BSAB ANNUAL REPORT 2017-18

Brent

drawn by Graphic Change

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3 Introduction by the Independent Chair of Brent Safeguarding Adults Board

It is my pleasure to introduce you to this annual report. I hope that you will find much of interest as we review the year in question and highlight our future objectives. We have tried to make the report accessible and informative. We received positive feedback on how we presented last year's annual report and we have tried to build on that approach.

The Board held its first adult safeguarding conference, with keynote presentations and workshops on making safeguarding personal, self-neglect, mental capacity and financial abuse. Adult safeguarding conferences will become an annual event and the second is already being planned. The graphics developed during that conference have been used to illustrate this annual report.

During 2017/2018, the Board worked towards completion of the safeguarding adult review concerning Adult B. There were complex police and social care investigations. The Board also began safeguarding adult reviews with respect to Adult C, Adult D and Adult E. Details of these cases are described in this annual report. Again, there have been complex police and social care investigations in some of these cases. The importance of finding safe and effective placements, and of offering health and social care services that can meet people's complex needs, is a recurring theme in these cases.

The challenge now for the Board will be to disseminate the findings of these safeguarding adult reviews and to use them to keep under constant scrutiny the strengths and vulnerabilities of policy and practice locally. Quarterly learning and service development seminars will be arranged to keep the focus on the learning from safeguarding adult reviews and to help the Board to drive improvements in policy and practice.

There remain considerable challenges of course. The public and third sectors continue to experience financial austerity, the impact of which directly affects the resource available to keep adults safe from abuse and neglect and to meet their care and support needs. Health and social care practitioners are having to manage increasingly complex cases. In addition to types of abuse and neglect that have become sadly all too familiar, such as physical and financial abuse, and neglect, practitioners are also having to be vigilant in identifying and responding effectively to cases of modern slavery and human trafficking, and of self-neglect and hoarding. The Board is working with partners to develop guidance for responding to such cases.

Obtaining reliable performance management data with which to scrutinise how effectively adults are being safeguarded from abuse and neglect remains a challenge but the Board has developed an approach to collecting quantitative data from across all agencies. Work is now underway to add a qualitative picture alongside the statistics which will enable analysis of the outcomes of policy and practice.

Along with its partners the Board remains vigilant about standards in care settings and increasingly concerned about unregulated providers. The Board has discussed safeguarding adult reviews that have been published by other Safeguarding Adults Boards and has raised concerns through the London Safeguarding Adults Board.

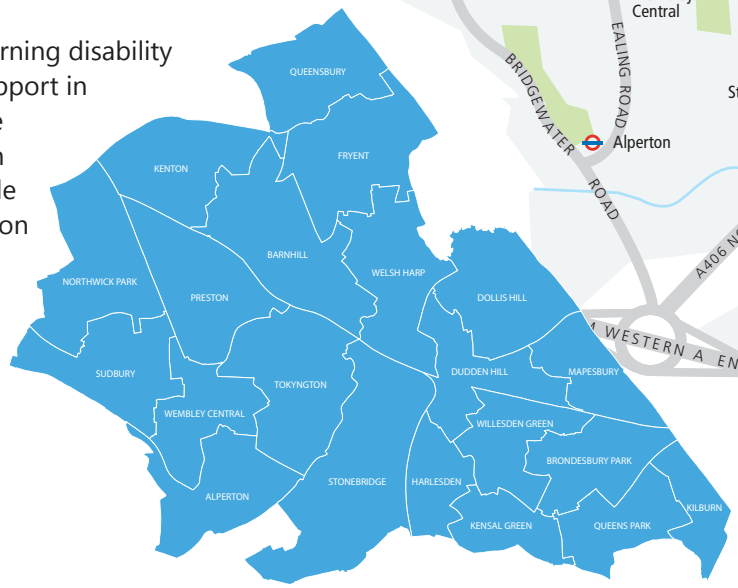
The commitment of agencies in Brent to work together to safeguard adults from abuse and neglect, at both strategic and operational levels, remains strong and provides a platform on which to build on the work described in this annual report.

Finally, I would like to record my appreciation for the work of James Pearce, Meenara Islam, Janine Georgias and Nikoleta Nikolova, who have managed and supported the work of the Board. This has enabled effective and efficient conduct of the Board's business. I also acknowledge everyone working on adult safeguarding in the Board's partner agencies. Adult safeguarding is indeed everyone's business.

