Brent Safeguarding Adults Board
Annual Report
2012/13

Introduction

This is the 9th Annual report of the work of the Brent Safeguarding Adults Board (BSAB). The aim is to provide an overview of the work done in 2012/13 and the difference this work has made to the residents of Brent as well as outlining the priorities for 2013/14.

The report's development was led by the BSAB, but the aim was to make it an inclusive process. A number of specific events were organised including the BSAB business planning away day (in addition to one to one interviews), a series of workshops with service users and carers front line staff, provider representatives, and the final event where the draft was finalised – the first Brent Safeguarding Adults conference in November 2013.

Safeguarding Adults

In 2000 the Government published 'No Secrets', which prioritised the need to safeguard vulnerable adults from abuse, which they defined as follows:

- A 'vulnerable adult' (now described as an 'adult at risk'): a person aged 18 years old or over "who may be in need of community care services by reason of mental or other disability, age or illness: and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation."
- Abuse: "A violation of an individual's harm or civil rights by any other person or persons."

'No Secrets' 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 the co-ordination of local action is local multi-agency Safeguarding Adults board and the local codes of practice which underpin multi-agency practice.

National Developments

Whilst 'No Secrets' still remains as the governments principal statutory guidance, there have been further national developments that continue to shape the understanding of safeguarding adults' policy and best practice and inform action in Brent. In 2012 the government published the draft **Care and Support Bill** which has outlined some key implications for safeguarding.

Until now there has not been a national legal framework for adult safeguarding, and strengthening safeguarding arrangements is a significant priority within the new Bill. For the Safeguarding Adults Board the proposed legislation requires that:

- The local authority to establish a Safeguarding Adults Board (SAB) in their area, which should include the local authority, the NHS and the police

- The SAB to develop its own plan (with the community) publish this safeguarding plan and report annually on its progress against that plan, to ensure that agencies activities are effectively coordinated, and
- The SAB arranges for a safeguarding adults review to take place in certain circumstances, where an adult dies or there is concern about how one of the members of the SAB conducted itself in the case

In terms of responding to alerts the proposed legislation requires that:

- Local authorities make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in their area with care and support needs is at risk of abuse or neglect
- Local authorities are not given powers to enter a person's property or take other similar action to carry out the enquiry.

This is an encouraging and significant step forward for the effort around safeguarding activity as it now becomes enshrined in statute.

Regional Developments

The implementation of the Pan London Safeguarding Adults procedures published in January 2011 still remains the main regional focus for safeguarding. The aim to ensure that 'adults at risk' do not fall between the gaps between London Boroughs (by identifying lead boroughs) or between services (by identifying lead roles and responsibilities remains, as well as avoiding duplication or omission of activity through these procedures. A key focus over the last year for most BSAB members has been the implementation of Pan London procedures.

Safeguarding Adults in Brent

The Brent Safeguarding Adults Board (BSAB) was established in 2008. The Board is made up of statutory, public and voluntary organisations in Brent and meets six times a year and is currently chaired by the Interim Director of Adult Social Care, Phil Porter. The membership of the board is set out in detail in Appendix 1. The BSAB's primary objective is to ensure the protection of adults at risk of significant harm and in order to achieve this it must ensure that safeguarding adults is everyone's responsibility.

Brent also has a Safeguarding Adults Team, which is based in Brent Adult Social Care. The team takes the lead on investigating all Safeguarding Alerts in Brent. The team is the key operational link between all the agencies represented on the BSAB and any other people and organisations that need to be involved in safeguarding adults in Brent.

Review of 2012/13 Business Plan/Priorities

The priorities agreed for 2012/13 were organised around the following themes:

1. Effective Implementation of the Pan London Procedures

The main aim of this priority was to improve practice at each stage of the Pan London process itself. This priority is primarily focused on the ASC Safeguarding Team and how they manage each stage of the process (for example, screening, Strategy Meetings, Investigations and Case Conferences), but was also applicable to the effective implementation, response and participation of other organisations on the BASB.

