Brent

BRENT SAFEGUARDING ADULTS BOARD ANNUAL REPORT **2015-16**

CONTENTS

FOREWORD

It is my pleasure as the incoming Independent Chair of Brent Safeguarding Adults Board to introduce this annual report of the Board's 2015/2016 activities and performance. With the support of Board members, the report has been compiled by the outgoing Independent Chair, Fiona Bateman, to whom thanks are owed for her leadership in interesting times.

The year that is reported on, namely 2015/2016, saw the implementation of the Care Act 2014. This placed Safeguarding Adults Boards on a statutory footing, specified the circumstances where Safeguarding Adult Reviews must and may be commissioned, required Boards to produce annual reports and business plans, and itemised the roles in particular of three statutory partners, namely the local authority, the police and the clinical commissioning group. The types of abuse and neglect with which Safeguarding Adults Boards must have policies and procedures, have been extended to cover, for example, self-neglect and modern slavery, alongside physical and institutional abuse, discriminatory abuse and domestic violence. The Care Act 2014 requires all agencies with roles in the protection of adults from abuse and neglect to co-operate both in strategic planning and in the operational delivery of services. It also emphasises that services should be acutely tuned into the needs and aspirations of people needing care and services, with a particular focus on the outcomes they desire through an approach known as 'making safeguarding personal'.

Thus, in the year reported on in this annual report, the focus has inevitably been on ensuring that the Safeguarding Adults Board, with the partner agencies represented on it, are Care Act compliant. In addition, however, the Board has also engaged in the on-going business of ensuring that adults at risk of abuse and neglect are effectively protected. This has included the completion and implementation of recommendations from a safeguarding adult review, investigation of concerns about the quality of care delivered by care providers, and the monitoring of practice when people may have to be deprived of their liberty. It has also meant raising awareness of the new legal rules relating to adult safeguarding, introduced by the Care Act 2014, amongst practitioners, managers and the general public.

Reading and reviewing this annual report, several points of significance emerge where I believe it is important to set down a direction of future travel. Firstly, within the data that are reported, there are a number of unknowns. These figures, where they appear, need to be reduced as they demonstrate, albeit as a rough measure, how making safeguarding principles are being implemented and how effective Board partners are at ensuring that the person is at the centre of the safeguarding processes. If, after screening or even at conclusion of any enquiry or intervention, staff are not able to confirm the person's ethnicity, primary support reason or mental capacity, then it demonstrates poor practice in recording and/or person centred investigations. The figures are not dissimilar when compared to national data, but the 'unknown' figures are higher than reported in Brent last year. BSAB has improved practice by setting targets in the past so this will be something to consider going forward.

Secondly, in order to demonstrate the commitment of partner agencies to the work of the Board and its sub-groups, it would be prudent and transparent to consider publishing attendance.

Thirdly, more needs to be done to establish a local process for disseminating learning from local and national safeguarding adult reviews. Rich learning is available from such reviews, for instance regarding effective practice with cases of self-neglect (Braye, Orr and Preston-Shoot, 2015) but a learning and development strategy is needed so that this learning is effectively cascaded throughout agencies and informs policies, procedures and practice.

Fourthly, raising awareness is a crucial part of adult safeguarding, alongside ensuring that systems are operated effectively to keep people safe. A communications strategy will help to ensure that all communities in Brent are aware of the work of the Board and how to engage with it. The annual report can play an important role here, for example by including more case studies on the work of the Board and its partner agencies. The work of the Board also needs to be informed by feedback from all of Brent's communities, not least in relation to issues such as hate crime, modern slavery, discriminatory and institutional abuse, neglect and self-neglect. Such feedback to the Board will help it to challenge what agencies are commissioning and providing, for example in relation to the provision of advocacy.

I look forward to working with the Board and the agencies represented therein and to engaging with Brent's communities to ensure that people at risk of abuse and harm are protected, and that people requiring care and support receive effective and person-centred services.

Michael Preston-Shoot
Independent Chair

Brent

NHS Brent

local mencap Brent

METROPOLITAN POLICE
Working together for a safer London

healthwatch Brent

National Probation Service

NHS Brent Clinical Commissioning Group

Brent lscb local safeguarding children board

CareQuality Commission

LFB LONDON FIRE BRIGADE

INTRODUCTION

The Brent Safeguarding Adults Board ['BSAB' or 'Board'] is a multi-agency partnership of statutory and voluntary agencies working together to review and improve local safeguarding arrangements.

From April 2015 BSAB acquired statutory functions to oversee and lead safeguarding across the London Borough of Brent. Partners within the Board retain operational responsibility for their core statutory functions, but through this partnership they:

- Participate in strategic decisions;
- Provide guidance on operational best practice;
- Gather intelligence on safeguarding practice in all health and social care provision in the area;
- Scrutinise and challenge reports for assurance that services are addressing risk and preventing harm to adults in need of care and support.

This report provides a summary of safeguarding activity carried out by BSAB and partners across social care, health and criminal justice sectors in Brent.

The report is divided into 4 sections:

- **Prevalence of abuse:** this section will set out what we know about the types and levels of risk faced by adults in need of care and support in the Brent area;
- **Multi-agency response to safeguarding risks:** this section will review the effectiveness of adult protection work to investigate and resolve cases where allegations of abuse and neglect were raised;
- **BSAB's strategic priorities:** this section will report on the work of each partner agency and what the BSAB has done collectively during the year to achieve its main objectives and implement its strategic plan;
- **Learning from case reviews to improve practice:** this section will set out the findings of any Safeguarding Adults Reviews and subsequent action taken to implement the recommendations arising from these, discretionary 'partnership' reviews and multi-agency audits of practice outcomes.

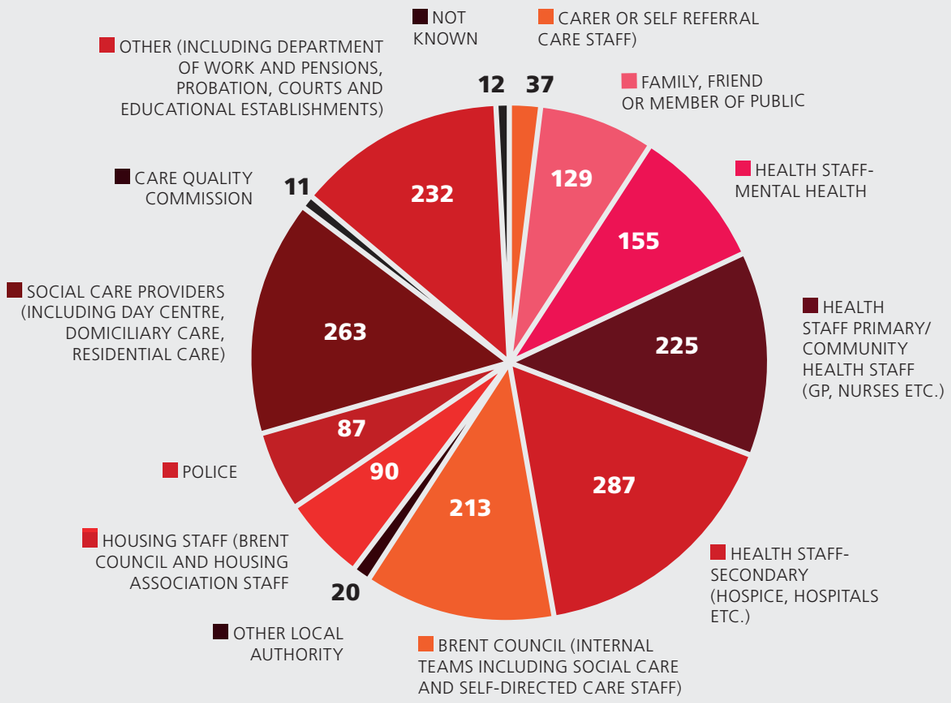
There is also information on the Board's expenditure for the period.