Professor Michael Preston-Shoot

4 Welcome to Brent

- Brent population: 334,800 and is the sixth most densely populated borough in London.
- 11.8% of the population aged 65 and over.
- 53% were born abroad making Brent the 2nd most popular borough for international migration.
- Life expectancy in Brent (male 80.12, female 85.1) is similar to the average for London (male 80.34, female 84.2) with Mortality rate from causes considered preventable 158.5 per 100,000 population (London average 167.7).
- According to the Trust for London, 33% of the population of Brent is defined as living in Poverty and 32% earn less than the London living wage, this is a higher rate than almost all other London Boroughs (one borough out of 32 is ranked higher).
- 2.65 people had a learning disability getting long-term support in Brent per 1,000 of the population against an average of 2.77 people per 1,000 in the London area (Source PH)



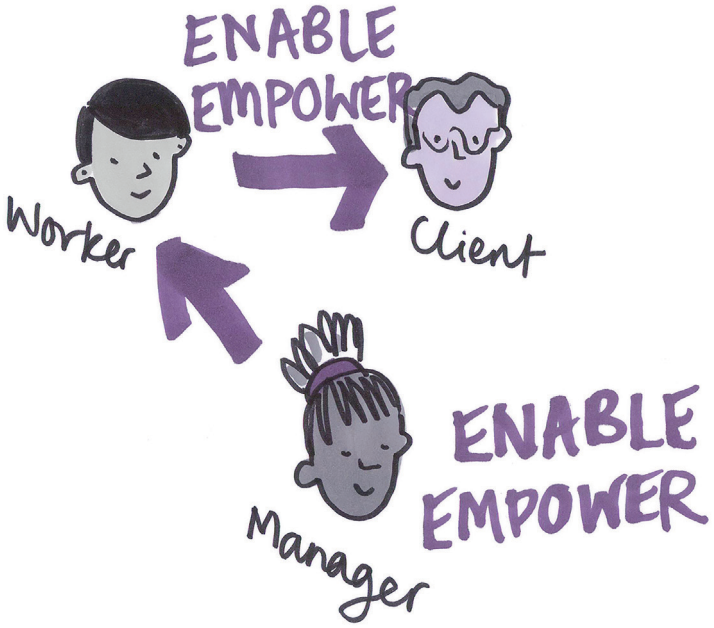
5 What Is Adult Safeguarding?

The profile of Adult Safeguarding increased in 2000 with the release of the 'No Secrets Guidance'. The Care Act 2014 made Local Authorities and its partners responsible for protecting vulnerable adults (loosely defined as adults with care and support needs) 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.

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

Enquiries and Reviews: Under Section 42 of the Care Act, the Local Authority has a responsibility to undertake an Enquiry to investigate a concern raised that meets the threshold. The outcome of this Enquiry will either be that abuse or neglect has been Substantiated, Not-Substantiated or that the outcome is Inconclusive. 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 or 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 four Safeguarding Adult Reviews can be found in section 14.

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 investigation should include an attempt to gain the views of the adult at risk as to what they would like to happen. This is called 'Making Safeguarding Personal'. If the adult at risk has the capacity to make a decision their wishes must be respected, even if that means remaining in a situation where they are at risk of further abuse or neglect.

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, the Local Authority can apply to the Court of Protection for 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 legislation is going through Parliament which may change the way that local authorities manage this area aimed at simplifying the process. An update will be provided in the next Annual Report.

6 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, 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.