This annual review highlighted that most organisations have implemented Pan London procedures, with underpinning policies, demonstrating widespread ownership, with just one organisation still in the early stages of implementation. Interviews and documentation reviews did show that organisations had a good understanding of Pan London processes and that safeguarding is seen as a priority by organisations despite capacity and resource pressures. Most BSAB organisations had undertaken significant staff training campaigns followed up by spot checks to test awareness levels and revisit training as necessary. Some felt that certain disciplines were easier to persuade that safeguarding is 'everyone's business' than others, but the knowledge of this was shaping future training campaigns.

The implementation of Pan London has brought a consistency of approach, understanding, awareness and expectations across BSAB organisations. Staff working within large multi borough organisations (like Central North West London Foundation Trust) can work to the same approach across boroughs. However, there is some duplication with Pan London and other organisational processes for example Serious Incidents within the NHS, and the dual processes can sometimes cause confusion and work has been done to align the Serious Incident process for Pressure Care in particular and the Pan London process operationally in Brent.

It was noted by Board members that it is hard to evidence the improved outcomes from implementing Pan London. However, a number of improvements have been made over the last year. These have driven by the multi-agency audits which are set out in more detail in Section 3 of this report

Another achievement was the introduction of an agreed ''self neglect' policy, (not currently contained within the Pan London guidance), and resources in the ASC Support Planning team have been aligned to co-ordinate individual cases, with multi-agency support from SGA Board partners. The effectiveness of this policy will also need to be reviewed the Board.

In addition to the actions in the action plan, areas where further work is required are focused on non statutory agencies, where implementation is not always as well embedded. For example, a provider workshop highlighted the wish for further training on Pan London processes and timescales, (followed up in next section). They also raised the importance of timescales compliance in the investigation process, as delays can potentially reduce their willingness to report safeguarding issues due to the associated costs of suspending and replacing staff.

Informal carer workshops held as part of the annual review revealed the need for greater work around raising awareness of safeguarding issues in general, the existence of the BASB and the safeguarding team, how to make referrals and under what circumstances one might make a referral. Work is underway to develop short and focussed training with these informal carer groups at the Carer forums. All groups interviewed had some awareness of the publicity poster and leaflet campaign the Board had carried out, but it was clear that this kind of activity needs to be repeated at regular intervals, and that there is a cost implication for this.

2. **Excellent case recording and case communication** - the Independent Management Review (IMR) carried out in 2011/12 last year, was clear that all agencies should have recorded and communicated information more effectively. Therefore, this priority is focused on improving case specific recording and communication across all agencies in core practice and all stages of the Pan London procedure.

Our review results found that in general, those coming into contact with the SGA team to discuss issues around safeguarding felt they gave good advice and guidance, talking through a range of options for staff to follow if a case did not meet the referral criteria. This advice was highly valued by social worker staff in particular. Staff also valued to opportunity to talk through complex cases with the SGA team and in fact requested/ suggested regular secondments to the team to build their own knowledge.

In terms of case recording and communications, there have been improvements made to case conclusions and decision making and this is now mandatory to complete on the system to ensure all outcomes are recorded. The multi-agency audits, sub groups and the board had suggested a number of changes to recording systems to ensure that this delivers on board requirements for information, which has made recording processes more efficient. The safeguarding alert form was altered to ensure it captured all the essential information for reporting and to enable the SAM to make a decision about the referral Brent SGA team are now concluding significantly more cases, more quickly than 2011/12, which will also contribute to improved outcomes for people.

Despite the focus on improving investigations, there remains a portion of 'inconclusive' cases which the board believe warrant further exploration through case auditing, to see whether the effective acquisition of evidence or improved recording of decision making on the 'balance of probability' could be further improved. The percentage of cases has fallen from 32% in 2011/12 to 23% in 2012/13, and targets will be set for this in 2013/14 to maintain the focus on reducing the number of 'inconclusive' outcomes.

There remains more work to undertake with providers on case recording and communications. Providers have requested more general training on a range of areas such as case recording, use of evidence and key processes as well as improving their understanding of referral criteria.

Whilst the advice of the SGA team advice was highly valued by staff, staff and providers requested more communication from the team on roles, responsibilities, referral criteria and thresholds, especially feedback as to why someone doesn't meet the criteria, as this remains unclear to some, but can be useful in preventing future inappropriate referrals. Signposting to other services or agencies, by the SGA team was not always clear and could improve. All acknowledged the staffing difficulties the team has experienced recently. The SGA screening tool has not been as widely distributed as it should have been.