PREVALENCE OF ABUSE IN BRENT

The Board received reports at each meeting during the course of 2015-16 on key performance data from Brent Council's Safeguarding Adults Team ['SAT']. It was advised that the processes for triaging concerns and undertaking enquiries had been reviewed to ensure compliance with new duties under the Care Act, including ensuring that terminology used by the team was consistent with the statutory guidance issued by the Department of Health which amplifies how the powers and duties, rights and responsibilities in the Care Act 2014 are to be understood and implemented.

In 2015-16 the SAT received 1,678 concerns relating to 1,468 separate individuals. This means that 210 concerns were raised in respect of an individual who had already been subject to a safeguarding enquiry during the year (12.57% of all concerns). It could be that some concerns were raised by more than one source and that these may have identified different risks to the individual concerned. It may also be an indication that adults at risk are specifically targeted and subjected to repeat abuse, as is reported to be the case for those adults who have suffered financial abuse through internet or postal scams. The Board monitors and reports this figure in part to highlight the risk of repeated or persistent abuse. It also demonstrates how effectively those responding to concerns are working with the adult at risk to identify all possible types of abuse or neglect and agree actions. These both protect the adult at the earliest opportunity but also support them and, where applicable, their carer, family and friends to build resilience so they are better able to safeguard themselves from future harm.

Safeguarding 'concerns' were received from a variety of sources

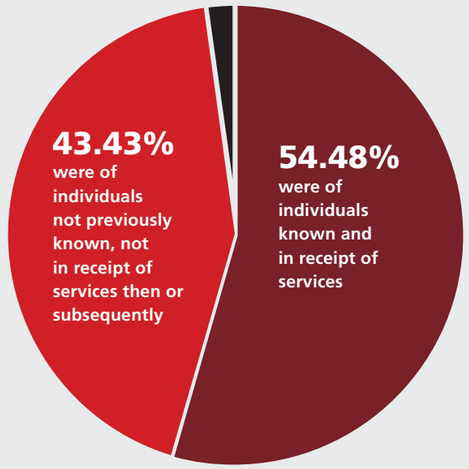


The source of referral and whether the individual was already known to social care services are no longer reported nationally; however, the Board continues to request this information as it is an important measure of how well one of our key messages, namely that 'safeguarding is everyone's responsibility' is understood. It is notable that there is a relatively high level of public awareness regarding safeguarding; 10% of concerns are raised by the public.

The SAT reported that they had reviewed their internal processes so that concerns could be initially triaged within 24 hours. Of the 1,678 concerns raised, 540 were not taken forward as safeguarding issues, a further 151 were concluded within 24 hours and a further 191 concluded within 7 days. The SAT reported that, in many of these cases, individuals were either not at risk of harm or were not in need of care and support. The SAT confirmed that, most would have been offered advice and information. Where there was a welfare concern they were referred to another, more appropriate, service, for example requesting an assessment of social or health care needs or a review of current care and support packages. In 3 cases the SAT referred to another local authority's safeguarding process as the adult at risk lived in another area. The team also reported that in high risk cases, as part of an initial enquiry, they made contact with each individual or a suitable representative. If necessary, for example because the adult lacked capacity and did not have a suitable person to support them, a safeguarding investigator would visit the adult at risk to discuss concerns and agree outcomes of any enquiry. During 2015-16 57 face to face meetings were held with adults, the majority of which were undertaken within 48 hours of receipt of concern but all visits were conducted within 5 working days.

Total number of safeguarding concerns received...

2.09% **were of individuals not known but who have since received a service.**



BREAKDOWN OF 'CONCERN' OUTCOMES

	CASES	INDIVIDUALS
Concern closed – no significant harm	540	489
Concern closed – risk of harm but the adult is not an "adult at risk"	151	141
Other local authority	3	3
Safeguarding Enquiry	984	835
Total	1,678	1,468

During 2015-16 BSAB partner agencies also agreed to report, where available, key performance data so as to allow BSAB to better understand how safeguarding concerns were identified and responded to across the partnership. It is still early days and understandable that many agencies will need to develop mechanisms to gather more accurate data. Indeed, a business plan objective for the next reporting year, 2016/2017, is to ensure that there is an effective common data set so that the Board has a coherent picture of safeguarding performance across the partnership. Nonetheless, the Board is grateful to Brent Clinical Commissioning Group (CCG), Metropolitan Police Brent, London Ambulance Service (LAS) London Fire Brigade, Care Quality Commission (CQC), Central and North West London NHS Foundation Trust (CNWL) and North West London Healthcare Trust (NWLHT) for providing this information and intends to build on this practice in the coming years so that BSAB is better able to carry out its statutory functions and support partners in core operational safeguarding activity. NWLHT report that staff raised 384 safeguarding concerns. Their report shows significant increase in reporting between each quarter, suggesting wider staff awareness of the duty to report and the procedure for doing so. The data also demonstrates NWLHT staff recognise all types of abuse, but by far the most common type of abuse identified by their staff was neglect (68% of all concerns). CNWL reported that staff raised 121 concerns. In all cases the adult was informed of the referral. 74% of concerns raised identified physical abuse (including allegations of domestic abuse and sexual harm) as the principle risk to the adult. A further 15% related to financial abuse. London Ambulance Service reported staff submitted 157 safeguarding concerns (a high proportion of which related to neglect or acts of omission). A further 258 referrals were made by LAS staff to Brent Council regarding the adult's welfare. London Fire Brigade carried out 2,139 home safety visits of vulnerable adults in Brent in 2015-16 and raised safeguarding concerns in 8 cases. They also reported conducting reviews into 3 deaths arising from fires in Brent during the period. Brent police reported that between April and September 2015 75% of the notifications referred by them related to individuals whom they felt had an underlying mental health concern and 69% were due to concerns of self-harm or neglect. Close liaison with Brent police continues. The period from the beginning of April 2016 to the end of September 2016 saw 45 cases referred to adult safeguarding by Brent police and 38 cases referred to Brent police by adult safeguarding. Whilst not all of the reported concerns received by adult safeguarding required a Care Act 2014 section 42 enquiries, this data demonstrates staff are more confident in distinguishing between welfare and safeguarding concerns and have a better understanding of safeguarding processes than in previous years. This is important as it ensures that staffing resources are more effectively used to carry out safeguarding work. It also reduces duplication and delay for adults because referrals are more frequently now submitted through the most appropriate channels.

Of the 1,678 concerns raised during 2015-16, 715 met the threshold[1] for a safeguarding enquiry. 904 enquires were completed during this period; some of these related to concerns raised before the reporting period, but another 62 individuals were supported by the SAT although the concerns raised did not meet the statutory criteria. The data below therefore relates to 616 individuals involved in concluded section 42 enquiries during the year.

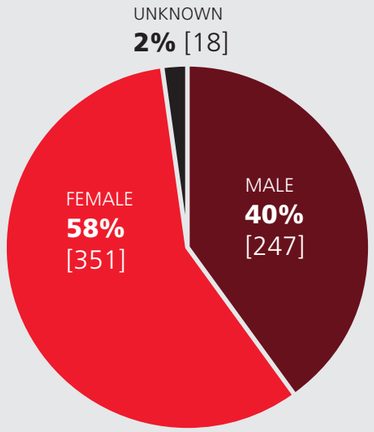
Making Safeguarding Personal principles have shifted the focus of enquiries from a process (driven by targets) to a response (motivated by achieving outcomes that matter to the adult at risk). As part of this change the formal process has become more flexible and there is also no requirement to report nationally on how quickly each process stage was undertaken. The Board did, however, request that the timeliness of enquiries was reported.

