Brent Safeguarding Adults Annual Report 2012/2013
Executive Summary

Brent's Adult Safeguarding board's (BSAB) primary objective is to protect adults at risk (vulnerable adults) and ensure they are safe from significant harm. The board is currently chaired by the director of Adult Social Care, and includes a wide range of organisations that are crucial to delivering this primary objective. Each year the Board produces an Annual Report, and this is the draft Executive Summary of the report for 2012/13. The Board identified 6 priorities for 2012/13 and an overview of progress against each of these priorities is set out below.

1. Effective implementation of the pan London Safeguarding Adults procedures

The work focused on ensuring that all the key statutory organisations in Brent had fully implemented the Pan London procedures. There was a particular focus on Brent Council's Safeguarding Adults (SGA) Team, which takes the lead on investigating all Safeguarding Adults alerts and referrals in Brent. It is the key operational link between all the agencies represented on the BSAB. The procedures have been implemented across all the key statutory organisations and training and operational policies are in place to back this up. However, further work now needs to be done to raise awareness with a wider range of organisations, particularly in the voluntary sector. The focus in 2012/13 was the quality of the response to any allegation - ensuring the person was safe and the allegation was thoroughly investigated. 10% of all SGA referrals have been audited through the Board's multi-agency case audit process to check the quality of process. The audits have provided evidence of the quality of the SGA response (and performance data shows that there was a reduction in the number of inconclusive investigations, they fell from 32% in 2011/12 to 23% in 2012/13. However, the audits also identified the need for a clearer focus on the speed of the response: the timescale for screening the SGA alert and the timescale from alert to conclusion of the SGA process. It has also identified the need to ensure that the 'adult at risk's' voice is clearly heard and their outcomes clearly recorded. The Brent Council SGA team has been restructured to ensure these are priorities in 2013/14.

2. Excellent case recording and communication

The work focused on improving case recording and communication across all agencies because this is the foundation for multi-agency working. There have been some identifiable improvements in this area. The advice provided by the SGA team was reported by most organisations to be very good. There are specific examples of improvements being made in information sharing including the reduction in duplication between the SGA procedure and health's Serious Incident process. Brent Council SGA Team has continued to improve their case recording systems and ensure that clear defensible decisions are being on best evidence and that the voice of the 'adult at risk' is clearly recorded in those decisions. However, further improvements are still required. The SGA team will need to focus on feeding back to 'alerters' after **all** SGA alerts to ensure that people know what has happened after they have a raised the alert. Providers (private and voluntary sector agencies) have indicated that they think they would benefit from further training in regards to the criteria for safeguarding and carrying and appropriately recording robust investigative actions.

3. Improved multi-agency working

This work focused on dealing with day to day work between agencies on individual cases because we know that the only way we can successfully protect 'adults at risk' is by working effectively together. There is evidence of good engagement from all agencies in the pan London SGA process. This has been facilitated by the SGA team taking the process to partners, for example, holding strategy meetings in hospitals and doctors surgeries to make it easier for other

people to attend. This is a positive step, but the commitment of all partners needs to be maintained going forward. For example, specific work was undertaken between the Police and the SGA team at the start of 2012/13 to improve communication, particularly at the alert stage, which improved joint working. However, during the annual review process, it was identified that police attendance at key meetings could be further improved.

The multi-agency safeguarding audits, which happen every two months, and always involve a range of people from different organisations, have underpinned this commitment to improving multi-agency working. They will continue to be a key focus for the Board. They have worked well, and have identified the strengths and areas for improvement, but one of the challenges in 2013/14 is that they have been led by the SGA team, and have tended to focus on the role of the SGA team and their records, and there is a need to make them genuinely multi-agency in 2013/14.

4. Core practice standards that prevent abuse

This work was focused on improving core assessments in health and social care as the evidence shows if agencies do their work right first time, we can avoid or reduce the risk of abuse. This priority has not been addressed systematically through the Board as individual organisations have their own quality assurance processes in place. However, there has been a focus on particular issues. For example, there was an increased focus in 2012/13 on reducing pressure ulcers, which led to improved equipment and processes in the local A&E and has identified additional work that needs to be undertaken in 2013/14 in nursing homes, community nursing and domiciliary care agencies. Reducing the risk of financial abuse has also been identified as an area which would benefit from a targeted focus on core practice across agencies to reduce the risk of abuse.

5. Commissioning for quality

This work focused on the importance of contracting and contract monitoring in setting and monitoring the standards that should reduce the risk of abuse. Like Priority 4 individual commissioners have their own quality assurance processes in place, so the Board has focused on improving the communication between commissioners (social care and health) and the regulator (Care Quality Commission). There are now quarterly meetings to monitor the quality of registered services commissioned in Brent, which influence the contract monitoring and quality assurance work that each organisation does. The Board wants to continue and build on this in 2013/14 to look at how it can improve the quality of all services, but also in how we can address particular issues such as the increase in pressure ulcers identified above. The Board will also require more regular and robust reporting of the impact this improved communication is having.

6. Cultural change

This work focused on increasing awareness of the abuse of adults. During 2012/13 there was a large publicity campaign which ran adverts in prominent public places. There is evidence that this has resulted in increased SGA alerts (alerts in the first quarter of 2013/14 were 25% higher than in 2012/13). This is positive because we have to make sure that people know how to report concerns and are comfortable raising those concerns. However, through the annual review process there is some concern that the publicity campaign may not have reached all parts of the community and may have missed some key organisations, such as housing and prisons. Therefore, there is a need to continue this awareness raising work and in addition to the general awareness raising we need to develop a more targeted approach, which not only focuses on awareness raising with different groups but also develops additional messages – the first campaign focused on stopping and reporting abuse, there is also a need to focus on helping people to stay safe and avoid abuse in the first place.