Along this communication theme, a regular flow of feedback to and from service users on their experiences and gauging their satisfaction with the process was felt to be important and useful to developing a high performing team. The customer care survey and carer survey provided some general information, and the follow up customer care training was specifically geared towards the needs of safeguarding clients. More detailed and specific information from customers would help to highlight areas for improvement.. A priority for 2013/14, after the implementation of the SGA team restructure, will be the introduction of systematic feedback through the Safeguarding Liaison Officers. It is proposed that each of the 4 SLOs will speak to people at the end of the SGA process to get independent feedback on the process and their outcomes.

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 (between the Adult Social Care Safeguarding Adults Team, Police and Health)

Central to the Board's evaluation of multi-agency working is the multi-agency audit process. 10% of all cases are audited against the Pan London process, but more importantly, to understand the impact and outcomes of the process for the adult at risk.

The audits happen on a 2 monthly cycle, and have involved over 20 different people from 10 different agencies. There were 6 audits through 2012/13, which focused on:

- Inconclusive Learning Disability referrals - identified because there were relatively high percentages of LD referrals ending in an inconclusive outcome. There has been a reduction in the level of inconclusive outcomes.
- Repeat Referrals – the Board wanted to understand what was driving repeat referrals. The Board was reassured that the majority of repeat referrals were unavoidable
- Quality of Investigations – one of the actions identified in the LD audit was a need to improve the quality of investigations, this audit provided a broader base for that improvement work, and a detailed action plan which included private sector providers
- Mental Health referrals – identified because the MH SGA capacity had transferred into the ASC SGA team. This confirmed the challenges that the Trust had identified and
- Nursing home referrals – due to high levels of nursing home referrals, and has led to a multi-agency focus on the level of pressure care incidents in Brent
- SGA alerts that had been screened and not progressed through Pan London – the performance data showed increasing percentage of alerts being screened out of the SGA process. The cases sampled evidenced to the Board that the screening process was robust and was focusing the SGA team on the right cases.

Each audit was reported to the Board with priority conclusions and actions – actions which fed into the Board's overall action plan. The action plans is overseen by the Performance and Audit sub group to ensure they are completed. Progress against this action plan has been good, but there are outstanding actions and these will be addressed through 2013/14. The actions have tended to focus on the SGA Team rather than partners, which is something that needs to be addressed in the audit methodology in 2013/14.

Another positive achievement is the noted improvement of attendance at strategy meetings made this year, particularly in relation to hospitals, Adult Social Services staff and the Police. However, further improvements need to be made in relation to urgent strategy meeting attendance from community and private sector providers, GPs (although some recent improvement is evident after the locality based GP SGA training which was undertaken in the last quarter of 2012/13)and hospital wards in relation to pressure ulcer referrals. Although these organisations are engaged and willing to set up meetings, locations which suit everyone can be a challenge, therefore working on how we can ensure that safeguarding is prioritised equally at operational level for each organisation is required. BSAB partners felt that there

needed to be further work to improve working with the Police and streamline reporting mechanisms, but also to develop more clarity around the identification of criminal safeguarding issues and to ensure that safeguarding is adequately prioritised.

Board Partners did express that although there have been improvements there is still more to do to strengthen multi-agency working. Strategically there are strong working relationships, but more contact and communication at operational level could filter this benefit down to operational working. A multi-agency approach to training has been identified as a key way of building these improvements. Adult Social Services have taken a lead on training through the 'Prevention, Communication and Workforce Development sub group', which has developed training around the SGA Capabilities framework. A matrix defining the level of information required for different target audiences, for example social worker knowledge requirements will be higher than members of the public. Future plans include the intention to map the national SGA capabilities (matrix requirements) against all roles across partner agencies and voluntary sectors, and to realign all training to this matrix and the Board's priorities. Agreeing the process for auditing and validating the content and expected outcome of agencies SGA development activities, and establishing further ways of sharing knowledge and expertise.

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

Through this objective the Board highlighted the critical importance of the work we all do, day to day, and how it is critically important in avoiding abuse. There is no doubt that this is an important objective, but its breadth (we are talking about the day to day practice of all health and social care professionals) makes it difficult to measure change and improvement.