[1] The criteria which the team applied is set out in s42 Care Act 2014. Which states that where there is reasonable cause to suspect that: • an adult has needs for care and support (whether or not the LA is meeting any of those needs); • is experiencing, or is at risk of, abuse or neglect and • as a result of those needs and is unable to protect him/herself against the abuse or neglect or the risk of it. The Local Authority is required to make (or cause to be made) whatever enquiries it thinks necessary to decide whether protective action should be taken and, if so, what and by whom.

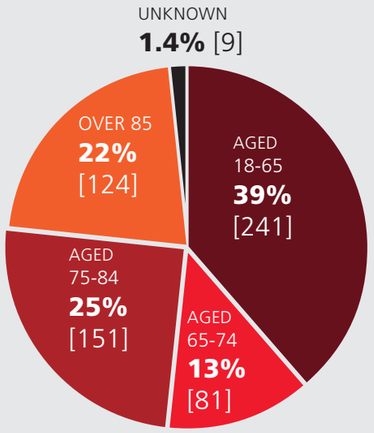
Given the complex nature of enquiries[2] it is reassuring that on average section 42 enquiries were completed within 51 days. The Board remains vigilant and the SAT have reaffirmed their commitment to tackling any drift in individual cases. There are now clear responsibilities within the Care Act 2014 for agencies to work together to protect adults at risk. The BSAB has an established partnership with clear guidelines on information sharing and good working relationships at strategic and operational level. This enables practitioners to work constructively on supporting an adult at risk, confident that any issues can be escalated to senior managers and safeguarding leads if necessary.

As with previous years the data demonstrates that safeguarding enquiries undertaken reflect closely the demographic make up of Brent

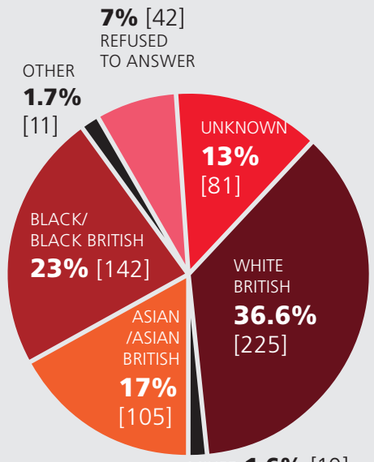
GENDER



AGE



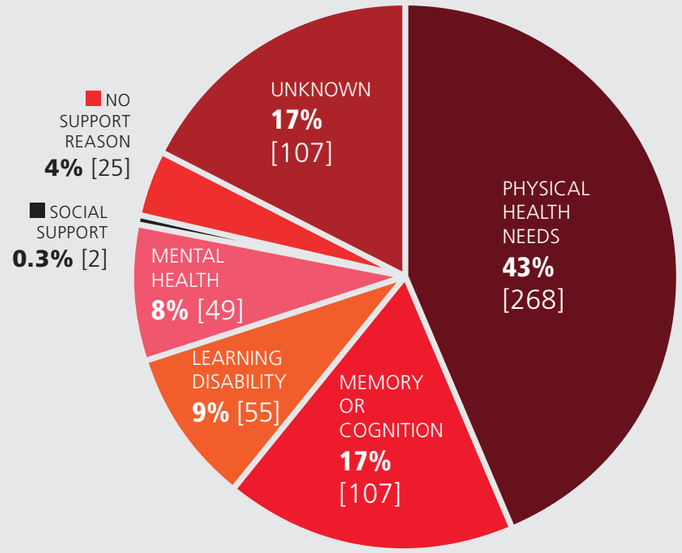
ETHNICITY



As set out above, safeguarding duties are only owed under the Care Act 2014 to adults who are in 'need of care and support'. It is therefore vital that those raising concerns identify as part of any referral the individual's 'Primary Support Reason' as not only will it ensure that staff receiving the concerns are better able to identify quickly when they have a duty to undertake enquiries, but it will also assist responders to make suitable arrangements to better support the adult and ensure they are fully involved in the enquiry.

[2] Enquiries will often require detailed investigations, including gathering evidence from numerous sources, working with the adult (who often has significant care needs which might impact on their ability to communicate or make decisions). Safeguarding enquiries should also involve the adult's wider support network and work with professionals from different disciplines and across partnership agencies in order to identify any risk and agree actions necessary to reduce or remove the risk.

The primary support needs of individuals in 2016 involved in safeguarding enquires was broadly similar to the profile nationally

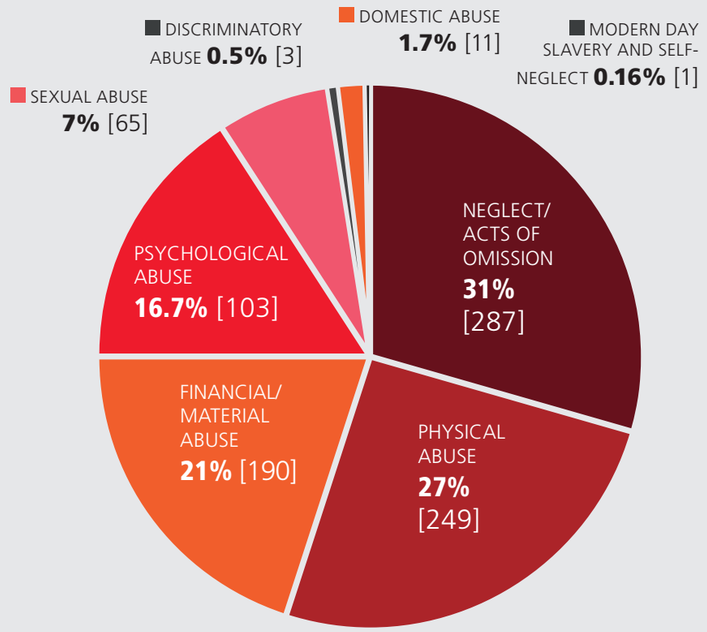


2016 compared to 2014 /15

	2016	2014/15
Physical Health Need	**43%** [268] of all section 42 enquiries	**36%** [183] and 40% nationally
Memory or Cognition Support	**17%** [107]	**6.5%** [9]
Learning Disability	**9%** [55]	**15%** [57]
Mental Health	**8%** [49]	**17%** [20]
Social Support	**0.3%** [2]	**7%** [26]
No Support Reason	**4%** [25]	**19%** [69]
Not Known	**17%** [107]	Unknowns were unreported

It is also very important that those reporting concerns notify the SAT of any difficulties the adult may have in communicating or deciding how best to protect themselves. An adult's ability to protect themselves may be restricted because they are under duress, a victim of coercive control or they may lack mental capacity because of memory problems or cognitive impairments associated with disability. In 2015/2016 248 individuals were assessed as lacking mental capacity and in a further 225 individual cases their capacity was 'not known'. Under section 68 of the Care Act 2014 the local authority must appoint an advocate for anyone who will have substantial difficulty in being involved in a safeguarding process but who doesn't have a suitable person (such as a friend, family member or community support) to represent them. Only 102 people were reported to have such support in place and the availability and effectiveness of advocacy will be a focus in the BSAB 2016/2017 business plan.

The graphs below reports the findings of the 616 concluded section 42 safeguarding enquiries



2016 compared to 2014 /15

	2016	2014/15
Neglect/Acts of Omission	**31%** [287]	**27.5%** [70] of all concluded enquiries
Physical Abuse	**27%** [249] of which 46% is perpetrated by someone known to the adult in their own home	**33%** [84]
Financial/Material Abuse	**21%** [190] of which 62% is perpetrated by a known associate in the persons home	**14%** [52]
Psychological Abuse	**16.7%** [103]	**10%** [36]
Sexual Abuse	**7%** [65] Enquiries alleging sexual abuse have risen significantly	**2.7%** [7]
Discriminatory Abuse	**0.5%** [3]	**1.4%** [5] this was split between discriminatory and Institutional abuse
Domestic Abuse	**1.7%** [11]	Not Reported
Modern Day Slavery and Self-Neglect	**0.16%** [1]	Not Reported

As set out above many partner agencies recognised and reported concerns relating to neglect or acts of omission. These may not have all gone on to require full safeguarding enquires under section 42 of the Care Act 2014, but it remains the most common form of harm to adult at risk. Almost 30% of cases investigated alleged that the source of risk was social care staff, 13% were alleged to be neglected by others apparently unknown to the individual, meaning that in around 57% of cases individuals were alleged to have been put at risk by those known to them. This could be anyone within the person's wider support network who, either voluntarily or through accepting paid work, had a duty of care to the individual adult, and was alleged to have failed to meet their duties, putting the adult at risk of harm. Not all of these cases will have been substantiated, but the high level of concerns in this area demonstrates how important it is that those supporting adults understand their responsibilities and the processes for notifying professionals if they are unable, for whatever reason, to meet those duties.

