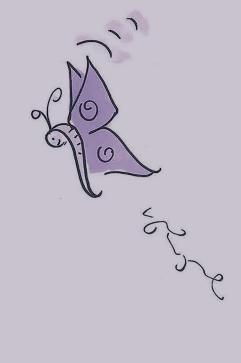
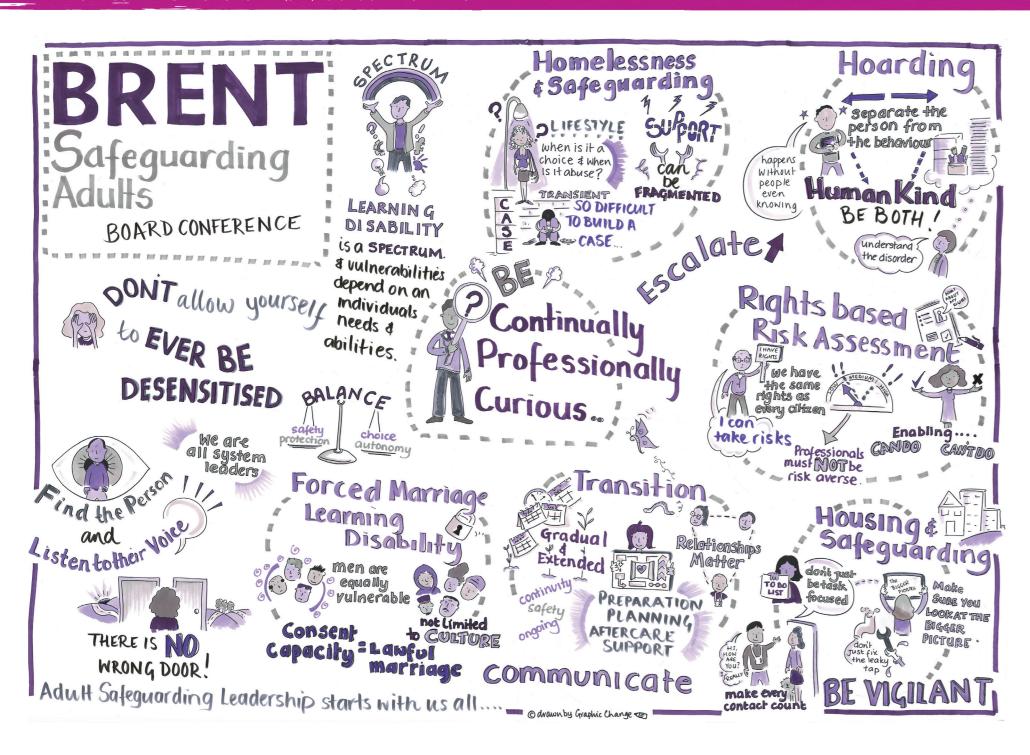
# Safeguarding Adults BOARD





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# INTRODUCTION BY THE INDEPENDENT CHAIR OF BRENT SAFEGUARDING ADULTS BOARD

Welcome to the Brent Safeguarding Adults Board (SAB) 2018-2019 annual report. Publishing an annual report is one of the statutory responsibilities of the SAB laid out in the Care Act 2014. The report provides a useful way for the SAB to communicate to the public about the work of the board over the past 12 months and also what we are planning for the future. I hope that you will find the content interesting, accessible and informative.

The Board held its second adult safeguarding conference which was very well attended and received positive feedback. There were keynote presentations on 'learning from safeguarding adult reviews' and 'challenges and good practices of working with adults with learning disabilities'. There were also workshops on forced marriage of people with learning disabilities, rights based assessments, transitions, hoarding and homelessness & safeguarding.

Another statutory responsibility of the SAB informed by the Care Act 2014 is to commission Safeguarding Adult Reviews where the criteria are met. During 2018/2019, the Board published a Safeguarding Adults Review for the first time

on Adult B. This was a tragic case that identified concerns about the adequacy of care, support and protection given to an adult with severe learning disabilities in Brent. The Board is finalising further Safeguarding Adult Reviews in the cases of Adult C and Adult D and is continuing its work on the case of Adult E. A summary of these cases is described in this annual report. Transitions, self-neglect, mental health and working with adults in the community with dementia all feature within these reviews. A decision with regard to publication will be decided on completion of each these reviews. Where the full report is not published, an executive summary of the review may be published to ensure lessons to be learned are disseminated as widely as possible. One of the main purposes of Safeguarding Adult Reviews is for the board to seek assurance that shortcomings have been addressed and lessons have been learned. A summary of the learning dissemination events carried out by the SAB can be found within the pages of this report.

The complex challenges of working with adults who are at risk from abuse and neglect remains.

The partners of the SAB have experienced financial cuts and many of our partners have been going

through restructuring programmes to cope with the decreases in funding. People are living longer and the number of people experiencing a cognitive decline with conditions such as dementia is increasing, putting a strain on services. How best to keep people safe whilst taking into account how they wish to live their lives is a complex challenge for all SABs and their partners.

During 2018-2019 the SAB has been focussing on modern slavery, domestic violence and self-neglect. The SAB is continuing to develop systems to obtain reliable data from partners asking them to show that adults at risk in the borough are able to live their lives free from abuse and neglect. Work has been completed nationally to make the national safeguarding data more consistent and Brent SAB has contributed to this important work.

The SAB has disseminated learning from Safeguarding Adult Reviews carried out elsewhere and heard presentations from a variety of partners. I have attended scrutiny meetings to inform elected members of the work of the SAB and been present when partners have been called to scrutiny where they have been required

to do so. For example, I presented last year's annual report to scrutiny and was present at the scrutiny meeting to discuss the London North West University Hospital following a CQC report in early 2019. I am also scheduled to present at a scrutiny meeting which will be reported on in next year's annual report to look at the case of the Adult B Safeguarding Adults Review where members will consider the lessons learned and provision for learning disabled people.

The SAB has worked with partners to complete a 'temperature check' on where we are in relation to 'Making Safeguarding Personal'. A 'Safeguarding Adults at Risk Audit Tool' (SARAT) was completed which asked partners to self-audit and provide evidence of their effectiveness in relation to safeguarding. In addition, the SAB commissioned an independent external audit into safeguarding cases in Brent to assure itself that the work being carried out in Brent was effective.

The Safeguarding Adults Board has prepared for a scheduled ADASS Peer Review which will look at Safeguarding in Brent and provide both operational and strategic oversight over the work carried out within the borough. The outcome



of this peer review will inform a future Board development day and will be reported on in full in the next annual report. The SAB is working on a new website and preparing to launch an online safeguarding survey jointly with the Children's Board. This is in addition to considering new referrals for Safeguarding Adult Reviews and preparing for a refresh of the Safeguarding Adults Board Strategic Plan. The coming 12 months are likely to be very busy indeed! A full update on these areas will be provided in next year's annual report 2019-2020.