We know from the multi-agency audits, that an incident (similar to the incident that led to the IMR) happened in 2012/13 and that the situation did not escalate as it had done in the IMR case. This case highlighted the improved performance of the SGA team and core practice of the care management teams, but the importance of residential and nursing providers carrying out robust assessments on admission and the Board ensuring that providers have the confidence to challenge placements even when there are pressures to accept, remains an issue, which the Board will need to focus on.

A key priority identified and agreed as a shared priority in 2012/13 was pressure ulcers. Within the NHS, during 2012/13 high numbers of pressure ulcers were observed going through A&E and in nursing homes. Investigation revealed that trolleys might be a contributory factor. Mattresses have now been changed to

memory foam, staff now assess pressure areas every 4 hours, and a grading tool for staff to use to risk assess has been developed which is shared with the safeguarding team via a database. It is also easier for staff to access pressure area prevention equipment and ordering this has been streamlined. A report on pressure ulcer care was presented to the Board in June 2013, and an action plan which will lead to training and development linking up with the Nursing Home Support Team. There is a current focus on the Pressure Ulcer Forum and encouraging care homes and nursing homes to attend, through which work on identifying targeted training needs has begun, including developing lists of all nursing homes complicit with training, and a domiciliary support list.

Board members concluded that is improved awareness generally, and referral processes are well known amongst most organisations, there is also improved risk identification. The NHS has undertaken work around better evidencing of mental capacity with staff, and the children's safeguarding board has improved national guidance and therefore practice by raising awareness around the fluctuating mental capacity of young people over periods of time.

A range of approaches to monitoring standards and to quality assure responses to safeguarding, exists across the board organisations but varies considerably in depth. Most organisations conduct audits, collate referral data, analyse trends and explore case discussion for example in piloting different tools such as the 'safer care round document'. (The 2 hour checking tool for pressure area care - NHS). Some audits resulted in changes such as increasing staff training and awareness (for example Transport workers working with clients with Learning Disabilities), writing staff guidance documents, training in nursing homes via the Nursing Home support team, developing tool kits and refining appropriate referrals by identifying through analysis.

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

There are good informal relationships and regular communication with providers and also between agencies on concerns about providers. Regular meetings between the Care Quality Commission representatives and the NHS, and Adult Social Services have been set up to monitor and discuss any issues around commissioning, contract monitoring or providers and an issue log is in place to monitor and record any issues. These meetings bring together intelligence from the NHS, ASS and CQC to enable robust monitoring of our commissioned and registered homes and agencies and to instigate inspections and proactive work with homes and agencies where concerns are raised. This information also feeds into provider meetings held by commissioning with individual home care agencies. The Board suggested that a new contractors pack which safeguarding would be a part of is developed as part of the on going work with providers.

Work has begun (as stated previously) on pressure ulcer prevention, with nursing support teams set to deliver training to providers. However, there is more work needed to deliver training on a number of areas on Safeguarding to Providers and Community Care settings. A workshop held with providers found that knowledge varies considerably, with some providers requesting more training safeguarding, processes, referral criteria, and investigations. They have also expressed the need for greater clarity on their role during investigations and in protection plans and how to supply evidence for safeguarding processes. They raised issues around the potential conflict of interest if they are leading an investigation into the conduct of their own staff. Also raised was the importance to providers of the safeguarding team adhering to timescales, as there can be significant costs to providers if staff are suspended and replaced by agency staff. This some felt could inhibit reporting and needs addressing.

At the business planning day, issues were raised around the variable quality of care in nursing homes. Patients are often being admitted to hospital with dehydration or urine infections which points to very basic quality issues. Often homes are reliant on one or two lead nurses, and when they leave things can deteriorate quite quickly. Within Brent, the GP contracted support to community care homes is on an ad hoc basis. The Board needs to lobby the Clinical Commissioning group for GP contracted support to be better structured, as well as generating more skills training on clinical practice in nursing homes.