CASE STUDY – CARER

BACKGROUND

This case concerned an 89 year old female of English heritage. A safeguarding concern regarding neglect by health care workers was raised by her daughter (carer) on the basis that:

1) Appointments were missed on a regular basis
2) There was poor communication between health care workers, the service user and her representatives
3) A pressure ulcer was identified

The carer completed treatment for mental health issues during the enquiry which added to the complexity of these issues.

INTERVENTIONS

Following a strategy meeting which was attended by all agencies involved in the case, the following action plan was put in place:

a) A carers assessment was organised
b) The communication strategy between stakeholders was reviewed
c) The case conference that followed the strategy meeting was held at the daughter's home to maximise her ability to participate

SUMMARY

This was an extremely complex case where an allegation of neglect by health care workers was substantiated.
The way that the enquiry was conducted meant that the relationship between the professionals and the family did not breakdown and there was a positive outcome for all stakeholders.

The Care and Support Statutory Guidance, issued by Department of Health, recognised that agencies needed to respond to those adults who were at risk of harm through self-neglect. Brent Council confirmed in April 2015 that a dedicated social worker would continue to process referrals where the risk arose from self-neglect. Where these cases meet safeguarding thresholds they will be recorded in future in the national safeguarding return reported above as a result of self-neglect's inclusion in the statutory guidance. BSAB were notified throughout the year that this continued to pose a significant problem for a small cohort of individuals in Brent. BSAB also recognised that the wider impact on communities where individuals were at risk of self-neglect or hoarding behaviours and as such thoroughly endorsed the approach taken by Brent Council. This approach permitted longer-term work with those at risk of self-neglect than might otherwise have been possible through the section 42 safeguarding process and is in line with best practice emerging from national research findings (Braye, Orr and Preston-Shoot, 2014). It also ensures that specialist knowledge can be accessed easily by colleagues with social care assessment and care management responsibilities. The number of concerns where self-neglect was a factor was reported and continues to be an area of significant activity. Indeed, the Hoarding and Self-Neglect worker worked with 39 people in 2015/16. The focus given by the Department of Heath statutory guidance (DH, 2016) on this issue has, as expected, increased awareness among professionals and this in part explains the rise in referrals. There are still significant challenges for agencies supporting those most at risk; not least because there are no new powers under the Care Act 2014 to support practitioners to intervene and the existing legal framework for statutory intervention is complex. During discussions at Board level during the year health partners also recognised that further work is needed to engage with and secure sufficient local treatment opportunities for individuals experiencing harm as a result of behaviours associated with self-neglect and hoarding disorders.

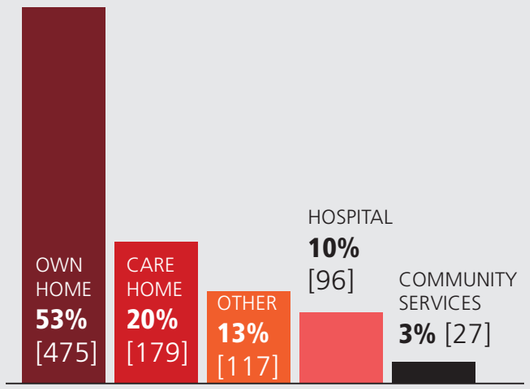
There has also been a significant rise in the number of individuals alleged to have suffered physical abuse (249 enquiries in 2015-16, compared to 84 in 2014-15). In addition, there were a further 11 reported cases of adults in need of care and support being the victim of domestic abuse. It goes without saying that adults, whatever their frailties, are entitled to live free from abuse and should benefit from protections provided by the criminal law. Safeguarding enquiries often run alongside criminal investigations. Figures for 2015/2016 are not available but in the first six months of 2016/17 there have been 31 people charged with or cautioned for offences involving "vulnerable adults", mainly

for theft and different types of assault. Criminal cases apply a different standard of proof. Findings in safeguarding enquiries are based on the 'balance of probability' rather than the 'beyond all reasonable doubt' that applies in criminal justice; they focus on slightly different outcomes too (namely, actions required to protect the adult rather than prosecute any perpetrator). However, the success of either type of enquiry rests on notification that abuse is occurring. In 2015-16, 46% of physical abuse allegations are reported to have occurred in the adult's own home by someone known to the adult. This highlights just how important it is for the wider public to be vigilant, aware of adult protection duties and local processes for reporting concerns, and to be confident that their concerns will be responded to appropriately.

There has also been a sharp rise in investigations of sexual abuse, from 7 in 2014-15 to 65 this year. In part this may reflect the rise in reporting of historical sexual abuse claims noted nationally, but improvements in communication between partner agencies have been made following a thematic review by BSAB (reported in the final section) to ensure that allegations of sexual harm by staff are reported to the SAT and that safeguarding enquiries and police investigations are undertaken speedily with appropriate supports to enable adults at risk to be involved.

The location of abuse is slightly different to figures reported last year, both locally within Brent and nationally. Whilst figures in Brent follow similar patterns of abuse reported nationally, there are some noticeable variations. For example, abuse or neglect is reported to occur most frequently in the person's own home. In Brent last year in 53% of all concluded enquiries the abuse was reported to have taken place in the person's own home, a significant rise from the previous year where this was reported to be 40% in Brent and 43% nationally. There is also a corresponding drop in reports of abuse/ neglect

Location of Abuse



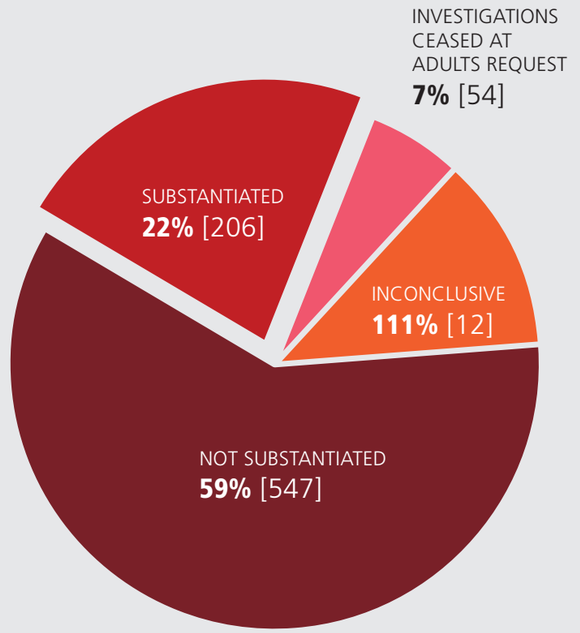
occurring within care homes in Brent, down from 28% in Brent in 2014-15 and 36% nationally to only 20%. This shows a positive trend in downward referrals from such settings, suggesting the improvements made to monitoring arrangements by commissioners and regulators is having a positive impact. It is not always possible to be certain about the location of abuse or neglect. For example, in pressure ulcer cases, when subsequent to hospital admission pressure ulcers are found, disputes can arise between the hospital and care providers as to their origin.

