely under-represents the work that is done by partners to safeguard those with mental health needs. The SAT report that many of the safeguarding concerns raised by mental health practitioners about their service users are accompanied by a protection plan.

On receipt of the concern the team review the work of the practitioner and offer support to ensure that the adult is safeguarded effectively from harm, but often it is not necessary to conduct further, additional enquiries and as such these cases are not included within this data.

This good practice is to be applauded as it reduces duplication and ensures that the adult is safeguarded at the earliest opportunity, working with those practitioner who know them best to reduce or remove any risk of harm. However, the Board recognise that those who need mental health support may face additional barriers to stay safe from abuse

and neglect. The Board, through its work programme of data analysis, case reviews and thematic audits, will continue to monitor the way in which agencies work together to recognise and respond to abuse or neglect and use what we learn to improve our processes and practice so we are able to better support this client group.

In addition, 8.6% of the population in Brent provide unpaid care.

It is estimated that 26,600 residents of the borough provide care of more than 1 hour per week with a significant rise in the numbers of people providing over 20 hours per week. This is relevant given the number of enquiries where the source of harm arises within the individual's home and by someone known to the person (26%).

Carers are a vital resource within our community and must be supported effectively to ensure that they are able to recognise signs of abuse or neglect and have the confidence to report this or seek help. In addition, agencies must ensure that carers can access advice and support so that they can carry out their caring role safely and do not cause unintentional harm. Similarly agencies need to be alert to risks of intentional harm and act swiftly to prevent or address this when it does arise. The Board recognise this and have set out how we seek to support carers within the Strategic plan for 2015-16.

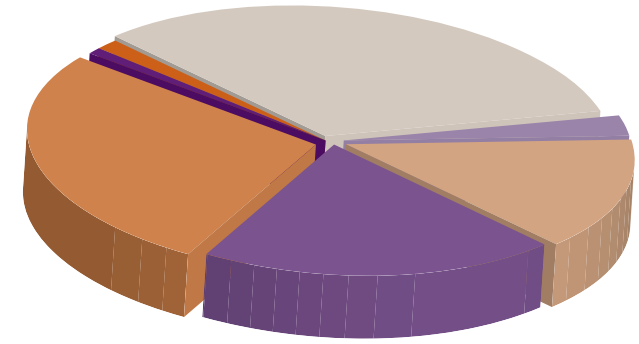
Carers are a vital resource within our community and must be supported effectively

What types of abuse are adults most at risk of in Brent?

The data confirms that the types of abuse reported in Brent is similar with the picture of need nationally. Physical abuse is given as the principle concern in 33% of concluded safeguarding enquiries in Brent during 2014-15 (27% nationally, 24% in London). A further 27.5% of enquiries related to concerns about neglect or acts of omission (32% nationally) and 14% of cases involved psychological and/or emotional abuse (15% nationally, 17% in London).

Cases of sexual abuse has fallen this year with only 7 enquiries (2.7%). This is lower than the national comparator (5%), but it is widely believed that sexual abuse is under-reported across the UK. The SAB will conduct a multi-agency audit of cases involving allegations of sexual abuse so as to ensure that agencies are working together effectively to recognise signs of sexual abuse, report this and carry out enquiries in an appropriate manner. Following on from this the Board will consider how best to raise awareness and address the needs of those who are victims of sexual abuse within Brent.

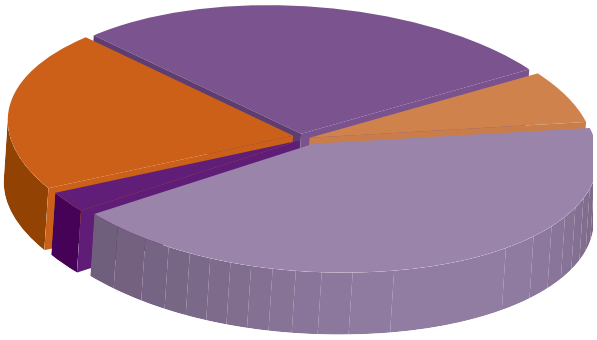
Type of abuse



- Physical
- Sexual
- Psychological and emotional
- Financial and material
- Neglect and omission
- Discriminatory
- Institutional

The location of abuse and neglect is similar to what is reported nationally though it is noteworthy that in Brent 28% of all concluded cases related to abuse alleged to have occurred in residential care (against 36% nationally and a slight reduction from 31% of cases reported in 2013-14) indicating preventative actions to improve the quality of care within residential settings have had a positive impact. This data is supported by the findings from local inspections carried out by CQC. This is explored in more detail below. By contrast the number of enquiries where abuse is alleged to have occurred in the adult's own home has risen slightly from 40% in 2013-14 to 43% (nationally this is also 43%) and again reinforces the importance of ensuring everyone understands how to recognise signs of neglect and abuse and report this.