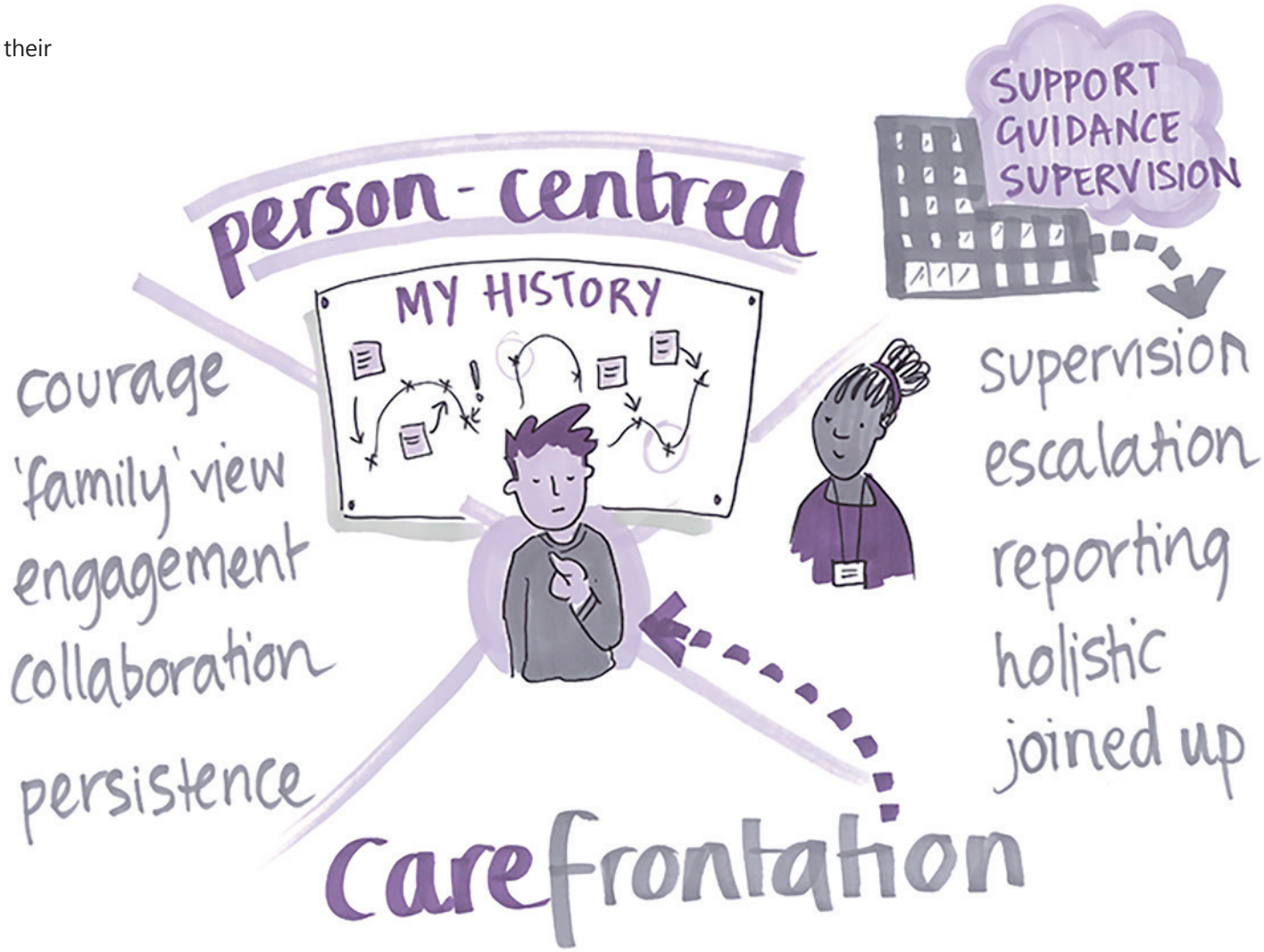
Prevention
It is better to take action before harm occurs.

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.



7 How To Report Abuse in Brent

If you wish to raise a safeguarding concern safeguarding form please refer to webpage **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** or **call 020 8937 4300** and they will help you.

8. Safeguarding Activity In Brent

Adults Team DATA 2017-18

The London Borough of Brent has its own dedicated Safeguarding Adults Team who screen concerns and carry out investigations. Here we provide information on the number of concerns which were referred to the Safeguarding Adults Team and how many progressed to a Section 42 Enquiry. The figures are broken down into quarters (Quarter 1 April–June, Quarter 2 July-September, Quarter 3 October-December, Quarter 4 January-March).

Number of Safeguarding Concerns received by the team 2017-18

399 in Quarter 1

463 in Q 2

420 in Q 3

392 in Q 4

Average figure = 418.5

The average figure for 2016-17 was 428 and therefore there has been a minor reduction in referrals in 2017-18

The Concerns which resulted in Enquiries in 2017-18

64% in Q1

65% in Q2

64% in Q3

73% in Q4

Average figure = 66.5%

The average figure for 2016-17 was 57% and therefore there has been a significant increase in enquiries undertaken in 2017-18