Finally, I would like to record my appreciation for the work of James Pearce, Daniel Morris, Meenara Islam, Janine Georgias and Nikoleta Nikolova, who have managed and supported the work of the Board. Thank You also to Graphic Change whose skilled artists produced the images used in this annual report, capturing the essence of professional discussions during the Adult Safeguarding Conference.

PROFESSOR MICHAEL PRESTON-SHOOT INDEPENDENT CHAIR

### WELCOME TO BRENT

Brent is one of the most diverse areas in London, second only to Newham. 65% of its population is from a black or ethnic minority background (source GLA 2018).

Population: 337 000 people making it the sixth highest in London (source GLA).

The average household earnings in Brent were the fourth lowest in London (source GLA). 1 in 3 of Brent's residents were low-paid (earning less than the London Living Wage) in 2017-18 (source is Trust for London). Brent has the 10<sup>th</sup> highest level of unemployment in London 7.4% unemployment in 2017 (source APS).

Life expectancy in Brent (male 80.3, female 85 years) is similar to the average for London (male 80.5, female 84.3 years).

Approximately 14.4% of the population reported that they had a long term health condition or disability (2011 Census).



# 3

### WHAT IS ADULT SAFEGUARDING?

The Care Act 2014 made the Local Authority and its partners responsible for protecting adults who are at risk of abuse or neglect. This gave safeguarding adults its first legal footing and replaced previous statutory guidance. The Act requires Safeguarding Adults Boards to publish an annual report and strategic plan, to commission Safeguarding Adult Reviews, and to hold partner agencies accountable for how they work together to protect adults from abuse and harm. The Act stated that partner agencies and services must work together to implement strategies to protect vulnerable adults. At the time of writing this annual report, a review of the ADASS pan-London safeguarding procedures has just been finalised and published.

### **TYPES OF ABUSE**

Physical Abuse, Domestic Abuse, Sexual Abuse, Psychological Abuse, Financial or Material Abuse, Modern Slavery, Discriminatory Abuse, Organisational Abuse, Neglect and Acts of Omission and Self-Neglect.

### **ENQUIRIES AND REVIEWS**

Under Section 42 of the Care Act, the Local Authority has a responsibility to undertake an

Enquiry where a case meets the criteria specified in section 42(1). Where the strict criteria are met. Section 44 of the Care Act states that Safeguarding Adults Boards must arrange a Safeguarding Adult Review (formally known as a Serious Case Review). A Safeguarding Adults Review is completed by a suitably qualified person completely independent of the local authority and its partners. The purpose of a Safeguarding Adults Review is to gather all the facts about the case and for the independent author to make recommendations, in order that the local authority and its partners can learn lessons and improve future practice to achieve better outcomes for vulnerable adults in future. Further information regarding the current status of Brent's Safeguarding Adult Reviews can be found in section thirteen.

### MAKING SAFEGUARDING PERSONAL

Capacity to make decisions is one of the key differences between safeguarding adults and safeguarding children. An adult has the right to make decisions about the way they wish to live their life. Any Enquiry should include an attempt to gain the views of the adult at risk as to what they would like to happen, providing any necessary support such as an advocate. This

is called 'Making Safeguarding Personal'. If the adult at risk has the capacity to make a decision their wishes must be respected. However, this view must be balanced with an assessment of the risks and an agreement reached as to how these risks will be monitored and managed.

### DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

If a person needs protective measures to be put in place to keep them safe, and is assessed as having lost capacity to make decisions about that particular area, either the Local Authority or the Court of Protection, depending on the circumstances, can authorise a DOLS. This gives the service or individual who provides care to a person legal authority to restrict their liberty in a specified way in order to keep them safe. There are strict criteria as to what is appropriate when putting such measures in place. This area currently sits within safeguarding adults in the Local Authority. At the time of writing the Annual Report, new guidance is being developed following changes to legislation. The new legislation will mean this area is referred to as Liberty Protection Safeguards (LPS). A reference to the updated guidance will be in the next Annual Report.

### PRINCIPLES OF ADULT SAFEGUARDING

These principles are contained in the statutory guidance that amplifies how the Care Act 2014 is to be understood and implemented. Published by the Department of Health and Social Care, the principles apply to all safeguarding adult activity, including section 42 Enquiries and Safeguarding Adult Reviews.

**Empowerment:** People being supported and encouraged to make their own decisions and informed consent.

**Prevention:** It is better to take action before harm occurs

**Proportionality:** The least intrusive response appropriate to the risk presented.

**Protection:** Support and representation for those in greatest need.

**Partnership:** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

**Accountability:** Accountability and transparency in safeguarding practice.

# SAFEGUARDING ADULTS MEANS PROTECTING A PERSON'S RIGHT TO LIVE IN SAFETY, FREE FROM ABUSE AND NEGLECT.

# HOW TO F

### HOW TO REPORT ABUSE IN BRENT

The Safeguarding Adults Board is a strategic board. The board does not process operational safeguarding concerns. This is carried out by Adult Social Care within Brent Council.

If you wish to raise a safeguarding concern there is a safeguarding form - please refer to webpage https://www.brent.gov.uk/services-for-residents/adult-social-care/preventing-and-reporting-abuse/ where you can download a form and email it to safeguardingadults@ brent.gov.uk If you have any trouble completing the form please contact the Duty Team at safeguardingadults@brent.gov.uk and they will help you. Alternatively, you may telephone 020 8937 4098/99.





### SAFEGUARDING ACTIVITY IN BRENT

### FOREWORD BY THE TEAM MANAGER OF THE SAFEGUARDING ADULTS TEAM

The London Borough of Brent has its own dedicated Safeguarding Adults Team. The team triage all safeguarding concerns and carry out Enquiries under Section 42 of the Care Act to ensure that vulnerable adults are able to live their lives free from abuse and neglect. These might be adults with health and social care needs, a learning disability or mental health problems. This has been a challenging year for the Safeguarding Adults Team in Brent. Although the number of concerns sent into the Safeguarding Adults Team has seen a slight decrease compared to last year, a higher

NUMBER OF CONCERNS WHICH WERE REFERRED TO THE SAFEGUARDING ADULTS TEAM IN BRENT			
Q1	370		
Q2	321		
Q3	398		
Q4	404		
Total	1493 concerns (1674 concerns were received in 2017-2018)		

percentage of these concerns have progressed to a Section 42 Enquiry. Currently 72.25% of concerns progress to Enquiry compared to 66% last year. This reflects the increasing complexity of the concerns sent to the Safeguarding Team and resulted in the Safeguarding Team completing an additional 151 Section 42 Enquiries compared to the last financial year. The outcome of these Enquiries are that abuse is substantiated in around one third of cases. In approximately 75% of cases the recorded risk was removed or reduced by the team and 75% of adults were satisfied with the outcome of the Enquiry.