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 adults, for example, promoting dignity and respect for all, including those with dementia

Key achievements over the last year around prevention include the poster publicity campaign 'Abuse, See it, Stop it' and leaflets distribution across a wide area in Brent including GP surgeries, schools, libraries, Day Centres, Community Care Placements, Leisure centres, shops, voluntary agencies, and Private companies in the Care industry (E.g. Telecare). In addition, website information was revised and updated. This has led in an increase of referrals from 200 to 300. The Board also carried out successful training for GPs on safeguarding which was well received.

The business planning day did consider the need to improve prevention activity in areas the board has considered but not been able to progress yet. The prison population has a significant number of vulnerable people, those with learning difficulties or mental health issues, who upon discharge to the community are often vulnerable and at risk. The Probation representative to the board has agreed to bring some initial information to start the conversation about ascertaining what kind of safeguarding activity might be beneficial for these cohorts. Two informal carer workshops also revealed significant lack of knowledge about safeguarding issues in general and on the referral process. Further training is planned with the Brent Carers Centre, and carers expressed that a running programme of short and focussed

sessions (1 hour every 6 months) would be the most appropriate way to address their needs.

The board felt that there will always be more work to do in ensuring staff have the right skills, which brings a strong role for Learning and Development, using the continuous learning from serious case reviews, ensuring staff are aware of the 'duty of candour' (NHS) and whistleblowing policies.

It was noted that Children's services do provide service user training, whereas the only organisation currently identified providing user training to adults (on identifying/preventing abuse to themselves) was Mencap. They acknowledged that this can bring difficulties with vague and hard to evidence reporting from users self referrals, but the board felt that it is still important and empowering and it would be good to explore this further in the future.

Board members expressed the desire to explore an even wider approach to prevention to bring about the cultural change desired which means developing an understanding of why safeguarding issues occur in the first place. Some agencies have already begun work in this area, but a more coherent approach would be more effective. For example; The setting up of early referral and intervention systems in Accident and Emergency departments in relation to identifying and intervening in domestic abuse situations; Examining the relationship between Pressure Ulcers and low staffing levels; Looking at how safeguarding affects younger as well as older people; Investigating the impacts of welfare reform, overcrowding in housing, and the recession on safeguarding issues, and developing a multiagency strategy on prevention which incorporates research into these underlying causes. This theme is taken up within the development of new priorities under board effectiveness.

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.

There is very good regular attendance by board members and attendees are high level so able to make decisions relating to practice, board members are also genuinely interested and concerned with the issues discussed.

Board members have good strategic working relationships with each other and do consult each other easily on safeguarding issues, but there is a need to translate this to develop greater co operation at operational levels as described above. There is still a view amongst some organisations to see safeguarding as the domain of the local authority and that more joint ownership needs to be further established. The national legislative imperatives may help to address this. Some board members interviewed felt that there was a need for the organisations attending to share more about their own safeguarding issues for joint learning purposes.

The annual review has also highlighted the need to broaden membership to strengthen operational working so that nursing/residential and home care providers are represented along with potential to invite a range of other organisations such as Social Housing Providers, the prison service and a Children and Families lead, in addition to the Local Safeguarding Children's Board representative. This as well as expanding the view of the board may well offer some useful challenge to the board.

The administration of the board needs to improve. Reports need to be circulated earlier, performance information needs to be presented in less dense reporting formats to make it easier to interrogate, and there needs to be more focus on co-production and less focus on 'signing off' papers.

BASB Priorities 2013/14

The 2013/14 priorities are underpinned by the outputs from a number of key activities:

- On going performance and activity data monitoring focused on the abuse of vulnerable adults dataset
- The 2 monthly multi-agency audits
- Board meetings, sub groups and issues raised by Members of the Board
- The Annual Review process which has underpinned the production of this Annual Report and included individual interviews, documentation reviews, workshops with service users, carers, front line staff, providers, the first Safeguarding Adults Annual conference and the business planning afternoon itself with the Board.

The conclusions the Board has reached are that:

- a lot was achieved in 2012/13 , there is still further work to do on last year's priorities (for example, and this should not be lost in the priority setting for 2013/14)
- However, there is also a need to rework the objectives to reflect the progress that has been made, but also to take a strong focus on particular forms of abuse as well as a thematic approach.

The priorities for 2013/14 are:

Reducing financial abuse and a more effective multi-agency response:

- Raising awareness of financial abuse
- Putting in place core actions (through statutory and voluntary sector partners) to prevent abuse
- Ensuring an effective multi-agency response to financial abuse
- Reducing the number of inconclusive outcomes for financial abuse referrals.