Section 42 Enquiries concluded in 2017-18

141 in Q 1

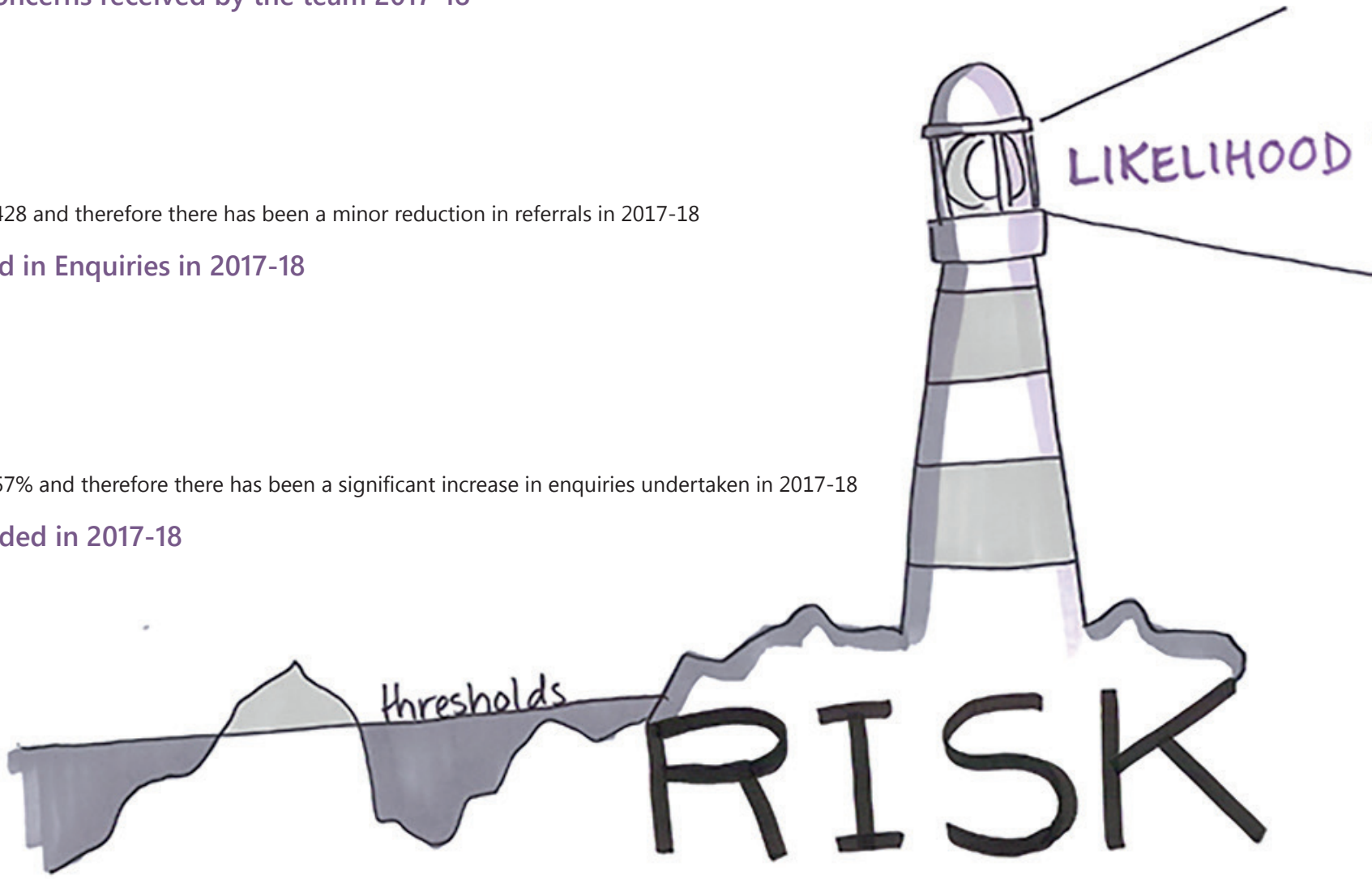
218 in Q 2

154 in Q 3

226 in Q4

Average figure = 184

The average figure for 2016-17 was 157 and therefore there has been a significant increase in S42 enquiries over the year as a whole.



Making Safeguarding Personal

The Adult at Risk and their preferred outcomes remain central to the work we undertake. We are improving in this area. MSP was one of the key themes at the BSAB Conference in March where we discussed the importance of all agencies working together to deliver a safeguarding response that recognises, upholds and promotes the wishes and desires of the Adult at Risk.