Location of risk



- Care home
- Hospital
- Own home
- Community services
- Other

Last year the SAB identified two specific types of concerns that they wanted to priorities in 2014-15 so as to either prevent incidence occurring or improve the outcomes for adult at risk or who had experienced these, namely:

1. Pressure sores

Individuals with fragile skin and/or restricted mobility can be at risk of developing sores on parts of their body which receives the most pressure. These pressure sores, also sometimes known as pressure ulcers start with skin discolouration but, if left untreated, can become very painful and at risk of infection. Usually, with proper care, most pressure sores can be avoided. It can therefore be an indication of poor quality of care.

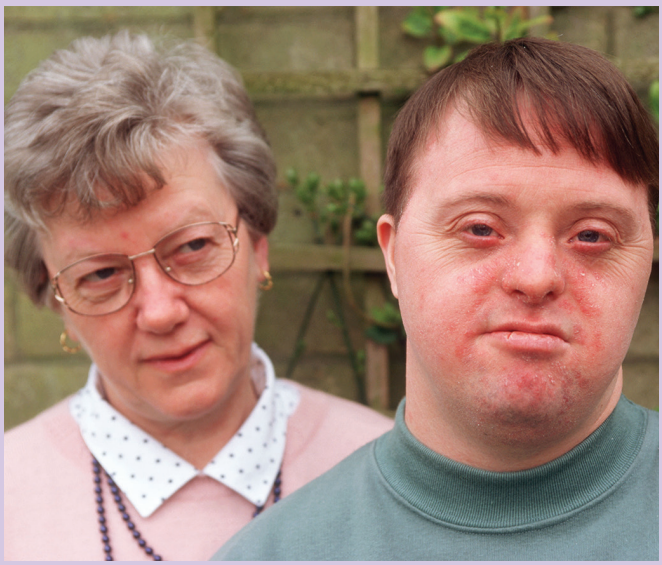
The SAB monitored the number of pressure sores and where the sore was acquired. In accordance with NHS guidelines for 2014-15 (which has now been superseded) 205 pressure sores graded 3-4 were reported as a safeguarding concern during the year. The concerns was reported to have arisen most frequently within the person's own home (96) but 59 cases related to residents in care homes, 36 were residing in hospital and 1 person was in receipt of services in the Community.

Again, it is reassuring that concerns were reported by a wide cross section of sources because this demonstrates that practitioners and carers are aware of the risks and how to report concerns, but given the nature of the issue it is unsurprising that most safeguarding referrals came from health professionals (53 from hospital or hospice services, 20 from primary health services and 3 from mental health practitioners). Carers also reported a significant number of concerns (20 coming from voluntary carers, 8 from residential care staff and 1 from non-residential social care).

Of the 205 concerns raised only 101 proceeded to an enquiry. Usually it would not be necessary to undertake a full enquiry if the sore was considered to be unavoidable because appropriate standards of care have been given. Where enquiries were required these were mostly carried out by Brent CCG staff rather than the Safeguarding Adults Team, as they have the necessary clinical expertise. Investigations followed a 'root cause analysis' method to ascertain if there was any evidence of neglect and, if so, by whom. During the period the CCG report the findings of 18 concluded enquiries to the SAB. 2 were substantiated, 3 inconclusive, 4 partially substantiated and 9 unsubstantiated.

As a result of these findings Brent CCG appointed a specialist Tissue Viability Nurse in February 2015 and by April 2015 she had already made contact with every nursing home in the area to explain her role and offer support on safe wound care. In her first two months she received 43 referrals and visited 14 residential units to review the care given to 38 individuals.

Of those cases 22 cases involved pressure sores graded 3-4, 14 of which were discharged within that period as the wound healed. LNWH NHS Trust also reported to the SAB that they had reviewed the work of district nursing teams across Brent to assess and prevent pressure sore damage on complex frail elderly patients, with complex medical needs.



Actions plans are in place to improve practice and provide a more comprehensive care package for pressure sore prevention. The Trust report that they have also reviewed the structure of the Tissue Viability Teams to ensure a clear pathway and seamless transition for patients from acute hospital care to the community settings.