The Safeguarding Team has been focusing on collaborative working and has been visiting

NUMBER OF CONCERNS THAT PROGRESSED TO A SECTION 42 ENQUIRY				
Q1	288			
Q2	231			
Q3	263			
Q4	295			
Total	1077 72% of concerns progressed S42 Enquiries (66% of concerns progressed to S42 Enquiries in 2017-2018)			

day services, G.P. surgeries, mental health establishments, hospitals, advocacy organisations and substance misuse services in order to establish better ways of working. This is creating a better understanding between us and our partner's whist leading to a better service for our customers.

The Safeguarding Team has been assessing how it manages working in areas such as neglect, self-neglect and hoarding. The number and complexity of cases in these areas has risen disproportionally in Brent and we are working with our partners to establish a self-neglect panel in line with Pan London procedures to ensure clients receive a holistic effective service.

NUMBER OF SECTION 42 ENQUIRIES			
CONCLUDEDIN 2018-19			
Q1	245		
Q2	226		
Q3	175		
Q4	245		
Total	891 concluded S42 Enquiries 739 were concluded in 2017-2018)		

BREAKDOWN INTO TYPES OF ABUSE				
2018/2019		Previous Year 2017/2018		
Neglect and Acts of Omission	34%	37%		
Financial or Material Abuse	22%	16%		
Psychological Abuse	13%	11%		
Physical Abuse	21%	22%		
Self-Neglect	4%	4%		
Sexual Abuse	4%	4%		
Organisational Abuse	1%	2%		
Domestic Abuse	1%	3%		
Modern Slavery	0.1%	0.1%		

MAKING SAFEGUARDING PERSONAL			
Number of people recorded as being asked what they would like as an outcome			
Q1	185		
Q2	187		
Q3	128		
Q4	198		
Number satisfied with the outcome			
Q1	131		
Q2	135		
Q3	97		
Q4	155		



### SAFEGUARDING ADULTS BOARD STRATEGIC PLAN 2017-2019

# INCREASING AWARENESS AND UNDERSTANDING OF SAFEGUARDING ADULTS WITHIN THE BRENT SAFEGUARDING ADULTS BOARD WORKFORCE AND WIDER COMMUNITY

To work towards this priority, the Community and Engagement Awareness group have been busy with a series of presentations to charities and community groups. The chair has also presented safeguarding awareness sessions namely sessions through CVS, The Carers Centre and Crisis Brent with on-going contact around homelessness issues. Visits have also been carried out to Plias and the Islamic college. The Safeguarding Adults Team and the Clinical Commissioning Group have also carried out visits to partners during training and team meetings to build links and promote adult safeguarding.

# CONTINUING TO WORK TOGETHER TO UNDERSTAND AND MEET THE CHALLENGES OF THE MENTAL CAPACITY ACT 2005 AND DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

As part of the learning dissemination plan, sessions have been arranged for staff on learning from Safeguarding Adults Reviews which included learning around the Mental Capacity Act and Deprivation of Liberty Safeguards. One specific multi-agency learning session was arranged specifically focusing on the Mental Capacity Act and empowering partners in completing assessments.

# SERVICE USER VOICE – TO ENSURE THE WORK OF THE SAB IS INFLUENCED BY SERVICE USERS AND THEIR REPRESENTATIVES

The Safeguarding Adults Board seeks assurance through the data that service users are satisfied with the safeguarding process and that their views are taken into account and actioned. In order to seek external assurance of this the board commissioned an independent audit of safeguarding cases whereby the auditor was asked to seek assurance whether the service users views were obtained, were they provided with appropriate support to obtain their views and were these views placed at the centre of any action taken.

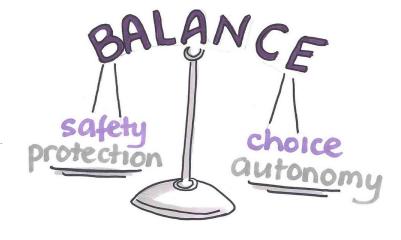
# MAKING SAFEGUARDING PERSONAL – CONTINUE TO WORK TO PROGRESS THE 'MAKING SAFEGUARDING PERSONAL' AGENDA

The Safeguarding Adults Board undertook a Making Safeguarding Personal 'Temperature Check'. This was a multi-agency audit of whether the partners of the board were implementing the principles of Making Safeguarding Personal and what assurance they were seeing in ensuring that this work was ongoing.



# TO USE TRAINING AND WORKFORCE DEVELOPMENT TO SUPPORT THE DELIVERY OF BSAB PRIORITIES

The newly created post of Strategic Partnerships Learning and Development Co-ordinator (for children and adults) has resulted in a number of learning and dissemination events scheduled throughout the year namely; two sessions disseminating the learning in the case of Adult B. one session on self-neglect, one session on multiagency working, two sessions on risk assessment and one session on Mental Capacity. Additionally, the Safeguarding Adult Board conference had a range of speakers and workshops to ensure multi-agency development. The agenda of the conference included briefings on: Learning from Safeguarding Adult Reviews, Forced marriage of people with learning disabilities, Rights based risk assessment, Transitions, Hoarding, Safeguarding awareness for housing providers and Homelessness & Safeguarding.



### TO INCREASE THE VOICE OF SERVICE USERS, CARERS AND THEIR REPRESENTATIVES IN THE WORK OF THE BSAB

The SAB has sought to assure itself that the voice of the service user and their carers and representatives has been taken into account in the referral, screening and enquiry process of safeguarding concerns. It has done this by monitoring data produced by the local authority and by commissioning an independent audit to report to the SAB regarding the service user voice. The SAB has also sought to do this by engaging with representatives from the third sector, Healthwatch and from the learning disability charity 'Sense'.



# STRUCTURE OF THE BOARD AND ITS SUB-GROUPS SAFEGUARDING ADULTS BOARD (SAB)

The Board is a partnership made up of statutory and non-statutory partners.

The Board meets on a quarterly basis.

Sub-Groups below have different aims and objectives linked to the Safeguarding Adults Strategic Plan and meet at frequencies agreed by the chair of each sub-group. The aim of the system is to work in partnership to develop strategies to safeguard adults at risk in Brent.

### CASE REVIEW

The Case Review sub-group considers referrals for Safeguarding Adult Reviews (SAR). Where the criteria are met, it commissions and manages reviews. In addition, the Case Review Sub-Group commissions and oversees learning reviews for cases that fall outside of the mandatory criteria for a SAR but where there is still learning for practitioners and their agencies. The Sub-Group aims to ensure that lessons learned are shared, acted upon and impact is assessed.

### COMMUNITY ENGAGEMENT AND AWARENESS

The Community Engagement and Awareness sub-group aims to deliver activities to ensure that the Board engages with, and seeks the views of adults at risk, their carers, families, frontline workers, advocates and communities in the delivery of its functions and activities. It also aims to positively promote and raise awareness of activities, campaigns and local work to ensure adults at risk are safe in Brent.