In Q1 the Adult at Risk's outcomes were met in 76% of cases

In Q2 the AAR's outcomes were met in 77.6% of cases

In Q3 the AAR's outcomes were met in 76.6% of cases

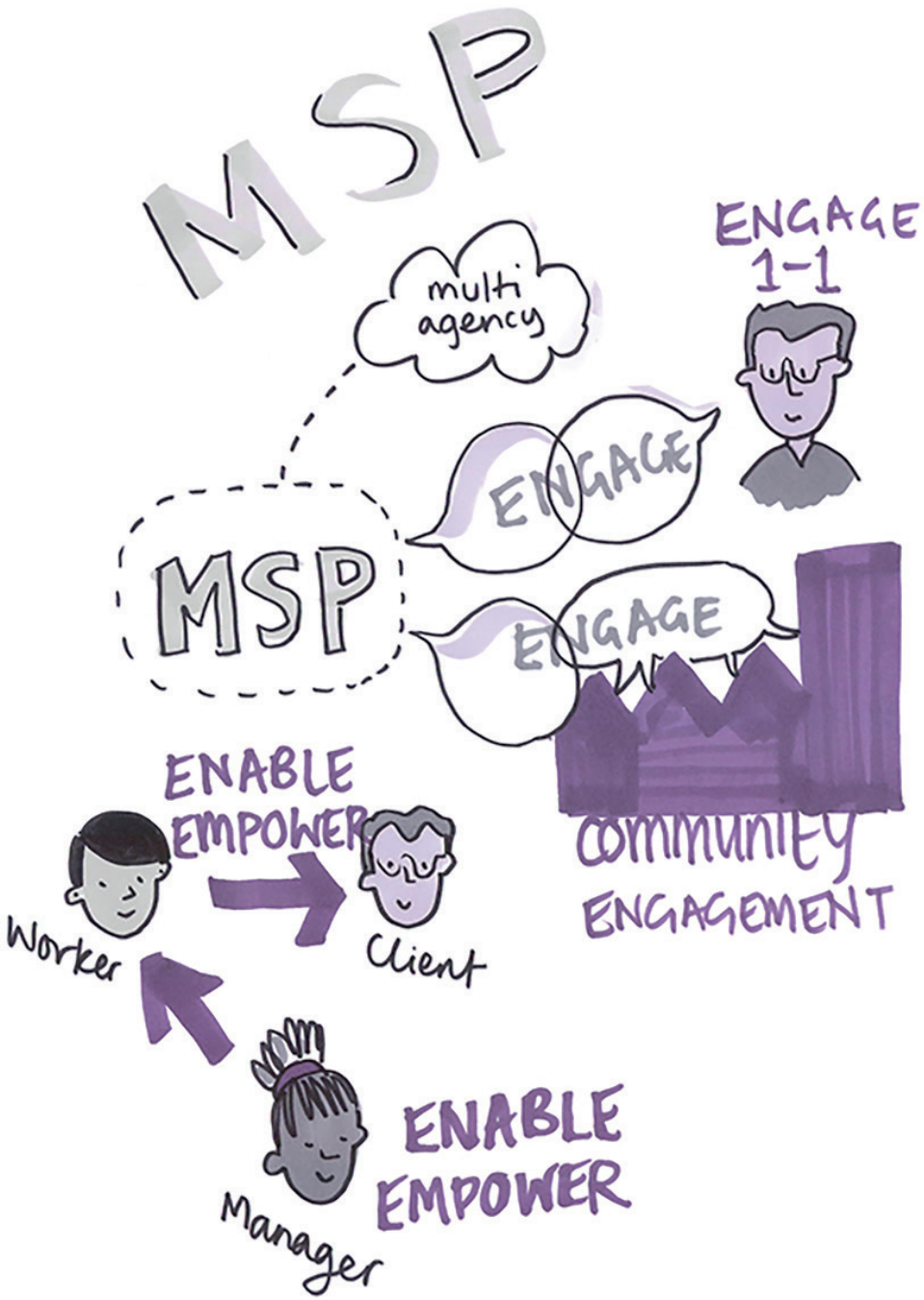
In Q4 the AAR's outcomes were met in in 83.8% of cases.

Over the last three years this means we have been able to support the Adult at Risk to meet their outcomes in 78% of Section 42 Enquiries.

Types of Abuse Referred to Adult Safeguarding in the LB Brent as a Concern

Neglect	37.24%
Physical Abuse	22.05%
Financial or Material Abuse	16.08%
Psychological/Emotional Abuse	10.93%
Self-Neglect	4.26%
Sexual Abuse	4.25%
Domestic Violence	2.60%
Organisational/Institutional Abuse	1.58%

Other (FGM, Modern Slavery, Radicalisation, Discriminatory Abuse, Exploitation) 1.01%



9 The Safeguarding Adults Board Strategic Plan 2017-2019

Increasing awareness and understanding of safeguarding adults within the Brent Safeguarding Adults Board workforce and wider community.

In order to achieve this objective, the Safeguarding Adults Board monitors the number of referrals and how many are progressed to a full Enquiry. Partners send data returns in order to identify trends and areas where resources may need to be targeted. Safeguarding Awareness Training has been offered to front line workers from different organisations to raise awareness and allow attendees to gain a greater understanding of safeguarding issues and how to raise a concern. The Brent Safeguarding Adults Board conference took place on 21.3.18 in the civic centre Conference suite. The conference consisted of a plenary talk presented by the independent chair, followed by six workshops including modern slavery, financial abuse, domestic abuse, mental capacity, self-neglect and making safeguarding personal. The event was attended by 67 multi-agency professionals across the borough and feedback from delegates and presenters was obtained to assist in future planning of community engagement. The Chair of the Adults Safeguarding Board has also delivered events and attended community based groups in order to promote and raise awareness of Adult Safeguarding.

Continuing to work together to understand and meet the challenges of the Mental Capacity Act 2005 & Deprivation of Liberty Safeguards (DoLS).

Awareness of the importance of the Mental Capacity Act is increasing. The board has worked with its partners to promote Mental Capacity Act Training to empower staff and improve confidence in using the Mental Capacity Act. In order to achieve this aim, the Learning and Development Sub-group has worked with partners to develop plans for multi-agency training to develop knowledge and expertise in this area. The Board asked its partners to report on training arrangements for staff to ensure that practice in this area is improved. A workshop concerning the Mental Capacity Act was arranged as part of an annual conference.