The Board will continue to monitor this work through its establishment concerns sub group, who are responsible for monitoring key data and report regularly to the main board on any emerging trends or issues of concern that arise from pressure sore data. The group is therefore best placed to ensure that the improvements in the provision of pressure sore care continues. In addition, the sub group will continue to ensure that 'Root Cause Analysis' investigations into avoidable pressure sores are conducted in a more timely manner, the outcome of those investigations are evidence based and recommendations for improvements are actioned in a timely manner.

Case Study: Beryl

Beryl is 54 and lives in residential nursing care as she needs support due to her severe learning and physical disabilities. Prior to moving into nursing care her family appointed neighbours to support her to manage her money. Brent Council's Client Affairs team became concerned that her trustees were not acting in her best interests as they had allowed a large debt to accrue. The team had been in contact with the trustees and were able to obtain bank statements from them. The team raised safeguarding concerns when the trustees gave unsatisfactory explanations for very large withdrawals from her bank accounts amounting to £10,000. A safeguarding enquiry was started that day and a Safeguarding Adults Manager made contact with the Police and the Office of the Public Guardian, who are responsible for registration and regulation of Powers of Attorney.

Beryl was supported by her social worker and an advocate, due to difficulties understanding the investigation and safeguarding processes to ensure her best interests remained at the heart of the enquiry. A protection plan was put in place in which the Client Affair Team applied to the Court of Protection to revoke the current trustees' powers and appointing a deputy to manage her finances so that her needs can continue to be met. At the time of writing the police investigation into possible fraud by the trustees is ongoing.

The SAB will be working with key agencies and the financial sector, in collaboration with Brunel University, to consider how best to address this type of abuse and better safeguard adults at risk.

Financial abuse:

Financial abuse is where an adult in need of care and support is the victim of theft, fraud or is being pressured to give money to other people. The SAB recognised that there was a need locally to focus on the risks of financial abuse to adults in Brent because of the high number of cases reported in previous years. It is noteworthy that, during 2014-15, there has been a substantial reduction in the number of concluded cases featuring financial abuse, which has dropped from 94 cases in 2012/13 to 52 cases last year (20% compared to 17% nationally).

In previous years the number of cases of financial abuse was far higher in Brent than reported nationally, this was thought to be because awareness of this type of abuse was reported to be very good especially among the Local Authority's SAT, social care and financial support staff. As a consequence more cases were reported to the SAT for investigation. Whilst awareness is still thought to be very high within the Local Authority the data does suggest that social care staff and finance officers are supporting adults at risk to undertake preventative action so that fewer people are experiencing abuse.

Despite their responsibilities, safeguarding practitioners don't have additional powers to investigate allegations and as such it is often difficult to conclude these enquiries quickly, though cases were, on average, completed within 69 days, or with any certainty. This is particularly true when the adult at risk lacks capacity to consent to investigations (42% of cases) as it can be difficult to secure cooperation of the banking sector, which can also frustrate the implementation of protection plans. This is reflected in a higher proportion of cases determined as inconclusive (21%).

It is reassuring that, despite the difficulties, staff implementing protections plans were able to reduce or remove completely the risk of financial abuse in 82% of cases. Whenever, during the course of an enquiry, the adult is found to lack capacity to manage their finances the SAT will work with the adult's family and/ or statutory partners to ensure that appropriate arrangements are in place to protect the adult from future harm.

But in recognition of the difficulties faced in tackling this type of abuse the SAB will be working with key agencies and the financial sector, in collaboration with Brunel University, to consider how best to address this type of abuse and better safeguard adults at risk, with a particular focus on raising awareness of what we can all do now to prevent harm by protecting ourselves from the risk of financial abuse.

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How do we support Adults at Risk?

Providing an effective response when safeguarding concerns are reported

On receipt of a concern the SAT assess the risk and make contact with the adult wherever possible and with any relevant services or support network to ascertain how best to protect the adult from harm and remove the risk. In 2014-15 85% of concerns are not taken forward for full investigations, either because no further action was requested by the adult (1.5%) or because the adult is signposted to alternative services (including health or social care provision) or provided advice and support to protect themselves.

The team carries out a duty visit within 5 days of a concern being raised whenever there is any cause to believe the adult at risk may lack capacity or may be experiencing harm. During 2014-15 the team undertook 80 duty visits (13%) of all enquiries.