In 2015/2016 the Care Act statutory guidance (DH, 2016) reinforced the need for practitioners to be mindful of risks such as 'honour' based violence, Female Genital Mutilation (FGM), domestic abuse and modern day slavery (including human trafficking). BSAB recognised that nationally reporting is low on these types of crimes, but received reports from Metropolitan Police and community safety colleagues on initiatives designed to identify and respond where human trafficking, modern day slavery and abuse linked to gang activity was suspected. The data suggests that much more needs to be done to raise wider public awareness of these issues and ensure multi-agency investigatory activity is focused on the adult at risk and positive outcomes for victims. Multi-agency response to safeguarding risks.

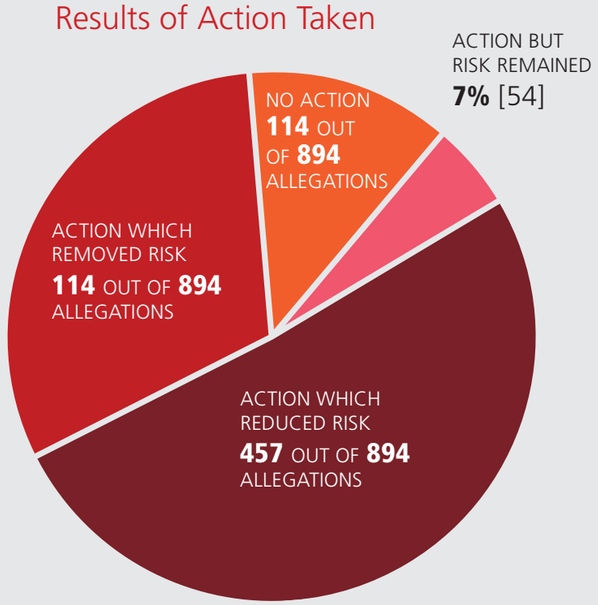
Data on the findings of safeguarding enquiries is no longer collected nationally. However, BSAB has continued to receive reports as many people involved in a safeguarding enquiry reported that they felt it was important to have a clear decision regarding the outcome of the investigation. BSAB had set practitioners an aspirational target to reduce inconclusive findings to 10% in order to effect a culture change across all agencies responding to concerns and ensure that staff were confident in their investigative skills and decision making. In order to support practitioners and assure decision making was robust the Board determined that the monitoring and evaluation sub-group would conduct multi-agency audits of case files. For example, an audit of mate crime cases was completed in 2015/16. The team and partners involved in enquires are to be commended as, for the second year running, they have been able to substantially reduce the percentage of cases with inconclusive findings. In 2015/2016 only 12% of all enquiries were inconclusive (reduced from 16.5% in 2014/2015 and 25% the previous year). In 2015/2016 the majority of cases (59%) concluded that the allegations could not be substantiated, only 22% of cases therefore substantiated the allegations.

Findings in respect of allegations is, however, only a part measure of the success of outcomes from section 42 enquiries. Most adults at risk and their carers, family and friends want to ensure that any intervention protects the adult. In 2015/2016 13% of concluded cases resulted in no action[3]. Therefore, in 87% of cases, irrespective of whether the initial allegation was substantiated, action was taken to protect the adult. In 5% of concluded cases practitioners believed that, despite action, some risk remained to the adult. In 51% of the cases action taken reduced the risk (40% nationally) and 31% removed the risk (23% nationally).

Findings of Concluded Cases



Results of Action Taken



[3] Nationally in 2014-15 30% of cases resulted in no action, in Brent it was only 9%.

CASE STUDY – MENTAL CAPACITY

BACKGROUND

The woman in this case had a diagnosis of dementia; from a country within the European Union, she had a good command of English. Following a hospital admission she was given respite care in a residential home due to concerns about the quality of care that she received from her family. The concerns about quality were escalated to a safeguarding concern about neglect and her respite at the placement was extended while the enquiry was on-going.

The family was unhappy about the placement although they did not object. She was also reluctant to accept support. A Deprivation of Liberty Safeguards (DoLs) authorisation was also requested.

INTERVENTIONS

The key issue in this case was the use of an interpreter for the safeguarding concern and the DoLs assessment. Conducting the assessment in her native language indicated that her communication skills had been underestimated and she was able to contribute to the Best Interest Assessment and the safeguarding enquiry. Abuse was not substantiated in this case but the following protection plan was in place

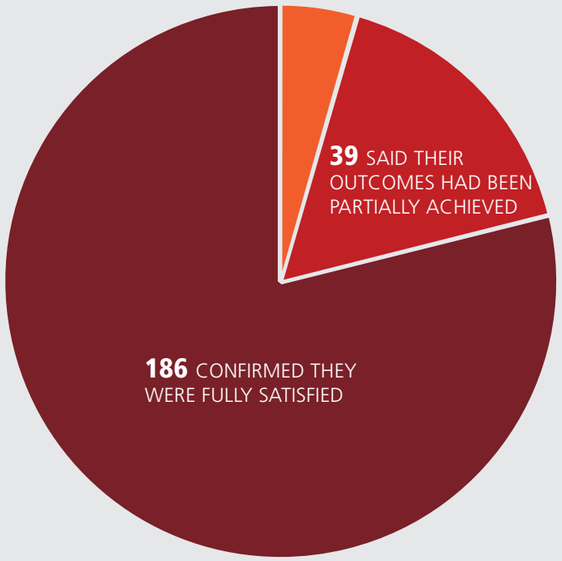
d) An Independent Mental Capacity Advocate was appointed to support her
e) Respite care was agreed

SUMMARY

This case study illustrates good practice with regards to four of the five statutory principles in the Mental Capacity Act 2005. These principles are supported decision making, the right to make unwise decisions, the least restrictive principle (intervention) and best interests.

Feedback directly from those involved in safeguarding enquiries, collected for the second half of 2015/2016, demonstrates positive steps towards embedding the 'making safeguarding personal' principles within safeguarding decision making. 406 individuals were asked at the start of the enquiry what outcomes they would like any intervention to achieve; of those 347 individuals agreed the outcomes with practitioners. Following completion of enquires, individuals were asked to comment on whether their outcomes were achieved. Whilst 11 individuals did not feel their outcomes had been achieved, 39 said their outcomes had been partially achieved and a further 186 confirmed they were fully satisfied.

FEEDBACK



Many adults at risk may not wish for section 42 enquires and may refuse support offered to protect them. In 2015/2016 in Brent 54 enquiries were stopped at the request of the adult at risk. Where individuals have capacity to make this choice the safeguarding practitioner has very limited powers to pursue activity, though they should all be fully aware of their duty to report any possible criminal activity. Practitioners must work with other partner agencies to support or offer advice and information to the adult at risk, and continue to assess needs in line with section 11(2) Care Act 2014.

CASE STUDY – MENTAL CAPACITY

BACKGROUND

Safeguarding concerns were raised by hospital staff who noticed friction tears on the lower back of an elderly lady on her admission. The hospital staff spoke with her daughter who explained this happened when she had moved her from her bed at home to give her a shower and wash her hair. She accepted this was against the advice she had been given regarding safe manual handling techniques. At the time the concern was referred for a safeguarding enquiry the lady was medically fit for discharge, but hospital staff were worried that discharging the patient back into the care of her daughter may lead to further injuries.

INTERVENTIONS

The SAT conducted a thorough investigation, gathering information from a variety of sources including family members, medical staff and care staff. The Safeguarding Adults Manager recognised that hospital staff had legitimate concerns that she could be at risk of further injury if her carer continued to use unsafe practices, but equally recognised the importance for the adult that she return home and that her daughter continue to care for her.

SUMMARY

A joint strategy discussion was held within 7 days of the referral, where a joint risk assessment confirmed that risks of further harm could be managed at home with monitoring through the district nurses with oversight from the adult safeguarding manager for a period of 4 weeks. This allowed discharge from hospital and for her to return home.