Service User Voice – To ensure the work of the SAB is influenced by service users and their representatives.

The Board regularly monitors the data returns that measure if a service user's stated outcomes were achieved at the point of closing the Section 42 Enquiry. This is an important indicator of progress made in Making Safeguarding Personal. In order to continue to work towards this objective, the Community Engagement sub-group has been reformed, following changes to key personal. This sub-group will work to develop systems to capture the views of the public and users of the service. This sub-group will continue to develop audits to capture this data over the coming year. Presentations by service user groups will become a regular feature of Safeguarding Adult board meetings.

Making Safeguarding Personal – Continue to work to progress the 'Making Safeguarding Personal' agenda.

Making Safeguarding Personal is central to effective adult safeguarding. In order to embed this priority into practice , the Safeguarding Adults Board has been working with partners to promote MSP as an area of practice and to ensure that this features in Safeguarding Awareness Training. Through its Workforce Survey, the Monitoring and Evaluation sub-group advised the Learning & Development sub-group to develop a series of 3 events to improve understanding of Safeguarding principles, Mental Capacity Act and Making Safeguarding Personal. These were delivered as part of the Annual Conference.

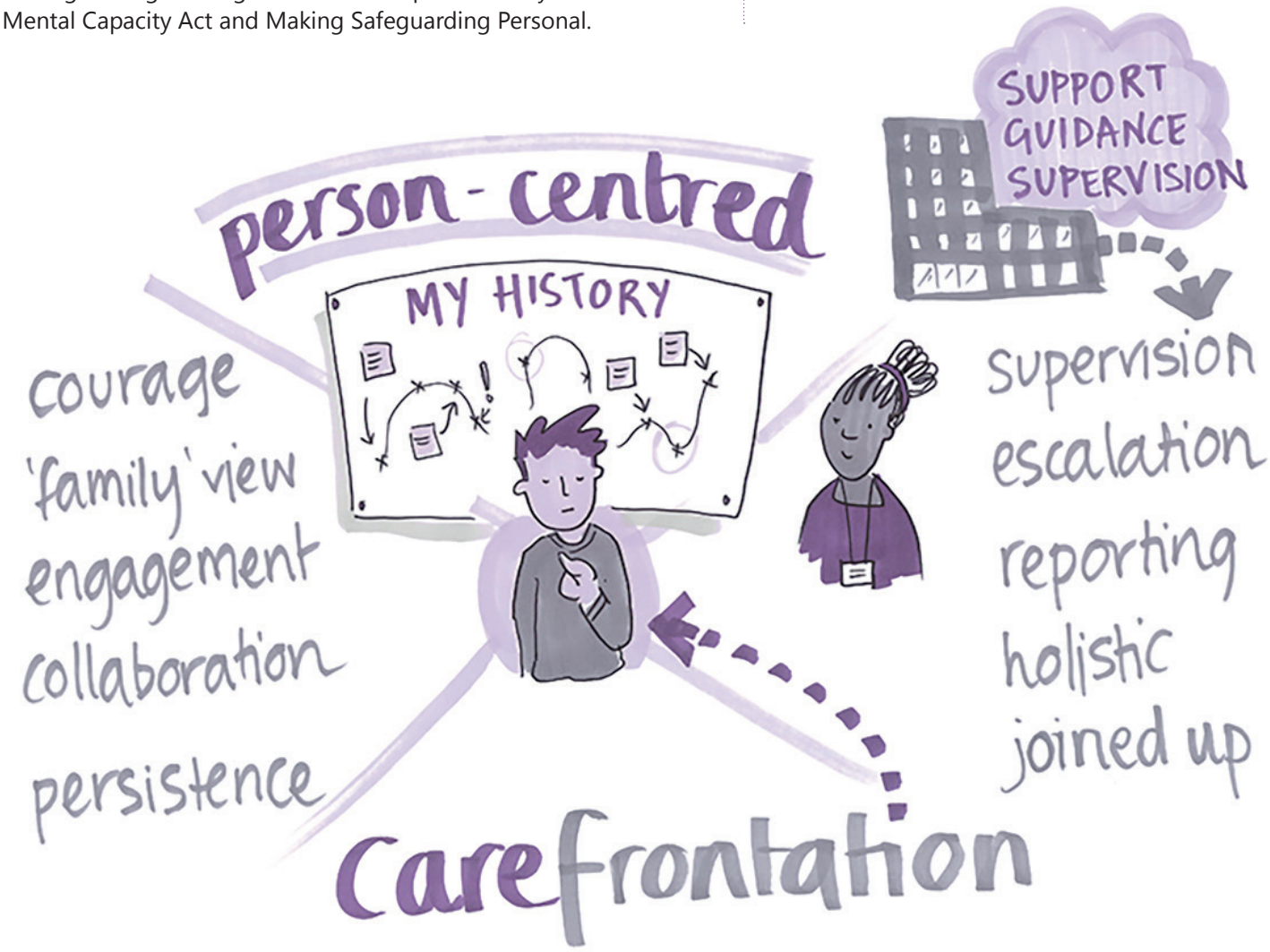
To use Training and Workforce Development to support the delivery of BSAB priorities