The LSAB monitor cases where subsequent concerns are raised against the same adult within a 12 month period as an indication of the effectiveness of protection plans and the screening process. In 2014-15 27% of cases there were repeat concerns, this accounted for 380 individual concerns. The current rate of repeat concerns is significant and the SAB will continue to monitor this in 2015-16 and work with the SAT to ensure that any screening process is designed so that adults at risk are protected at the earliest opportunity.

Provision of independent advocacy support to those who are unable to protect themselves and without family/friends to assist

If a person has substantial difficulty in understanding or deciding how they wished to be supported in a safeguarding enquiry and does not have support from friends or family the local authority should appoint an independent advocate to help them. Of the concluded investigations in 2014-15 54% people appeared to lack capacity and, of those, 34 were supported by independent advocates. However, a small proportion of cases recorded capacity as unknown (2%). This is far below the national comparator (20%) the SAB intend to monitor this figure as an indication of the impact of capacity training and, so that we can better safeguard those without capacity or who have substantial difficulty understanding the processes, will also look to receive reports on the number of people who lack capacity and do not have support from family or friends to ensure that advocates are appointed when necessary.

Conduct effective investigations

The burden of proof for safeguarding investigations is the civil rather than criminal standard, namely that it is more probably than not that the allegation was true. In 31% of enquiries the allegations were substantiate (31% nationally), a further 6% were partially substantiated (10% nationally) and in 45% of cases the allegations were not substantiated (30% nationally).

The Board set itself an aspirational target last year to reduce the number of inconclusive investigations to 10%. This was ambitious given that in previous years inconclusive investigations accounted for 22% (2012-13) and 25% (2013-14). Those figures are

in line with safeguarding enquiries nationally where 22% of investigations are inconclusive. However, Brent SAB set the 10% target in recognition that many people who had experienced the safeguarding process reported that they felt it was important to have a clear decision regarding the outcome of that investigation. The purpose of the target was to effect a culture change across all agencies responding to concerns to ensure staff were confident in their investigative skills and decision making.

The restructuring of the Metropolitan Police locally means there is now a dedicated safeguarding team within community safety unit. This has improved attendance at strategy meetings and provided dedicated contact for Safeguarding Adults Team to obtain advice, which has undoubtedly had a positive impact. The Local Authority also supported staff to bring about this change through the provision of investigation skills training. In addition the Safeguarding Adults Team worked with external agencies and commissioners to monitor the quality of all investigations. The positive impact of these measures cases is demonstrated by a reduction in the number of cases found to be inconclusive to 16.5%. The Board have agreed to retain the 10% target so that we can be push for continued improvement and be assured safeguarding interventions are effective.

Work with the adult at risk to reduce or remove the risk

The Council has continued to embed 'making safeguarding personal' principles within the SAT. In 2014-15 86% of concluded enquiries in Brent either removed the risk (36%, 23% nationally) or reduced (50%, compared to 40% nationally). In 9% of cases no action was taken (compared to 30% nationally), but this means that in 5% of cases the risk remained despite the safeguarding intervention (8% nationally). By contrast to the national picture we are able to demonstrate good, effective safeguarding practice within Brent. The Board however recognise there is always more that can be done to develop the way in which all partners address safeguarding concerns so that the response reflects the wishes of the adult at risk, but also effectively reduces or removes the safeguarding risk. In 2015-16 the Board will further develop the 'Making Safeguarding Personal' programme and develop tool kits for practitioners across the partnership to support robust decision making. In addition the Board will use key performance indicators and are working to develop reliable means for collecting service user feedback so that we can better measure the impact of any intervention.

Work to prevent abuse and neglect by ensuring quality commissioned services

Partners have continued to capitalise on improvements to contract monitoring arrangements introduced in previous years and closer working relationships between commissioners within Brent and regulatory agencies. For example Brent Council's ASC commissioners introduced new contract monitoring arrangements putting at their heart safeguarding and restructured the way in which it carries out individual reviews of ASC care plans so that any concerns regarding standards of care within social care provision is identified sooner.

In 2015-16 the Board will further develop the 'Making Safeguarding Personal' programme and develop tool kits for practitioners across the partnership to support robust decision making.

In addition, Brent CCG now include safeguarding as a regular item on the agenda within their provider assurance meetings so they can share best practice and any lessons learnt from audits and reviews carried out by their quality assurance teams or by the Board.

In 2014 the SAB also adopted the Establishment Concerns group into its structure. This group is responsible for monitoring key data from each member agency and reporting regularly on any emerging trends or issues of concern that arise. The sub-group already meets quarterly to share and analyse information from safeguarding enquiries, individual care planning reviews, contract monitoring and regulatory activity to ensure a coordinated robust multi-agency response to issues of poor quality of care within health or social care establishments in Brent. Their work is then reported to the main SAB meeting.