THE BOARD'S STRATEGIC PRIORITIES IN 2015/2016

Prior to the introduction, in April 2015, of specific statutory functions BSAB had operated as a partnership sharing good practice and encouraging improvements in safeguarding practice. This crucial role is recognised in the Care Act 2014 statutory guidance by the Department of Health (2016), with Safeguarding Adults Boards required to seek assurance from partners that they undertake their responsibilities in a way that prevents abuse and neglect before any concerns arise or respond to actual or perceived safeguarding risk so that harm is averted.

In order to fulfil this duty BSAB received regular reports from those responsible for commissioning health and social care services, providers of such services and regulatory bodies. For example, Brent CCG confirmed they had developed a specific Outcome and Standards Framework for adult safeguarding for use in all provider contracts and safeguarding which is now routinely monitored at provider assurance meetings. In addition, the CCG and Council provided reports into the care coordination for individuals with complex learning disabilities who lived out of the area, confirming how this programme of work would feed into a joint overarching learning disability strategy and wider mental health learning disability care-pathway development under the Mental Health Programme Board. The Board was also reassured that work was progressing to support those with learning disabilities to access appropriate health care and that the take up in Brent of annual health checks and health passports was reported to be one of the highest in England. Brent CCG provided reports into the positive impact that the new Tissue Viability nursing service has had, working with care homes within Brent to ensure patients and staff have rapid access to specialist advice and expertise. They also reported arrangements for reviewing serious incidents regarding pressure care in Brent. This important work will continue to be monitored by BSAB's establishment concerns sub group.

Cross partnership activity remained a core part of BSAB's work in 2015-16. The Independent Chair attended meetings of the Council's Overview and Scrutiny Committee and Health and Wellbeing Board to report on activities of the Board. She also accepted an invitation to sit on the Safer Brent Partnership, becoming actively involved in strategies to improve community safety for vulnerable adults. This and the regular attendance by the Council's Head of Community Safety at BSAB meetings, enabled the Board to remain sighted on the effectiveness of multi-agency response to the challenges posed by radicalisation and extremism under the 'PreVent' programme. For example, a report by the Head of Community Safety into a noticeable increase during the year in referrals for young adults who had been groomed by extremist groups encouraged discussion of joint working opportunities to improve access to longer-term psychological care/ support to improve mental wellbeing and resilience for those at risk of such exploitation.

Confident that all partner agencies were committed to meeting the new statutory requirements, members agreed to a very ambitious work programme set out within the 2015/2016 Strategic Plan. As specified within the plan, establishing an effective sub group structure was itself a key priority for 2015/2016 so as to enable progress outside of the main Board meetings of key activities. The work programme was contingent on full support from all partner agencies to establish, chair and attend sub group meetings throughout the year. BSAB representatives who acted as chair or vice chairs within the sub groups undertook considerable additional duties on behalf of the partnership. Their commitment is to be commended; this enabled important work (as detailed below) at a time of continued organisational change and a high turnover of key personnel. Involvement also of partners' operational senior managers at sub group level allowed BSAB's sub groups to scrutinise qualitative and quantitative information in far more detail than had been possible previously at the main Board meetings. Their involvement helped to strengthen the link between the work of the Board and frontline practitioners. This is particularly true of the Case Review, Establishment concerns and Learning and Development sub groups.

The financial support by statutory partners supported the Board to complete key tasks allocated to the Monitoring and Evaluation group. Difficulties in securing a Chair or regular attendance meant increased reliance on the Independent Chair and other Independent Reviewers to complete audit work, but agencies played an active part in those reviews and in the organisational safeguarding audit which was completed by the Police, Local Authority and Health partner agencies. Key representatives from CNWL and Brent CCG also played a crucial role in the 'challenge and support event' held to review the self evaluation and assist relevant agencies to identify priorities for their own agency to take forward. Furthermore, the re-establishment of an active Community Engagement and Awareness sub group has enabled work to begin as a priority on a programme of community wide events. More importantly, it has assembled a network of experts from across the partnership that will enhance the Board's ability to campaign, raise awareness and champion key safeguarding messages in a variety of innovative ways. The Board should be in a stronger

position in 2016/2017 to support and develop the sub groups once it has secured business management and administrative support. This is essential in order to effectively manage meetings so that attendees have all necessary information (often required from across partner agencies and other relevant bodies) in a timely manner and so that much of what was identified within the 2015/2016 Strategic Plan can be firmly embedded into the usual business of the Board.

Another key priority for the Board was to ensure that 'making safeguarding personal' ['MSP'] principles were embedded into service provision and the focus of multi-agency safeguarding enquires to improve outcomes for adults at risk. The data reported above demonstrates significant strides have been made to embed these principles within enquiries undertaken in line with the section 42 safeguarding duties. In addition, Brent CCG and CNWL have worked with staff at Park Royal Hospital to ensure patients are involved in the safeguarding process and that outcomes identified are meaningful to the patient. Findings from safeguarding organisational audits recognised that further work was needed so agencies from across the partnership could capture and report key performance measures. This will then better demonstrate that staff are adhering to these principles of good practice, whether they are recognising and reporting concerns, conducting enquiries or responding to specific adult protection issues.

In addition, a review was undertaken by BSAB to test the understanding of new expectations to identify, report and respond to safeguarding adult concerns by all partners in preparation of the adoption of the Pan- London Safeguarding Procedures. This identified opportunities for reducing duplication and simplifying reporting so that information is not lost where there are concerns regarding an adult's welfare or community safety, but where the risk is not imminent or of a safeguarding nature. This was reported also to the Safer Brent Partnership so that work could continue into 2016/2017, in conjunction with that partnership, to

CASE STUDY – MAKING SAFEGUARDING PERSONAL

BACKGROUND

The case involved a 57 year old male with serious physical health issues which restricted his mobility. His family raised a safeguarding concern regarding financial abuse when they became aware that his partner had gained access to his bank account.

INTERVENTIONS

The most important aspect of the enquiry was the initial contact with him. This contact enabled the team to identify the following desired outcomes:

1) Repayment of any misappropriated funds (restorative justice)
2) To change the nature of the relationship with the person alleged to be causing harm but not to end this relationship

The situation was complicated by the fact that family members, who had been involved in the enquiry, did not agree with this course of action. They wanted the intervention to focus on proving the existence of abuse with a view to pursuing the person causing the harm.

How the man presented during contact, along with the fact that he did not have a mental disorder, did not provide any evidence to contradict the presumption of capacity. As a result the team decided to support him with achieving the outcomes identified above in spite of the family's objections.

The enquiry established that unauthorised withdrawals had taken place on several occasions. In response, the team contacted the person alleged to have caused harm and organised and monitored a repayment schedule. Additionally, he was given support in changing the nature of his relationship with his partner.
The police were made aware of the situation but they did not believe that they had a role in the case.

SUMMARY

In this case the team followed applied the principles of Making Safeguarding Personal and restorative care to ensure that his desired outcomes were achieved in spite of pressure to the contrary from family members.

support those adults often most difficult to engage with formal services, but who are often at high risk of exploitation, abuse or neglect.

Briefing sessions to BSAB partners' staff, housing providers and Brent Council Members highlighted the importance of these principles. The Learning and Development subgroup also worked hard to ensure MSP was reflected in all levels of learning and development work in the borough. The Group agreed that to achieve this they would need to ascertain if safeguarding training delivered by BSAB partner agencies and their commissioned services had been reviewed since the Care Act 2014 and evaluate if training included new expectations (including MSP) set out under the Act. The sub group also agreed they would then review the Board's training competency framework for safeguarding adults and develop a toolkit for core safeguarding training to provide assurance of the quality of training delivered in the borough. The group devised an online survey which was completed by 50 organisations in Brent, including frontline housing support and social care providers, most of whom (98%) reported that they offered frontline staff training to raise awareness of safeguarding duties. 94% had reviewed their provision since the Care Act 2014 came into force, though only 68% had changed the content to include the making safeguarding personal principle. The findings of the survey demonstrated the impact that a competency framework would have and work is underway by the group to complete the quality assurance mechanism so that providers can be confident when they design or commission training programmes for staff and volunteers that these will meet the expected basic standards.