Members of the Case Review and Executive sub-groups are well placed to disseminate learning to staff concerning the Safeguarding Adult Reviews. Currently there are four Safeguarding Adult Reviews being progressed with learning updates being provided by independent reviewers by way of Learning Panels. The introduction of a shared part time Strategic Partnership Learning and Development Coordinator for

safeguarding adults and children in December 2017 has enabled learning seminars to be offered on risk assessment and on mental capacity assessment, two issues that emerge prominently from Safeguarding Adult Reviews nationally. Each completed Safeguarding Adult Review in Brent will be followed by dissemination events to ensure that lessons are learned. Feedback from partners is that both online and face to face adult safeguarding training has raised the profile of key areas such as the Mental Capacity Act and Making Safeguarding Personal.

To increase the voice of service users, carers and their representatives in the work of the BSAB

This is a priority for the coming year. The aim is through the Community Engagement and Awareness sub-group to ensure that the Board captures information from service users and their families.



10 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 vulnerable adults in Brent.

MONITORING AND EVALUATION

The Monitoring and Evaluation sub-group conducts regular multi-agency audits to ensure the effectiveness of safeguarding arrangements across local partner agencies and against the BSAB work plan to achieve consistent and robust outcomes for adults at risk. In addition it will seek assurances regarding the application of learning and experience from practice and single agency audits in Brent.

CASE REVIEW

The Case Review sub-group considers referrals for Safeguarding Adult Reviews. Where the criteria are met, it commissions and manages reviews. In addition the Case Review Sub-Group commissions and oversees the conduct of case reviews that fall outside of the mandatory criteria for reviews but where there is still learning for practitioners. 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.

LEARNING AND DEVELOPMENT

The Learning and Development sub-group aims to ensure that safeguarding learning and development activity equips organisations, staff and partners with information to ensure adherence to pan London Safeguarding Procedures. The sub-group aims to embed and promote safeguarding learning & development across partners and providers to ensure appropriate response by services and individuals to safeguarding concerns and to develop a strategy to ensure that this standard and learning is maintained consistently.

ESTABLISHMENT CONCERNS

The Establishment 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 raised beyond the thresholds set out by the Pan London Safeguarding Board.

THE EXECUTIVE

The Executive 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 will be 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.

11 Anna: a case study

Concern

Anna, a European national who had been living in Brent for seven years with her father, was admitted to Park Royal Centre for Mental Health on Section 2 Mental Health Act 1983. On admission, she had significant bruising to both her eyes and arms. On day one she said it was the result of a physical assault by her 15 year old sister.

On day two, she alleged it was her father who caused the harm and on day 3 stated it was her boyfriend/drug dealer.

She presented as vulnerable to exploitation.

Staff were concerned she had been subject to human trafficking and modern slavery which involved her being forced to take illicit drugs and engage in prostitution.

It was unclear to staff who the person/s causing harm were though it was evident from her non-verbal communication that they were known to her.

She often appeared frightened and appeared in need of protecting from them.

Anna's Father exercised his right to Nearest Relative Discharge. This was barred by the consultant in charge of Anna's care due to the safety concerns.

Father attempted to abduct Anna from the ward assaulting both her and staff. He was arrested and charged with common assault.

Response

Ward staff completed a body map to indicate extent of injuries.

Safeguarding concern raised based on information available at the time

Anna's 15 year old sister was referred to Family Front Door.

Staff involved police who were initially unable to interview Anna as she was unwell.

Staff conducted further routine enquiries but were unable to initiate National Referral Mechanism as Anna did not make a full disclosure about the nature of the (modern slavery/human trafficking) abuse.

Mental capacity tests conducted into Anna's lifestyle choices and accommodation on discharge.

Visitors were banned as unable to identify the person/s causing harm. Also the boyfriend/suspected drug dealer had tried to give her bottled drinks which staff checked and these had been tampered with. Drinks were confiscated.

Staff contacted Anna's mother in Europe (with Anna's consent). She wanted her daughter to return home.

Offered appointment at local sexual health clinic.

Offered input by Trust Drug and Alcohol specialist.