Brent CCG now include safeguarding as a regular item on the agenda within their provider assurance meetings so they can share best practice and any lessons learnt

How does the SAB drive improvements?

Identifying and acting on priority issues

In 2013-14 the Board identified key areas for the partnership to action. The first of these were to reach out to existing community groups to explain the work of the Board and secondly to engage more widely with other key strategic partnerships within the Borough.

As Independent Chair I attended meetings with BHeard, the Learning Disability Partnership and the Health and Well-being Board to explain the work of the Board, including presenting last year's annual report and discussed the priorities for the year ahead. In addition, the Board has worked alongside the Safer Brent Partnership's Violence against Women Sub Group to devise a coordinated programme of work to tackle issues such as Domestic and Honour based violence, FMG and forced marriage.

Work was also undertaken with Public Health colleagues and the Community MARAC to identify any gaps in provision for people wrestling with substance misuse and at risk of abuse or neglect. Partner agencies have also undertaken consultation with service users, for example CNWL spoke with service users and carers to better understand user and carer experience of local safeguarding services to make improvements to their referral process. There is still a lot more work needed and this remains a key priority for the Community Engagement and Awareness group in 2015-16.

Another key action for the year was to introduce an organisational safeguarding audit tool for partners. In August 2014 the Local Authority and Health partners completed an audit of their safeguarding policy and practice. The results were then verified by a sub group of the SAB and reported to the SAB and NHS England. This report also fed into the Board's Strategic plan for 2015-16. In 2015-16 all partner agencies will complete a similar audit to review the safeguarding policies and practice across the partnership. Thereafter a rolling programme of self or peer audits will be devised and include the private and voluntary sector health, social care providers and Registered Social Landlords within Brent.

Partners also made improvements to recruitment practices to ensure greater safety for service users, as the Board had identified this need following auditing work in 2014. For instance, in line with responsibilities set out in the Care Act, member agencies have identified a Designated Adult Safeguarding Manager ['DASM'] who will be responsible for coordinating any investigation against an employee or volunteer and reporting, when necessary, cases to the Disclosure and Barring Service ['DBS'] for follow up action.

The SAB will set up a virtual network for DASMs and safeguarding leads in Brent to provide training support to this group and ensure a strong network able to share intelligence on those who may pose a threat to adults at risk. Partners, including the London Ambulance Service and LNWHT, have offered training on safeguarding to their Human Resources dept and changed their internal HR procedures to ensure safer recruitment processes. In addition, the Establishment Concerns group offers a forum for sharing intelligence about concerns in recruitment practices or with personnel in health and social care providers.

Case Study: Jack

Jack is 20 and attends a residential school during term time as he has learning and sensory disabilities as well as mental health needs. During weekends and holidays Jack is cared for in another residential placement as previously his family struggled to manage his complex needs. A safeguarding concern was raised by the school staff when they noticed scratches and bruising and Jack had said they had been caused by a member of staff at the residential care home.

A safeguarding enquiry was undertaken, including requiring a report from the Provider and GP. However, whilst this was undertaken Jack's family contacted the Safeguarding Adults Manager and made additional disclosures which were also investigated and found to be substantiated.

As a result of the enquiries 2 staff members were removed from working directly with Jack and disciplinary actions have been taken under the Providers policy & procedures. The provider was required to demonstrate improved practices. In addition, it was agreed to review the level of support offered to Jack within the residential care home and he is more settled in the placement.

■ Establishing mechanisms for developing policies and strategies for protecting adults

Partners have continued to work together, in accordance with the expectations set out in Pan London policy and procedure , to improve the experience and outcomes for those in need of care and support. A particular focus in 2014-15 was on the needs of those with a learning disability. Brent CCG conducted an audit of practice relating to the provision of services across the Brent social and health care sectors. This reviewed the outcomes of interventions by health and social care practitioners to evaluate whether these were meeting the required standards. An action plan to take forward improvements was then devised and this is monitored by the Learning Disability Partnership and will report to the SAB in 2015.

The LNWHT also worked closely with Brent Mencap and Brent Community Learning Disabilities Team to develop a Health Passport for people with Learning Disabilities. This document is key to highlight important information about the individual to staff caring for them such as communication needs likes and dislikes and aids communication between health practitioners in the community and hospital settings so as to ensure appropriate and safe care.