BSAB has, for many years, had a focus on evidenced based decision making and as such has placed a high value on accurate data reports. The Board's Quality Assurance framework was designed to build on this by incorporating multi-agency safeguarding data and partner agencies' self evaluation of safeguarding practice so as to broaden the Board's evidence base, rather than to continue to rely on a single agency perspective. That framework is designed to allow partners to identify key issues so that multi-agency training opportunities or awareness campaigns can target key areas for improvement, for example supporting professionals to make effective referrals when they have a safeguarding concern and the effective use of advocates.

In recognition of their new statutory functions the Board identified that it would be a key priority for 2015/2016 to make best use of data. As set out above a number of key partners were able to provide information to compliment the Safeguarding Adults Collection data. There is still work needed to fully implement and secure regular multi-agency data reporting, but it is reassuring that partners recognise the value that collating and analysing multi-agency safeguarding information has for each agency's core operational effectiveness and for the work of the Board. CQC has, for example, confirmed that in 2015 their safeguarding key performance indicators were revised and that these would be made available from September 2016, allowing more consistent reporting of how well the regulatory body responds to safeguarding concerns. Adherence to and regular reporting according to the BSAB quality assurance framework will now form part of the Board's core business. This will ensure that measures of success identified within the strategic plan continue to be closely monitored.

BSAB were also keen that work undertaken during 2015/2016 would build on findings from case audits and organisational evaluations from the previous year. As such the strategic plan detailed a number of key actions designed to improve the identification of risks

or types of abuse or against categories of adults at risk where, it is believed, harm is underreported. BSAB received reports confirming that threshold criteria had been revised in light of the new statutory duties under section 42 of the Care Act 2014 and the positive impact of this has already been reported above. In addition, partners reported internal audits undertaken to quality assure safeguarding work. For instances, NWLHT reported that they undertook reviews into 12 cases where safeguarding adults was a factor. The Safeguarding Adults (SGA) Team review all incidents that are logged on the NWLHT incident recording system in order to identify any incidents that are a safeguarding concern. In 2016/17 all serious incidents that are reported will be highlighted to the SGA team in order to ensure that safeguarding concerns are immediately identified.

Many partner agencies also actively engaged in the Pan London review and responded positively to those recommendations. BSAB and the Safer Brent Partnership have, as a result of that review, agreed an action plan to improve referral pathways to early intervention and appropriate support for individuals who are at increased risk of abuse, neglect or exploitation as a result of poor mental health. Both Partnerships agreed that they would wish to see, as a measure of success, improved identification and multi-agency risk management to reduce incidents of vulnerable adults coming to the attention of police as a first response.

The strategic plan proposed a programme of themed audits to include sexual abuse, disability hate crime and mate crime. In September 2015 the Board received a report of the 'Mate' crime case audit. This looked at 4 cases where the person alleged to have caused harm had befriended a vulnerable adult or exploited an existing relationship of trust. The findings provided reassurance that agencies work effectively together to keep adults at risk safe and to remove impediments to effective care provision. It recognised that more could be done to enable adults at risk to secure access to the courts and to ensure that criminal or civil proceedings were completed in a timely manner. In addition, the Board recognised that a greater understanding of and awareness of hate and mate crime risk indicators among frontline police and those in care management roles could have prevented the safeguarding incident. This work should go on to inform strategic developments in this area and training programmes for practitioners.

LEARNING FROM CASE REVIEWS TO IMPROVE PRACTICE

From April 2015 the Board must review cases meeting the criteria set out in section 44 Care Act 2014[4]. Prior to this duty coming into effect BSAB had already commissioned a review following the tragic death in May 2014 by suicide of a young adult who was residing in supported living accommodation and had, shortly before her death, been supported by mental health services.

The purpose of any Safeguarding Adult Review is not to ascertain the cause of death or to attribute blame. Rather it is to understand how systems may have failed to protect the adult at risk, report on any best practice and identify effective learning and improvement action to prevent future deaths or serious harm occurring again.

The findings of this review were presented to the Board in September 2015 by the report's Independent Author. Within his report, the author recognised that the adult had lived in circumstances that she had found stressful. She had, for example, experienced an abusive relationship. She was also reported to have alcohol and substance misuse issues. She had also lived in her accommodation for 6 years and, whilst she had expressed frustration at not moving on, she had refused offers of alternative accommodation. At the time of her death she was facing possession proceedings for rent arrears. The report found this was likely to have placed increased stress on her, but also meant she disengaged from on-site support at a time that was crucial to her. Her GP had been treating her for depression since 2010 and had referred her for counselling which she had briefly attended. However, she had not attended the GP practice throughout 2014. She had been described by multiple services as refusing offers of support, but had also reported to have been receptive in the past to social support and practical assistance. The Independent Author of the review reported that there appeared to be a consistent pattern that when she felt rejected by a service she would not be willing to be seen by that

[4] Section 44 Care Act requires that a Safeguarding Adults Board must arrange for a review of a case involving an adult in its area with needs for care and support (whether or not the local authority was meeting those needs) if there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult and either the adult has either: a) died and the SAB knows or suspects that the death resulted from abuse or neglect or b) the adult is still alive and the SAB knows or suspects the adult has experienced serious abuse or neglect. 'Serious abuse or neglect' is defined as where the adult would have died but for an intervention, has suffered permanent harm or reduced capacity or quality of life as a result of the abuse or neglect. [14.163 of the DH guidance]

service, meaning that services were then able to use her disengagement as reasons for withdrawing their support. The report found that despite a history of self-harm and suicide attempts dating back to 2011, no agencies (including the supported living provider, police, London Ambulance service or mental health services) believed the risk of harm from future suicide attempts was high. As a consequence, her suicide had not been thought of as predictable or preventable by any of the agencies that worked with her. Her family had, however, raised concerns and sought to obtain help for her shortly before her death, concerned that she was at risk.

The Independent Author made nine recommendations, including improvements to risk assessments for those who face possession proceedings or are at risk of self harm or suicidal thoughts. They also advised improvements to practice regarding supporting those who had experienced domestic violence, were at risk of dis-engagement from support services or were being discharged from services where self-neglect or self harm remained a concern.

In December 2015, Brent Housing Services confirmed that they have reviewed all those who had 'overstayed' the recommended length of stay in supported living. They confirmed that there was a small cohort of tenants that had been assessed as low risk, but relevant support services were in place should the landlord wish to seek possession proceedings. In addition, in line with the recommendations, Housing services confirmed that they had written to all providers to remind them that they are required to provide all staff with mandatory Domestic Violence (MARAC) and CAADA-DASH Risk Assessment training and have in place Information Sharing Service Level Agreements with the local Safer Neighbourhood Team in order to share relevant information regarding safeguarding vulnerable service users. Contract monitoring arrangements now require that providers report all serious incidents (such as a resident's hospitalisation from self-harm or a suicide attempt) and have in place mechanisms for assessing risk to, and the mental capacity of, a service user as part of a discharge plan to Brent Council's Contract and Relationships Team. The Contacts and Relationship team monitors discharges from services each quarter to ensure that providers have carried out all necessary assessments.