# WE ALL HAVE A ROLE TO PLAY ...

### PROVIDER CONCERNS

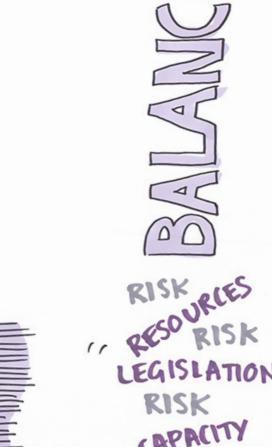
The Provider Concerns sub-group members share knowledge and intelligence about local care services and engage key stakeholders, identify collective concerns or issues, and agree an appropriate multiagency response. Partners ensure a robust multi-agency approach to all quality concerns that are raised.

### THE EXECUTIVE

The Executive is a meeting of the statutory partners (the local authority, the Police and the Clinical Commissioning Group) and is accountable to the Brent Safeguarding Adult Board through quarterly outcome reports that focus on the progress of work under the Brent SAB business plan and risk management log. The primary purpose of the group is to ensure that the business of the Brent SAB is effectively managed and progressed to ensure that partner agencies are fulfilling their statutory obligations under the Care Act 2014 and the accompanying statutory guidance.

### MONITORING AND EVALUATION/ LEARNING AND DEVELOPMENT

The Monitoring and Evaluation workgroup completed a survey and generated a work plan which was submitted to the Safeguarding Adults Board. This recommended that the SAB focus on key areas including raising awareness, best practice sharing events, Mental Capacity Act training, making safeguarding personal training and learning from Safeguarding Adult Reviews. The SAB has arranged learning events on these areas (see section 9). The two sub groups were merged in 2018-2019 due to some overlap of the functioning of the two sub groups.





### CHANGES TO THE BOARD AND THE STATUTORY PARTNERS

### THE SAFEGUARDING ADULTS BOARD

The Case Review Group met on seven occasions over the year in order to monitor the progress of the current Safeguarding Adult Reviews and consider new referrals. The Executive Group also met on seven occasions in order to ensure regular meetings of the statutory partners (The Police, The Clinical Commissioning Group and the Local Authority). The Community and Engagement Group met on five occasions to refresh its work plan and to agree a presentation to raise awareness of Safeguarding in the Borough. The Provider Concerns sub-group was refreshed and met on two occasions. New pan London Safeguarding procedures we agreed in April 2019 which included a new information sharing agreement.

### **BRENT COUNCIL**

Brent Council is in the early stages of planning a transformation programme across Adult Social Care and a further update in relation to the progress being made will be outlined in the next annual report. It has to date made significant changes to the way that it commissions and monitors social care providers following completion of the Adult B Safeguarding Adults

Review. The Council faces a reduction in its budget and is planning accordingly.

### METROPOLITAN POLICE

The Metropolitan Police has moved from a borough-based management model to a Basic Command Unit model of three boroughs. This change has resulted in Brent being clustered together with London boroughs of Barnet and Harrow. This has involved changes to the management structure. BSAB has monitored closely the impact of this change on its work.

### **BRENT CLINICAL COMMISSIONING** GROUP (CCG)

Brent CCG has announced that it is planning to create a Northwest London Clinical Commissioning Group, merging eight CCG's into one. This is an ambitious plan which at the time of writing is in its early stages of planning and implementation. BSAB will be monitoring closely the impact of this change on its work.

### **COLLABORATION WITH OTHER** STRATEGIC BOARDS AND SERVICES

Regular meetings continue to take place between the Chairs of the Safeguarding Children Board, Safeguarding Adults Board and Safer Brent Partnership. The three chairs identified Modern Slavery as an area of collaboration and commissioned a task and finish group. This group produced a detailed paper on Modern Slavery and is now convening further meetings to develop a procedure for front line practitioners. The SAB is working on a new website in partnership with the Local Safeguarding Children Board and preparing to launch safeguarding survey jointly with the Children's Board, the results of which will be published in the next annual report.

### **CURRENT SAFEGUARDING ADULT** REVIEWS

The Safeguarding Adults Board did not commission any new Safeguarding Adults Reviews in the year 2018-2019. However, it continued overseeing the preparation of Safeguarding Adult Reviews C, D and E.

### PARTNER ORGANISATION CONTRIBUTIONS





















**Care Quality**Commission











### HEALTHWATCH BRENT AND ITS INVOLVEMENT IN THE BRENT SAB 2018-19

The national Healthwatch network was established through the Health and Social Care Act 2012. Through this, each local Healthwatch has the legislative right to:

- Have a seat on the Safeguarding Adults Board.
- Undertake visits to health and social care settings for adults. These Enter and View visits are carried out by staff and volunteers who review the quality of care for those using services and their families, friends and carers.

We combined these two roles to present a report to the Board about six Care Homes we visited.

Overall, the care homes had reasonably good awareness and practice of adult safeguarding. But some were far better than others. For example, one was excellent with recording all risks and events related to safeguarding but was rather impersonal in its day to day interactions with residents. Another was a very warm and cosy environment but safeguarding related information was recorded only when an incident occurred.

This prompted a great deal of discussion at the board that resulted in two significant recommendations being taken forward –

• The Establishment Concerns sub-group of the Board was given the additional task of sharing

- good practice between nursing and care homes in Brent
- And all key stakeholders should be part of this group – NHS, Council, CQC, Healthwatch Brent and Police.

This group was set up in December 2018. It was clear to see that this joint approach allowed for effective action to improve concerns with certain services. We look forward to the further development of this group to find ways of sharing good and excellent practice across all care homes.

A direct example of improving safety for Brent residents came through our Enter and View visit to a Sheltered Housing Scheme this year. The visit aimed to look at various aspects of life in the sheltered home, such as psychological & social well-being, care planning, complaints, and staff/workforce.

The lack of a communal space in one scheme made gathering the views of the residents more difficult; however, everyone worked together to make this happen. The volunteers discovered that there was anti-social behaviour occurring in the area outside the scheme which made the residents feel unsafe. They had also experienced intruders, some under the influence of drugs, gaining access to the scheme.

The Healthwatch Brent team gathered evidence of anti-social behaviour and inspected the premises thoroughly so that detailed evidence could be presented to the Housing Officer later in the day.

After a meeting with the housing officer a series of changes were agreed, including:

- Operational CCTV approved with remote monitoring, which also helped to address a fly tipping concern
- Doorways monitored, and any suspicious activity reported to the police
- Security lights to be installed and the addition of security gates will be explored.

All residents we spoke to were concerned about safety. Our Enter and View volunteers were able to contribute to multi-agency working to resolve issues affecting the residents. Because of our visit, the lives of residents of the Sheltered Housing scheme has been dramatically improved. They now feel safer and have more confidence in reporting issues to the Housing Association and the police.