Learning from national reviews often identify poor communication between agencies as a root cause for poor outcomes in safeguarding investigations. Partners attending the SAB comment that meetings are not only a useful source of information on emerging issues or areas of good practice in safeguarding, but also act as an opportunity for strategic leads from across health, social care and criminal justice sectors to build professional networks which help to overcome this at strategic level.

Over the last year many partners have taken steps to ensure those networks extend beyond senior management to better support those with operational responsibility for safeguarding. For example, the National Probation Service now has a named safeguarding lead for London. They have also agreed to collect and make available data centrally, so as to reduce risk of local differentiation. This should improve the availability of information so that decisions on how to move forward on the safeguarding issues within the NPS and the Board are evidence based.

In addition CNWL now has two dedicated safeguarding leads to support frontline staff, act as link between staff and Brent Council's Safeguarding Adult Team and provide support to the SAB's sub groups. CNWL have also established a system to analysis number of concerns raised to the SAT so that they can gain a better understanding type of abuse most often faced by their service users to better

inform their own risk assessment process. There are monthly meetings between the Brent Safeguarding Adult Manager and the Lead Social Worker to understand this activity. The Trust also meets weekly with Brent CCG to ensure safeguarding enquiries and protection plans for in-patients are implemented.

The London Ambulance Service ['LAS'] changed the way in which it reported concerns so as to distinguish between safeguarding needs to adults at risk and a request to the local authority or police to conduct a welfare check on an adult who may require support or a change in the care they currently receive. As a consequence they have identified that over 66% of their referrals fall into the later category. This should reduce duplication for the agencies therefore ensuring officers, both within the LAS and SAT, have more time to respond to their core functions and mean adults in need of a safeguarding intervention are supported faster.

Again there is always more that can be done and the SAB has identified within the Strategic plan a number of ways that we intend to build on this to strengthen multi-agency liaison in the coming year.

■ Ensuring our workforce understands their safeguarding responsibilities.

The SAB has a training competency framework which sets out the expected standards of knowledge for practitioners working with adults at risk. This framework is advisory and offers support Board partners devising training programmes for staff. Board members can also report directly to the SAB on the training opportunities provided.

Across the partnership, in many cases, partners have made safeguarding and mental capacity training mandatory. For instance, the London Fire Brigade have delivered fire safety training and fire safety awareness to partner agencies to promote Home Fire Safety Risk Assessment and smoke alarm installation in homes where an adult at risk resides.

LNWHT requires staff to attend training across issues such as PREVENT, Domestic Violence, Slavery and Human Trafficking, Forced marriage, Deprivation of Liberty & Mental Capacity (specifically in relation to patients with Learning Disabilities). Staff are required to complete the mandatory safeguarding training on a 3 yearly cycle and report 95% of staff have attended level 1 training. The LAS require that all staff receive basic awareness regarding their safeguarding duties, clinical staff receive level two training and key personnel trained are trained to level three. In total 4178 staff were trained in 2014-15. The LAS also issue staff with a Safeguarding pocketbook which details the safeguarding roles and responsibilities of all key agencies.

Local Authority and CNWL social care staff working in Brent attended training on the new assessment and care planning responsibilities under the Care Act 2014. Safeguarding adults training is mandatory for all staff within the Local Authority's ASC department and CNWL Trust. E-learning material is available and wherever possible team based training is hosted. In CNWL the safeguarding adults training compliance for 2013/14 shows a mark improvement with current compliance at 92%. The Safeguarding Adult Survey 2014 supported by the recent CQC visit show that staff have a greater awareness of safeguarding and how to report a concern.

■ Learning lessons from local and national cases with poor outcomes

Locally Brent Safeguarding Adults Board commissioned reviews into two cases this year, one of which met the threshold for a Safeguarding Adult Review and the Board was also contributed to a further case which was subject to a Domestic Homicide Review. All of these reviews are yet to be concluded and so will be reported in next year's annual report, but the learning from these has already shaped the Strategic plan for 2015-16 and driven service transformation.

For example, CNWL Trust reported that learning lessons from a serious incident has driven

forward the dignity in care agenda at Park Royal Mental Health Service including the introduction of single sex accommodation.

Furthermore, LNWHT carry out reviews on all patients with Learning Disability who die in the Trust. These deaths are flagged up to the Deputy Director of Nursing by the Bereavement Co-ordinator for independent review of their care to identify issues arising including evidence of discrimination or lessons to be learned. The trust have reported that no issues of discrimination or lack of care were identified during the reviews.