Reducing avoidable pressure care incidents:

- Targeted training focused on informal cares and care providers (residential, nursing and home)
- Single multi-agency dataset, which reports to the Board and drives service improvements
- Implementation of an agreed multi-agency action plan.

1. **Improving Processes and procedures to embed high quality standards**: This is to incorporate a focus on the **effective** implementation of Pan London processes and timescales; to include the focus on excellent case recording standards through further training, auditing and monitoring; and core practice standards to improve safeguarding, now that Pan London has been implemented across most agencies. This will involve greater sharing of information across agencies, Community Safety unit information sharing and greater communication between agencies on cases.

2. **Improving Multi-agency working and Board Effectiveness:** This is to bring the board's focus from the previous (yet necessary) focus on establishing processes and procedures of dealing with Pan London, safeguarding issues and agency interfaces to more towards **effective outcomes**.

    a. The board has established some good effective working relationships and could now extend its practice to developing broader **prevention strategies** by researching the underlying, wider underlying causes of safeguarding incidents. This would include the effects of recession, welfare reform, housing overcrowding.
    b. Bringing a more holistic approach and wider debate to the board on wider issues of abuse than the most common known, (financial, sexual, physical, emotional, psychological), but with a clearly set outcomes for each activity, for example, to educate and raise awareness of the community about forced marriage, FGM.
    c. A revision of the **performance data** we currently collect, to examine what the data really tells us and what we could usefully collect which could better inform the board of its effective ness. This alongside the setting of some **SMART measurable objectives, an agreed dataset,** with review timelines could bring a new focus to the work of the board around outcomes and prevention.
    d. In addition regular learning and sharing lessons from Serious Case Reviews and a **Peer Review** was suggested to bring external challenge to the Board, as well as an **induction** for new board members joining.

3. **Changing broader culture, commissioning for quality, skills and standards:** This remains as a priority as there is still some further work to do with providers and others as the Board seeks to embed establish the message that safeguarding is everyone's business.
    a. The suggestion of a **generic training package** designed by all the agencies together to be delivered in a **multidisciplinary setting** would

enhance working relationships operationally, but also broaden safeguarding themes to include the work of the fire brigade, occupational therapists and other disciplines, but also train staff across disciplines to identify and recognise safeguarding issues in the multitude of ways and settings in which it can present.

b. Using **user feedback** on their **safeguarding experience** more to **shape safeguarding practice**, **highlighting dignity and respect** and shaping service delivery should increase as part of core service design and **contract specification** more explicitly than is currently the case

c. Taking the **safeguarding message** from beyond the professional and voluntary and provider base to **others in the community** such as civic leaders, multi faith forums, GP's (specifically relevant for Brent with high levels of hate crime) to raise awareness in a more focussed way with those who may be uniquely placed to spot abuse in the community, for example Female Genital Mutilation, forced marriage, addressing the tolerance of abuse of those with Learning Disabilities and so on.

Appendix 1

Brent Safeguarding Adults Board membership – 2012/13

Chair – Director of Adult Social Services: Alison Elliott
Brent Council: Head of Reablement and Safeguarding – Phil Porter
Brent Council: Head of Commissioning – Steven Forbes
Brent Council: Legal Services – Fiona Bateman
Brent Council: Safeguarding Team manager – Devika Govender
Brent Council: Head of Housing Needs – Laurence Coaker
Brent Mencap – Ann O'Neill
Local Safeguarding Children's Board – Sue Matthews
Brent Clinical Commissioning Group – Clinical Director, Mandy Craig
Brent Clinical Commissioning Group – Assistant Director, Sarah Mansuralli
North West London hospitals Trust – Deputy Director of Nursing, Bridget Jansen
Ealing Hospital Trust – Community Services Director – Yvonne Leese
Central and North West London Foundation Trust – Borough Director, Natalie Fox
Brent Police – Detective Inspector – Mike West
London Fire Brigade – Borough Commander – Terry Harrington
Care Quality Commission – Judith Brindle
Probation Service – Deirdre Bryant
London Ambulance Service – Hannah Storer