### BRENT CLINICAL COMMISSIONING GROUP

NHS Brent Clinical Commissioning Group (CCG) is a clinically-led statutory body responsible for planning and commissioning of health care services in Brent, and overseeing the safeguarding arrangements of health providers in Brent (whether NHS commissioned or not). The CCG maintains good constitutional and governance arrangements with capacity and capability to deliver safeguarding duties and responsibilities. This includes:

- Effectively commissioning services, ensuring that all service users are protected from abuse and neglect;
- Ensuring comprehensive and effective single and multi-agency safeguarding arrangements are in place;
- Ensuring health providers participate in local safeguarding arrangements, and contribute to multi-agency working;
- Ensuring lines of accountability for safeguarding are clear, and reflected in governance arrangements.

NHS Brent CCG has raised the profile of modern slavery as a safeguarding area across the local healthcare economy, and ensured health providers were compliant with the Modern Slavery Act 2015.

The Designated Nurse for Safeguarding Adults attends and contributes to the Brent

Safeguarding Adults Board and its sub groups. The CCG also supports work in relation to the following areas: Prevent; Violence Against Women and Girls; and Multi-Agency Risk Assessment Conferences.

The new safeguarding reforms and legislation are transforming the safeguarding landscape. There is a focus not only on protection, but also on a 'Think Family' approach, strengthening the prevention agenda, and promoting contextual safeguarding. The CCG champions the Think Family approach, which promotes co-ordinated thinking and delivery of services to safeguard children, young people, adults and their families/ carers. The CCG reviewed its Safeguarding Health Outcomes Framework. This is a consistent reporting framework for providers to enable a clear picture of Safeguarding Adults and Children across North West London, and provides assurance for the CCGs, Trust Boards, and Local Safeguarding Boards and partnerships.

The safeguarding team in the CCG delivered safeguarding training to health staff in the CCG and wider local heath economy. This improved the competency of all those involved in safeguarding activities, enabling the principles and duties of safeguarding adults and children to be consistently and conscientiously applied.

The Designated Nurse for Safeguarding Adults

led the Learning Disability Mortality Review (LeDeR) programme within the borough. This aimed to drive improvement in the quality of health and social care service delivery for people with Learning Disabilities (LD). Learning from the reviews is reported across the borough to improve practice.

Safeguarding adult cards across the NWL were updated. These cards are used as a quick guide to support all staff in their practices. The quick reference cards can be used to look up local authorities and designated professional contact details across North West London.

NHS Brent CCG was involved in standardising pressure ulcer referrals, using the Department of Health Safeguarding Adults Protocol. The CCG will provide on-going monitoring and support to provider organisations in addressing their own challenges in preventing and managing pressure ulcers.

The CCG continues to undertake quality assurance visits in health providers. These visits are a learning opportunity, and help each provider meet their duties to safeguard adults at risk, and promote the welfare of those identified to be at risk of harm, abuse or neglect. Providers are advised of area of concerns in safeguarding adults and recommendations to promote improvement.

### CASE EXAMPLE OF COLLABORATIVE WORKING

AA, an adult at risk, diagnosed with emotionally unstable personality disorder and schizophrenia. He also had history of heroin and crack use and had a tendency to use diazepam to manage his tinnitus. He was known to the mental health team and was also receiving weekly support from Drug and Alcohol team. There was a period of time when AA was unreachable. All attempts to see him at home were unsuccessful. All calls directed to voicemail. This was considered unusual for AA as he engaged in his weekly coffee morning and arts group with Drug Project. 101 were contacted who completed a welfare check, again unsuccessful. AA was registered as a missing person.

Drug Project contacted NHS Brent CCG for their intervention; this prompted the escalation of the concern to partners in the borough. Within minutes of the escalation, the whereabouts of AA was known. He was described by the reporter as safe and well.

This was a good example of collaborative working between partners in the borough. It demonstrated sharing ideas, knowledge, and information to promote the welfare of people.



### LONDON AMBULANCE SERVICE (LAS) PRECIS OF ANNUAL REPORT 2018-19

### **OUR PRIORITIES IN 2018-19**

- Secure sufficient resources to develop safeguarding in the Trust
- Monitor trust's safeguarding processes and compliance
- Support Trust with safeguarding practice & requirements
- Assure Trust processes by driving consistency and improvement in safeguarding practice
- Forge effective relationships internally and externally

### WHAT WE DID

- Secured funding to increase safeguarding team by 100% to enable a dedicated safeguarding specialist in each area of Trust.
- 7% increase in safeguarding concerns and referrals to 23,471.
- Introduced 24/7 safeguarding telephone line for staff
- >90% safeguarding training Compliance
- Introduced Quarterly Safeguarding Newsletter
- Produced new safeguarding pocketbook for staff
- Introduced Chaperone and Supervision policies

- Held Safeguarding Conference for over 170 staff and partners
- Introduced Learning Disability and Mental Capacity Act Strategies.

### **OUR PRIORITIES FOR 2019-20**

To be outstanding in quality standards and drive continual improvements

- Excellent Governance and Assurance of Trusts safeguarding processes and compliance
- Development of the Safeguarding Team
- Successful delivery of safeguarding training plan, local education and supervision
- Safeguarding innovation and review current practices to identify cost savings.
- Ensure integration of 111 & IUC
- Forge effective relationships internally and externally to safeguarding children and adults

In conclusion the LAS is committed to safeguarding and has invested in the safeguarding team to ensure Trust is compliant with standards and provides the highest level of care for its most vulnerable patients.

The Full LAS annual report can be found on the Trust website.



### **LONDON FIRE BRIGADE 2018-19**

The London Fire Brigade's (LFB) commitment to safeguarding is stated within its Integrated Risk Management Plan. LFB has a proven track record of engaging positively at both strategic and tactical levels with partner organisations. The LFB has continued to work towards facilitating a broader partnership and community engagement approach and has contributed to LSAB's development of information sharing and referral pathways among agencies to deliver a joined up approach to safety, health and wellbeing of London's diverse communities. Furthermore, LFB has voluntary contributed £1,000 for four years to the Safeguarding Adults Board and Safeguarding Children Board to help the Boards meet their priorities.

In line with 'Making Safeguarding Personal' (MSP) principles, LFB has worked towards facilitating a broad partnership and community engagement approach, which focuses on prevention as well as protection, with outcomes aimed at addressing both people's safety, as well as their wishes. Our main tool to protect individuals continues to be Home Fire Safety Visits (HFSVs), and many of those participating in this service are vulnerable adults. A significant proportion of safeguarding referrals raised by LFB staff are as a direct result of HFSVs, where individuals are found to have additional safety, care and support needs, or are

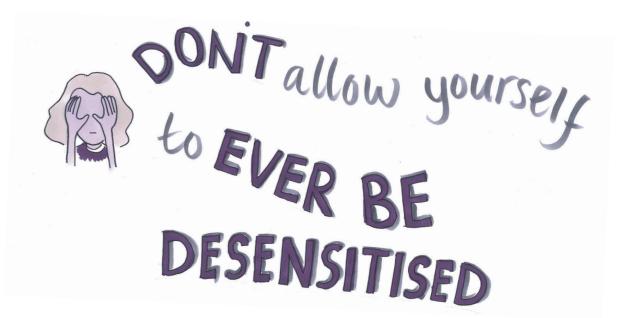
at risk of abuse and neglect by a third party, or fall under the self-neglect category.