The Board has also responded to issues arising from national concerns and serious case reviews, especially:

Winterbourne View:

The Board continued to receive regular reports from Local Authority and Brent CCG to ensure that learning disabled patients placed in-patient facility out of Brent was seen by their care coordinator at least every 2-4 weeks.

During 2014-15 10 patients (80% of the Winterbourne cohort) were moved into Brent community placements. NHS England identified a further two patients who required a Care Treatment review, both reviews were completed. Most reassuring was the speed by which local community placements were identified for two patients admitted to inpatient facilities between September 2014 to March 2015, both of whom were placed in community settings within the same period. Whilst 2 patients remain in out of area in-patient placements robust plans are in place to ensure they are moved to local community placements by the end of June 2015. CNWL Trust also reported that whilst some Trust patients have remained in hospital settings, work is progressing to ensure that they are safely transferred at the earliest opportunity to a more suitable placement. Regular reviews are undertaken with these patients.

The Trust has also been working with partners to develop local provision to meet the needs of future patients and to address particular needs for those children and young people transitioning into adult services.

Work is also underway with the Council and other key stakeholders for the development of a local challenging behaviour pathway which will be embedded into a joint overarching Learning Disability strategy. This work will be overseen by the Brent Learning Disability Partnership Board. In addition, wider mental health learning disability care-pathway development is currently underway, coordinated across 8 North West London CCGs under the Mental Health Programme Board and NHS England Specialist Commissioners are working with Brent commissioners to develop a transitional pathway for those patients transitioning from Low, Medium and High Secure facilities. The LSAB Monitoring and Evaluation sub group will continue to receive updates biannually to ensure continued progress to achieving the aims of this improvement programme.

Saville:

CNWL was involved in the Saville investigation and assurance has been given with the development of an action plan. This action plan has begun addressing safeguarding access to patients (including volunteers and celebrities). It also reviews mechanisms for listening and acting on patients/carers and members of the public concerns.

Prevent

Prevent aims to reduce the risk of terrorism by stopping people becoming terrorists or supporting terrorism. Prevent focuses on working with adults who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist related activity. The key challenge for the partnership is to ensure that where there are signs that someone has been, or is being, drawn into terrorism staff can interpret those signs correctly, are aware of the support that is available and are confident in referring the person for further support. Many Board partner agencies report they have already or are looking to ensure a programme of training to raise awareness of Prevent as part of their mandatory and statutory training programme.

■ Regular audit/ monitoring of safeguarding and care management activity

Alongside the auditing work undertaken by the SAB already mentioned within this report, partners carry out regular audits of their own activity in order to ensure that care is provided in a way that takes into account the needs and, as importantly, the wishes of the adult in need of care and support. For example, the Local Authority's ASC department audit 10% of all cases to ensure that individuals are support appropriately. The feedback from these audits help partners to continually improve services.

The SAB's subgroup conducted audits throughout the year to consider areas of concern raised either locally or nationally. The sub group reviewed the SAT's cases to consider whether the SAT responded appropriately and effectively in cases where there were concerns about social care providers, including services provided by the Local Authority. They also reviewed cases where the alleged perpetrator was also an adult at risk and, on another occasion, considered whether the SAT recognised and responded appropriately where the adult was at risk of undue influence. The findings from these audits were reported to the Board and used to inform our work programme.

Work is also underway with the Council and other key stakeholders for the development of a local challenging behaviour pathway which will be embedded into a joint overarching Learning Disability strategy.

Mary is 19 and has a learning disability, she has been accommodated by the local authority for the last 4 years because she had suffered substantial neglect, sexual and emotional abuse. Her social worker is concerned that her partner, who was a family friend, is abusive to her. She has demonstrated to staff that she understands the risks posed by continuing the relationship and has confirmed that her partner hits her and is verbally abusive when he drinks alcohol, but considers herself to be very much in love and is happy in the relationship.

A number of safeguarding concerns have been raised and investigated previously, but as Mary did not want any support the cases were closed and no action taken. Her social worker accepted that her disability didn't prevent her from making some decision, but questioned the assumption she was able to freely weigh up the risks posed to her immediate and long-term wellbeing if she remained in the abusive relationship. She also questioned whether sufficient consideration had been given to what impact fear of reprisals from her boyfriend might have on Mary's capacity to engage with the safeguarding enquiry. Her carers reported that they believed Mary would stay away from the placement to avoid the chance that they would see and report visible signs of abuse, placing her at greater risk. As a result a further safeguarding enquiry was undertaken.