CNWL Foundation Trust also confirmed that their Clinical Risk Assessment & Management Policy and the Care Programme Approach Policy have both been developed since this tragic death. These both reinforce the importance of capacity assessments and person-centred care planning, requiring that any

assessment should be developed jointly and agreed with the service user and put in writing. All service user care plans and risk assessments are now being audited regularly. They reported that an audit in November 2015 had demonstrated compliance with good practice expectations. Discharge procedures have been tightened so that the discharge plan is agreed with the service user and put in writing to them and their GP within 24 hours. If it has not been possible to agree discharge with the service user, this is escalated to the Team Manager/Nominated Deputy and Responsible Consultant for agreement of the discharge at the daily multi-disclinpinary meeting. GPs are able to challenge decisions to discharge from the service if they feel the service user still requires specialist input; procedures for effectively managing such challenges were to be written into the Trust's operational policy. The Trust also reported they were reviewing the protocol for service users who are non-compliant with treatment and/or difficult to engage and that a learning briefing had been issued to all staff in the team to implement the above practice standards.

The Trust had also reviewed caseloads with the relevant team, reporting that these had decreased significantly since the incident and that workload pressure was closely monitored by the Team Manager. Other operational changes, including higher visibility of a newly appointed Substance Misuse Consultant and a 'Team approach' to casework means that work is distributed equitably according to capacity in real time. The Trust also redesigned referral pathways so there is now a 'Single Point of Access' (SPA) primarily for GPs to refer service users at any time (24/7) to secondary mental health services. SPA will triage the referral and arrange a rapid response (face-to-face) using the following response criteria: Emergency (within 4 hours) and Urgent (within 24 hours). This should improve access to help for anyone concerned they (or a family member or friend) is at risk of harm or requiring urgent support, including outside of normal working hours.

So as to disseminate the learning from this case, BSAB's Independent Chair presented the findings to the Brent Supported Housing providers' forum.

In December 2014, BSAB agreed to undertake a thematic review to ascertain how partners could improve the multi-agency response to allegations of sexual assaults, particularly when these arise in acute mental health settings. A panel, made up of representatives from BSAB, the Local Authority, Brent CCG, Metropolitan Police and CNWL, agreed the terms of reference for the review and the appointment of an independent reviewer. An internal review by the Trust, carried out by the same independent reviewer, had

identified concerns in respect of physical environment, safe staffing levels, risk assessment management and responses to incidents of sexual safety. She commented that there had been substantial evidence that the Trust had made improvements and made recommendations for further improvements. As this was an internal report, the Trust remain responsible for ensuring that changes are implemented, but their commitment to improvement and willingness to be open and transparent in sharing learning is to be commended.

The wider multi-agency thematic review commissioned by BSAB focused on two more recent cases identified by the multi-agency panel as representative of concerns relating to sexual safety of service users which required a multi-agency response. The author reported that she found examples of agencies acting with sensitivity to service users' needs, effective multi-agency collaboration and good work with service users on the initial protection plan. She also commented that there were areas for improvement. In particular she advised that:

- mental capacity was not explicitly considered and reference was needed to safeguarding decisions; in one case the service user was not offered support of an advocate;
- a more robust multi-agency strategy would have ensured MSP was delivered from the outset and achieved agreement on the level of disclosure to the clinical team supporting the service user;
- in both cases there was insufficient focus on the service user's restorative care needs which resulted in drift and a lack of ownership in this regard.

In addition, the report does identify a delay in referring allegations to SAT in one case, though it is noted that the police were advised immediately and investigated the allegation.

The Trust have initiated further improvements, particularly in relation to tracking of on-going safeguarding enquiries and Trust staff now meet monthly with the SAT manager to prevent any drift in cases. They also hold regular assurance meetings with Brent CCG's safeguarding lead. The CCG reports, in response to this report, that their own internal reporting and governance structures were strengthened so there is now a clear process for reporting safeguarding concerns within the CCG. In addition, learning has been shared with safeguarding leads in practice forums. The Trust intends to ensure improving focus by practitioners on restorative justice and to create more positive working relationships with the police. This should enable robust criminal investigations and timely decisions regarding prosecutions including through the provision of joint training between police and health staff.

The Trust reported that some of the changes made in light of the earlier internal review had an immediate impact with allegations dropping significantly in 2015/2016. Frontline staff from both the hospital and SAT reported communication has been much better. The Trust have also engaged with Healthwatch to agree how best to improve communication for patients about keeping themselves safe on wards and reporting any concerns.

In December 2015 the Board also received an update on the implementation of recommendations from a Domestic Homicide Review into the murder of an adult at risk in October 2013. At the time of her death, BSAB and Brent LSCB gave an assurance to fully support this review and many of our partners were directly involved in the case and provided information to support the learning. The review concluded that prior to the murder agencies were aware of a number of allegations against the perpetrator; however, because concerns were not shared a full picture of the potential risk posed by the perpetrator was not known by any one agency and his behaviour was not recognised as a potential pattern, but instead dealt with as individual incidents. The report suggested improvements in key areas may have reduced the risk, for example safer recruitment, shared risk identification and referral responses so that these adhere to a 'whole family approach'. It also highlighted that failures to adhere to policy, including safeguarding adults' policy, contributed to poor responses to referrals. It criticised a number of agencies for failing to adhere to Mental Capacity Act 2005 duties and best practice principles, for example the use of a family member as an interpreter resulted in a lost opportunity to hear the victim's voice.

In response to the recommendations from this review Brent CCG delivered a comprehensive training programme for GP's and Primary Care colleagues for Adult Safeguarding and the Mental Capacity Act. The training was well attended and feedback evaluation positive. Brent Council's Adult Social Care department also confirmed they had completed the actions arising from the recommendations.

The Board has subsequently incorporated all outstanding actions which are pertinent to adult safeguarding duties from these reviews into a BSAB multi-agency action plan. This is a working document, meaning that any outstanding actions and actions arising from newly commissioned reviews will be monitored regularly, initially by the Case Review group. This group will be able to request confirmation from partner agencies that they have taken action, and challenge any drift or poor performance. In turn partners will be able to demonstrate the impact that changes to practice have made in ensuring adults are protected from abuse and neglect. The group intends to monitor the implementation of actions on a quarterly basis and will feedback to the main Board and, through the Board Chair, to SBP as required.

BSAB BUDGET REPORT

In recognition that the BSAB would, from April 2015, fulfil statutory functions as set out in the Care Act 2014, partners agreed that it would be necessary to contribute towards the costs involved in meeting these obligations. In line with DH statutory guidance (2016) the Board's statutory partners, namely Brent Council, Metropolitan Police: Brent, and Brent Clinical commissioning group agreed to contribute towards these costs.

It should be noted that the most valuable contribution came from partners in the form of staff dedicating time and their expertise, particularly in respect of preparation and attendance at board meetings, but also most crucially active engagement in the work of the sub groups where much of the business of BSAB was conducted. Partners recognised that coordinating those meetings and progressing the work needed would require substantial additional input; they also agreed it was important to secure an Independent Chair to provide the leadership and, where necessary, challenge to progress this important work.

As this was the first year that the Board would operate separately in this manner and was also the first year of the legal duty to undertake safeguarding adults reviews a provisional budget was set at £80,514. Set out below is the 2015-16 account.

ITEM	PROJECTED COST	ACTUAL SPEND	COMMENT
Independent Chair costs	16,500	28,325	Includes costs for undertaking administrative work
Board administrator costs	35, 014	0	Not appointed during period due to internal restructure in Council
Conference and awareness campaigns	10,000	0	This money has been carried over to fund a conference in July 2016 and ongoing awareness campaigns throughout 2016-17
Safeguarding adults reviews and discretionary 'partnership' reviews	15,000	29,811.18	BSAB completed one SAR in 2015/2016 and undertook two further reviews, reported above
TOTAL	80,514	58,136.18	

GLOSSARY

CAADA-DASH Risk Identification Checklist, Domestic Violence and Abuse
CNWL Central and North West London NHS Foundation Trust
CQC Care Quality Commission
LSCB Local Safeguarding Children Board
MARAC Multi-Agency Risk Assessment Conference
MSP Making Safeguarding Personal
NWLHT North West London Healthcare Trust
SBP Safer Brent Partnership

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