Our training has been developed to make all staff aware of their responsibilities to report safeguarding concerns. The training is comprised of different modules, each is matched to the different levels of staff responsibility. Teams that work routinely with adults and children at risk receive an enhanced training provision to allow for more in depth knowledge of safeguarding issues and emerging themes.

The LFB has an ongoing process of review and sharing of best practice; however, we believe there is potential to improve this process by introducing greater scrutiny centrally. With this in mind, one of

the most experienced managers from our central safeguarding team is undergoing SAR Champion training, and this will influence our future approach to learning from SARs.

As a result of a recommendation from a Safeguarding Adult Review the Brigade delivered an information sharing pilot with the London Ambulance Service to provide Home Fire Safety Visits to high risk hoarders (who had been identified by the LAS). Following the success of the pilot this partnership work was embedded into core business, and we have since started considering the option of replicating this arrangement with the Met Police. We will be exploring this option further during 2019/20.



### LONDON NORTH WEST HEALTHCARE NHS TRUST

London North West Healthcare NHS Trust (LNWHT) is one of the largest integrated care trusts in the country, bringing together hospital and community services across Brent, Ealing and Harrow.

Established on 1 October 2014, the Trust employs more than 8,000 staff and serves a diverse population of approximately 850,000.

London North West Healthcare NHS Trust is responsible for the following services in Brent:

- Central Middlesex Hospital
- Northwick Park Hospital
- St Mark's Hospital
- Community services across Brent including the Willesden Centre for Care.
- Urgent Care Centres

### **INTRODUCTION**

LNWHT has a well-established safeguarding adults team; the team leads on all aspects of adult safeguarding across the organisation. The team is responsible for training and development, responding to adult safeguarding concerns, liaising with local safeguarding adult and children teams and data collection and analysis.

The team attends Safeguarding Adult Boards

and subgroups and works closely with local stakeholders and partners.

Key performance information for the Adults Safeguarding Service at London North West Healthcare NHS Trust is summarised below.

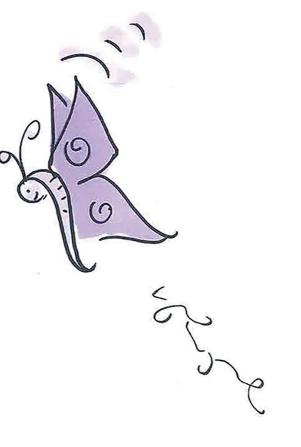
Adult Safeguarding Alerts 2018/2019 (statistics across Brent, Ealing and Harrow):

LNWHT safeguarding adult alerts, notified by staff, saw a slight decrease by 2.8% 2018/19. This however has not affected the strong safeguarding culture that exists in the Trust and that the focus on training continues to have a positive impact on staff awareness of their safeguarding responsibilities.

The Safeguarding Adults Team monitors and analyse all referrals made at the Trust. The analysis helps the team spot trends in types of abuse and informs future development of staff training packages.

### ADULT SAFEGUARDING CONCERNS

	QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4	TOTAL
2017-2018	207	198	177	194	776
2018-2019	177	180	178	219	754



	QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4	TOTAL
Discriminatory abuse	0	0	0	0	0
Domestic violence	18	11	22	22	73
Financial or material abuse	11	7	9	10	37
Modern slavery	1	1	3	0	5
Neglect and acts of omission	116	127	91	141	475
Organisational abuse	0	0	0	0	0
Physical abuse	13	20	29	14	76
Psychological abuse	5	0	6	9	20
Self-neglect	8	8	19	29	64
Sexual abuse	3	4	5	0	12

The Trust currently employs a Learning Disability Specialist Nurse. The nurse oversees the delivery of training and education to Trust staff, recently setting up and training a team of learning disability (LD) champions within the nursing workforce. The service provided by the LD nurse includes the assessment and support of patients with Learning Disabilities attending the Trust for care.

The adult safeguarding team have been involved in the Trust's commitment to improve care provided to patients with dementia. In the past year the team contributed to the development of a new patient pathway for patients suffering with confusion. Additionally, the Trust has signed up to John's Campaign which enables relatives and carers of patients, who are suffering with dementia, greater access to the hospital outside of normal visiting hours.

In the past year the Trust reviewed its actions against the Kate Lampard recommendations; in particular focusing on the volunteer workforce. As a result of this review the volunteers have been properly vetted and screened with a bespoke induction program provided that includes a focus on Safeguarding.

In the last 12 months the governance of the adult safeguarding process at the hospital have been reviewed and improved upon. A monthly steering group provides professional oversight of the safeguarding process and an escalation report is produced that informs the Trust board of the progress made against the organisation's adult safeguarding responsibilities. A secure database has been introduced to track all safeguarding referrals made within the Trust. This also provides

key data that supports the work of the team. All complaints and incidents are now reviewed and those containing safeguarding elements are identified and referred as appropriate.

The Trust has reviewed key safeguarding policies over the last year with new policies being agreed and introduced. An element of this work has resulted in the provision of safeguarding supervision to staff involved in safeguarding cases.

The Trust remains committed to delivering its responsibilities detailed within the 2014 Care Act. The year ahead provides a number of new challenges that will be delivered by the team.

The Trust will continue to work in partnership with local Safeguarding Adult Boards ensuring attendance and engagement at the quarterly board meetings. The priorities for the year ahead include the provision of new training levels to comply with the new intercollegiate training recommendations and working to embed adult safeguarding supervision as good practice across the organisation.

The Trust will review its current policies and practice in relation to modern slavery and ensure that there is increased staff awareness around this issue.

The safeguarding adults team will continue to raise the agenda of support for vulnerable adults throughout the organisation and continue to work closely with children's safeguarding to embed the Think Family approach into all that we do.

### **SENSE NATIONAL CHARITY**

Sense give Safeguarding a very high priority across the whole organisation, with a Safeguarding board that has an independent chair, the board review all Safeguarding incidents that are reported across the organisation. We have targeted getting all incidents recorded on a secure data base, this means we are able to follow progress with resolving issues, being aware of when cases can be closed.

Members of the board include academics who have a specific interest in Safeguarding issues and experience of the social care sector.

As a member of both Brent SAB and the case review sub-group I am in the privileged positon of being able to share learning and ensure that I can bring both a local and national perspective to the work of both.

Last year we committed to reviewing and updating our Safeguarding training, we deliver a mix of blended learning for all staff, no matter what role they have as we believe that Safeguarding is everyone's responsibility, we updated our Policy and related Policies.

### PRIORITY 2019/2020

Ensure all staff and volunteers receive training

Embedding Making Safeguarding Personal in practice

Regular awareness raising by sharing good practice – eg. from membership of Voluntary Organisations Disabilities Group, Ann Craft Trust Hope.