A professionals meeting was held with the social worker, safeguarding adults manager, police and representative working with her carers where a detailed shared risk assessment and management plan was agreed. The Police lead the safeguarding enquiry due to the criminal nature of the allegations. Part of the plan was to meet with Mary to discuss how to best support her. During this meeting Mary felt confident to speak about the abuse she had suffered, recognised that she had been placed under pressure to give her partner money and, most importantly, accepted that she would need support to protect herself from further harm. A protection plan was agreed with her which took into account that she still wanted to continue the relationship.

■ Awareness raising campaigns

Mencap continued to campaign to raise awareness of the damage caused by Hate Crime and how to report it (see **www.report-it.org.uk**). This has involved working with those most likely to experience it and alongside police colleagues to ensure that when this is reported adults at risk are offered support. As a result of this campaign the police report a dramatic increase in the numbers of crimes reported, which has risen from 468 in 2013-14 to 619 last year. This figure includes all types of hate crime. Disability hate crime is still under-reported, accounting for only 3 referrals over the year. So there is still much that is needed to be done to ensure everyone understands that they are entitled to live a life free from abuse.

The London Fire Brigade has also taken a lead in Community action on Dementia in Brent, promoting safety in the home to people living with Dementia.

Disability hate crime is still under-reported, accounting for only 3 referrals over the year. So there is still much that is needed to be done to ensure everyone understands that they are entitled to live a life free from abuse.

Deprivation of Liberty Safeguards activity in 2014-15

The Mental Capacity Act 2005 provides a framework for making decisions on behalf of people who don't have the mental capacity to do so for themselves. Deprivation of Liberty Safeguards (DoLS) procedures are designed to protect vulnerable adults who can't make decisions about treatment or care, who need to be cared for in a restrictive way. For example, some people who have dementia, a mental health problem (but are not detained under the Mental Health Act 1983) or a severe learning disability and need to be under constant supervision in their daily activities and/or they would not be free to leave those arrangements because they are necessary to keep them safe from harm.

The aim of the safeguards are to:

- make sure people can be given the care they need in the least restrictive way. This means following good practice in care homes and hospitals
- prevent decisions being made to suit the home or hospital rather than the needs of the person receiving care
- provide safeguards for people in receipt of restrictive care to ensure regular reviews of their care
- provide the rights to challenge unlawful detention against the person's will.

Best Interest Assessors (BIAs) find out whether a deprivation of liberty is in the best interests of the person. If the authorisation is to be granted, the BIA ensures the least restrictive option is in place. They act independently from those responsible for deciding and funding the care required for a vulnerable adult.

Nationally there has been a sharp rise in the numbers of applications for authorisations following a legal case in March 2014 which provided clearer guidance on when the safeguards should be applied. This decision ensured many more people benefited from the additional assessments undertaken and, where applicable, advocacy support available to ensure that the care they received is in line with their best interests. Brent Council, in line with the picture nationally, saw a rise from 18 cases in 2013-14 to 449 applications in 2014-15, 29 cases related to people receiving care in hospital and 420 were for individuals living in residential care. 29 requests were not granted. In addition, there were a further 16 cases referred for assessment where the person was living in supported living accommodation. These are considered separately through applications to the Court of Protection and 7 applications have been submitted to date.

The change in the law has had a national impact and put pressure on qualified BIAs. In response to this increased pressure the SAB secured funding to train further BIAs and partners are working together to raise awareness among providers, regulators and care management staff of the need for health and social care providers to recognise appropriate cases and refer for authorisation. Despite this considerable pressure it is to be applauded that 214 of the assessments were completed within the strict time limits given under the procedures and a further 235 were completed within the extended time limit.

The Board continues to play a key role in the strategic oversight of the management of the DOL Safeguards, highlighting the changes in practice required as a result of the changing case law and responding to the Law Commission's proposal for reform of the legal framework.

What next…

The LSAB has set out in the Strategic Plan the work plan for 2015-16. The focus for the year will be to evidence improvements in practice and ensure that partners are compliant with the new safeguarding duties set out in the Care Act.

Central and North West London NHS
NHS Foundation Trust

Ealing and Harrow Hospital NHS
NHS Trust

London North West Healthcare NHS
NHS Trust

London Ambulance Service NHS
NHS Trust

CareQuality Commission

LFB
LONDON FIRE BRIGADE

METROPOLITAN POLICE

Brent lscb
local safeguarding children board

mencap
The voice of learning disability

Brent Community Safety Partnership

National Probation Service

healthwatch

Brent

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