Ensure staff and managers all have MCA training

Spreading the use of Safe Guides across all Sense services (Safe guides are personalised guides for the people we support) these meet their individual communication needs e.g. in a format that is designed for them.

Ensure that 100% of all staff are trained and have regular competency checks

Use safeguarding adult reviews from the national repository to a greater degree to raise awareness of issues and learn from the reviews, use these to review policy and practice.



### BRENT COUNCIL – ADULT SOCIAL CARE

It is every person's fundamental right to be protected from abuse and neglect, able to live safe and well. Brent Council and the Adult Social Care Department, with a lead role for safeguarding, are committed to ensuring adults at risk in our area are protected when they need to be, treated fairly and with dignity and respect, and able to easily get the support when they need it.

During 2018-2019 we received and acted upon 1493 safeguarding concerns. Of these concerns 1077 met the criteria for a Section 42 Enquiry, which means we had a statutory duty to make decisions with the adult at risk about the actions to take to stop, prevent or mitigate the impact of abuse.

### WHAT WE DID

- Supported the majority of adults at risk (82%) to feel satisfied with their achieved outcome at the end of a safeguarding intervention. A further proportion (15%) were partly satisfied
- We raised awareness, so organisations as well as residents know how to report concerns of abuse. For example, our safeguarding manager presented information on abuse and how to raise concerns to residents and day centres.
- Worked together with partners and attend the MARAC, MAPPA and Community MARAC, contributing to a multi-agency response

- to help adults achieve the outcomes from safeguarding they have identified.
- Continued to work in a holistic and proactive way with commissioners of care to ensure residents in receipt of care services are protected.
- Our Direct Services worked with the Metropolitan Police to deliver training for staff and carers on hate and mate crime, so vulnerable adults can access the justice system.
- Supported adults to have access to advocacy and helped to link people to services that reduce social isolation.
- Continued to develop person-lead practice, including better risk assessments and safeguarding plans co-created with the adult at risk to assure their future safety.

### WHAT WE PLAN TO DO

- Continue to focus on Making Safeguarding Personal, which means it is person led and engages the person throughout to address their needs.
- Strengthen our approach to self-neglect and hoarding in partnership with organisations throughout Brent.
- Embed a strength based approach, focused on an individual's recovery, resilience and ability to protect themselves from abuse.

 Prepare for the changes in legislation and practice as the Deprivation of Liberty Safeguards (DoLS) move to the new Liberty Protection Safeguards in 2020.

Our practice – a case example: Ms A lived on her own in a housing association property. She was victim to a scam, and the scammers then targeted her on a number of occasions. Ms A no longer felt safe in her home and neighbours trying to support her were also at risk. Ms A was supported into a period of respite away from the property, so that she could make a decision while not in immediate fear, about her long term wishes. Ms A decided not to return to the property and is now thriving in a more supported environment. Police reported that her property was broken into after she had left, so were positive about the outcome and that she was no longer at risk. The Safeguarding Adult Team will support the housing association to learn lessons for the safety and wellbeing of other residents.



### CENTRAL AND NORTH WEST LONDON NHS TRUST (CNWL)

### **CNWL PRIORITIES AND ACTIVITY IN 2019**

Implementing and embedding the new MCA guided decision-making template on the clinical system which has been developed using good practice and case law.

Developing a CNWL 7 minute briefing format to cascade learning lessons from SARs to be shared across teams and create a repository for these centrally.

Improving recording of family groups on the clinical record system thus maintaining a think family agenda and bringing safeguarding children and safeguarding adult information together.

Auditing the use of the safeguarding node on the clinical record system sharing findings and action plans across teams and the Borough.

Working with the newly appointed LPS Implementation Lead to ensure staff are fully briefed and prepared for the transition to LPS from DoLS in October 2020.

Continuing to adopt and embed a multi-agency approach to self-neglect and hoarding.

Promoting professional curiosity in safeguarding adult practice through dissemination and discussion of CNWLs Clinical Message of the Week.

Continuing to develop the series of keeping safe leaflets, for example—domestic abuse, self-neglect. Feedback from service users and carers on the leaflets produced has been very positive. CNWLs Sexual Safety leaflet has been adopted by other NHS Trusts.

### **CASE STUDY**

Mr X was admitted to PRCMH on Section 2 of the Mental Health Act: his first admission to a mental health unit. This followed a relapse in his bipolar affective disorder and presented as manic and elated. He was married with a teenage son and held a position of trust in the local community.

Safeguarding concerns were raised by ward staff due to his sexually inappropriate behaviour towards other male service users. This had involved touching and caused significant offence and distress to those adults at risk.

Each incident was reported to the Police in line with Trust policy and in accordance with the wishes of the adults at risk. Initially, Police were unable to interview Mr X as his care team deemed him to be too unwell to interview and he lacked capacity to consent to be interviewed. The Police officer

maintained contact with CNWL staff and X was subsequently interviewed at a later date.

A Safeguarding Strategy Meeting was held, attended by CNWL, Police, and his employer, and chaired by the Safeguarding Adult Manager. Actions agreed included more fact finding by all agencies around a previous unreported incident several years ago.

Mr X said his actions were not sexual. The service users involved chose individually not to press charges. Mr X chose to resign from his employment and moved with his family from Brent.

The safeguarding outcome was that the concern was upheld. X was unwell at the time. Staff acted quickly to support all service users involved and they could not have predicted the incident. X was not known to present with any sexual risks. Information came to light after the event at the Strategy Meeting. His risk assessment and management plan was updated to reflect this new risk.

### BRENT COUNCIL – TRADING STANDARDS

Financial abuse has wide ranging consequences for the victims which is why Trading Standards prioritise this area of work. Whether a victim has been subject to a mass marketing or doorstep scam immediate actions are required to stop the victim suffering any further loss.

It is widely acknowledged that victims of scams, specifically the elderly and consumers made vulnerable by their circumstances, experience deteriorating health, loss of self-confidence and in many examples, loss of independence. It follows that that this then creates additional financial costs and demands on the health and social care sector.

The Care Act 2014 creates a duty for local authorities to take steps to prevent individuals being subject to financial abuse. Preventing people becoming victims is a key element of maintaining health and wellbeing in later life.

The Trading Standards Service offers 'Rapid Response' to rogue trader victims and will immediately attend the scene when we receive notification a doorstep crime is suspected and the alerted perpetrator is still on site. This will increase the chances of apprehending the perpetrator.

We work in partnership with the police on Operation Liberal where officers visit domestic properties where building work is visible and make spot checks to ensure builders have provided contracts and cancellation rights.

The Service has a contract in place to receive referrals from the National Trading Standards Scams Team where victims have sent money to bogus prize draws or similar, via the post. We visit the consumers and explain what has happened and where possible, return the victims their money. Advice is given on how to spot and avoid being a victim again in the future.

We deliver talks to relevant groups as part of our community engagement work to highlight and prevent scams and doorstep crime. The talks focus on what to look out for and report any suspicions. Examples of this were taking part in the national scams awareness month, attending neighbourhood watch events and speaking at the Age UK Brent scams.

The Team support the 'Banking Protocol' which sees the Police and/or Trading Standards respond to calls from banks staff when they suspect a vulnerable person is withdrawing cash for suspicious building works.

We continue our partnership work between Trading Standards and Adult Social Services to safeguard adults at risk against scams and mass marketing fraud recognise as area of best practice.



# 11

### SAFEGUARDING ADULT REVIEWS

### **ADULT B**

The SAR in relation to Adult B concerned a person with learning disabilities and autism who spent much of her life in residential care. Adult B was found to have an infection 2016. Clinical evidence suggested that it is most likely that the infection was sexually transmitted and professionals were clear that Adult B did not have the capacity to consent to having sexual relations. The SAR was completed in July 2018 and was the first Safeguarding Adults Review to be published by Brent Safeguarding Adults Board. The review examined the care provided to Adult B, how services are overseen and how the risks were managed. In response to the lessons to be learned identified within this SAR:

Brent adopted a model of separating commissioning into residential (and nursing) and community teams, with officers developing a specialist knowledge of a portfolio of providers.

- When reviews are undertaken from a commissioning perspective, all Brent clients are now reviewed rather than a sample.
- Improvements made to the 'provider concerns' meeting which brings together the pro-active and reactive intelligence held by

the local authority and the partners.

- Transforming Care policy development including the development of an integrated learning disability team which went live in October 2018.
- A drive within Brent to promote health and communication passports.

Development of the New Accommodation Independent Living (NAIL) project where the local authority is the landlord of supported living accommodation.

The elected members have raised that they wish to discuss the case of Adult B within the scrutiny committee to ensure oversight over service provision. This is likely to take place in June 2019 and will be reported on in the next annual report.

- To ensure front line learning for staff, the Chair of the SAB has undertaken:
- Two large learning dissemination events where staff and operational managers from all partners were invited to discuss the learning from this case.
- Information provided at Safeguarding Conferences in 2018 and 2019.

### **ADULT C**

This review is in its final stages of completion and is expected to be completed in summer 2019. The key facts of the case are that in the pre-millenium era, whilst in secondary school, Adult C suffered a severe mental health crisis. His parents removed him from school and he lived an isolated existence in poor living conditions well into adulthood. The SAR aims to undertake a dual analysis forming a view of whether the actions taken at the time were acceptable given the systems in place at that time; or whether Adult C was failed and the standard of practice substandard. It will also examine how the agencies worked together, whether there were missed opportunities to safeguard Adult C and explore whether this could happen again or systems are in place so as to prevent a repeat.

### ADULT D

Adult D was commissioned as a SAR in early 2018. The key facts of the SAR are that Adult D died in his early 70s. He had a diagnosis of depression in later life with suicidal thoughts. He had health issues, namely COPD, which impacted on his mobility. He began severely neglecting himself which led to him being hospitalised. Whilst in hospital he was assessed by Adult Social Care and was given a care package on his discharge from hospital. His home was 'blitz cleaned' by a specialist company. Initially, he engaged with the care package but over time

began refusing entry to carers. Due to his nonengagement the care package was cancelled. Adult D was later found dead in his home after a warrant was issued to allow the housing provider to gain entry to check the functioning of the gas meter. This SAR is expected to be fully completed in late 2019. The SAR aims to examine: the application of Metal Capacity Act, personal choice, and the systems in place to monitor missed calls by commissioned care providers. It will also address arrangements for move on accommodation, and mental health support for depression when GPs feel unable to manage the symptoms. It will touch on the role and resources of outreach teams and community engagement services on offer for people who feel lonely and isolated. It will investigate the internal workings of Adult Social Care, focussing on the interfaces between customer services, duty social work teams, support planning teams and the review team and will compare how commissioning worked at the time to how it works currently.

### ADULT E

This review focuses on an older adult with dementia who was living in extra care accommodation. He had a history of leaving this accommodation and of being returned by the police. On the last occasion he left the accommodation, it was not noticed for some hours that he was missing. He did not have his alarm and tracker with him. He tragically died before the police were able to locate him. The review is focusing on whether all appropriate steps were taken by the extra care provider and the agencies supporting this placement with respect to mental capacity and risk assessments, the supply of technological aids and adaptations to support the placement and to keep Adult E safe, and whether adequate consideration was given to whether or not to deprive him of his liberty according to law. A reviewer has been appointed and initial information about how agencies worked with Adult E is being collected.



# BRENT SAFEGUARDING ADULTS BOARD BUDGET, INCOME AND EXPENDITURE 2018-2019

INCOME 18/19	AMOUNT
Clinical Commissioning Group	£25000
London Borough of Brent	£37400
MOPAC	£5000
LFB	£500
Total	£67,900

ITEM	EXPENDITURE
February 2018 SAB conference	£9,000
SAR: Adult C	Deferred until completion
SAR: Adult D	Deferred until completion
SAR: Adult E	Deferred until completion
Independent Chair Fee's 30 days	£16,500
Planned Multi-Agency Audits	Deferred until next financial year
Website development	Deferred until next financial year
Joint Survey (SAB contribution)	Deferred until next financial year
Annual Report Costs	£800
Promotional material costs	£360
Printing costs	£100
Cost of Board Meetings (Including	£858.50
room hire and catering)	
Total Expenditure	£27,618.50
Reserves to carry over to next year for deferred payments:	£40,281.50



### THE COMING 12 MONTHS AND FUTURE LEARNING EVENTS

Currently Brent has 3 Safeguarding Adults Reviews at various stages of completion (Adults C. D and E). The focus of these reviews is to learn lessons and develop strategies to reduce the risk of similar events happening in future. Learning events will be scheduled at important stages of the reviews to ensure that necessary changes can be made to procedures and practice. The SAB will also continue to consider new referrals.

Lunch 'n' Learn Sessions focusing on topical issues will be scheduled throughout the year and the Safeguarding Conference will take place in Spring 2020 which will focus on key areas of safeguarding practice identified by the board, and current Safeguarding Adult Reviews both within Brent and elsewhere.

The board will open itself up to scrutiny by engaging with an ADASS Peer Review and invite the reviewing team to comment on the positives and areas for improvement for the Safeguarding Adults Board.

A tri-borough (Brent, Harrow and Barnet) multiagency learning event is scheduled for December 2019 and will reported on in the next annual report.

There is a planned audit examining adults with dementia living in the community to provide

the board with assurance that risks are being assessed and the provision meets the needs of the sample audited.

The Board will undertake a development day scheduled for October 2019 to refresh its strategic plan and consider the best structure for the board.

The joint safeguarding website with the partnership arrangements for safeguarding children will be launched later in the year as well as a joint safeguarding survey with the Safeguarding Children Board.