Outcome

Anna was in hospital for approximately10 weeks. During this time, visitors were banned as part of the safety plan. Contact with family and friends was maintained through phone calls.

Anna was repatriated back to her mother's address in Europe. She was escorted by nursing staff. Anna had mental capacity to make this decision.

12 Changes within the London Borough of Brent

Changes in Brent

The Brent Council's Strategic Partnerships team became operational in May 2017. It consists of a Strategic Partnerships Manager and three Strategic Partnerships Officers to support seven partnership boards: Health and Wellbeing Board, Safeguarding Children Board, Safeguarding Adults Board, Brent Children's Trust, Partners for Brent, Pensioners' Forum and Disability Forum.

A further review of the team took place in early 2018, leading to the replacement of the Strategic Partner Officer post with a Strategic Partnerships Lead for Safeguarding Adults. This reflected the need for a higher level of strategic support to the Chairs and Boards and created greater officer leadership.

The Safeguarding Adults Board Training Co-ordinator position became vacant in May 2017. This subsequently led to the creation of a new part time Strategic Partnerships Learning and Development Co-ordinator post within the Strategic Partnerships team. This new role is responsible for supporting both the Safeguarding Children Board and Adult Safeguarding Board multi-agency learning and development programmes. The post holder took up this role in December 2017.

Impact of support changes

These changes have enabled Brent's strategic partnerships to maximise communication and collaboration through more cross-partnership discussions and activity.

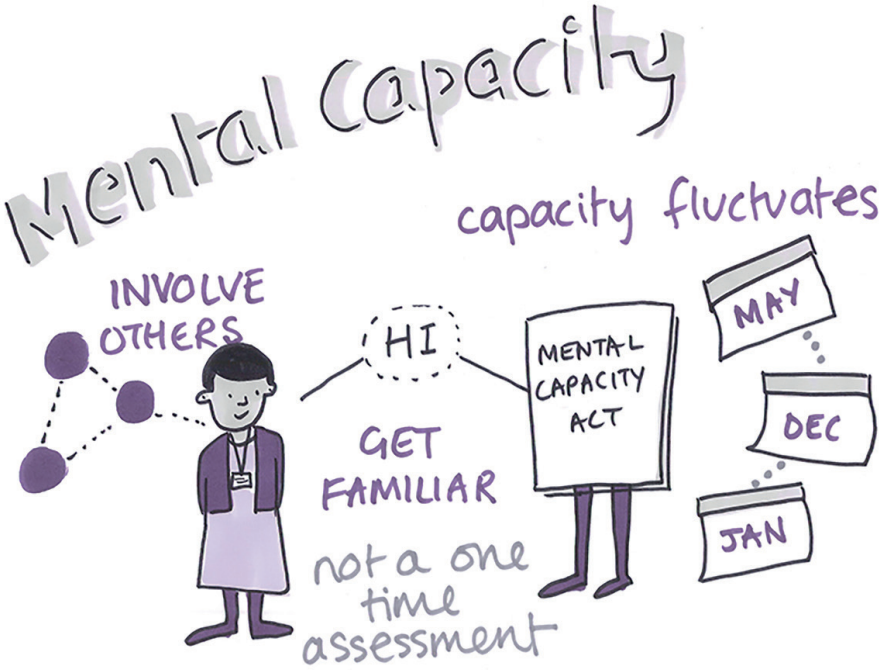
The absence of a dedicated Safeguarding Training Coordinator post from May 2017 had a detrimental impact on the safeguarding adults learning and development offer during 2017-18. The introduction of the shared part time Strategic Partnership Learning and Development Coordinator in December 2017 has enabled the Safeguarding Adults Board to have a more focussed approach to the implementation of the Adult Safeguarding Board learning and development offer moving into 2018-19.

Collaboration with other Strategic Boards and services

To identify additional areas of strategic partnership board collaboration in 2017, regular meetings now 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 to develop new procedures based on understanding the needs of victims of modern slavery and trafficking, existing support provision in the borough, identifying gaps and developing possible solutions. It is anticipated that the findings of this task group will be submitted to the Boards and Safer Brent Partnership in the autumn of 2018.

Current Safeguarding Adult Reviews

The Safeguarding Adults Board commissioned 3 new Safeguarding Adults Reviews (C,D and E) in the year 2017-2018 in addition to finalising the investigation and learning from Safeguarding Adult Reviews carried over from the previous year 2016-2017. This will be further explained later in the report.



13 Joanna: a case study

Concern

Joanna, an elderly woman who lived in Brent for a number of years with her husband and two sons (son A and son B). Joanna was described to workers as always having had a tendency to hoard items at home which she later described to workers as 'nik-naks'. However, with the support of her partner, this issue remained manageable during her young and middle-aged life. However, Joanna's husband later passed away in old age. Following the death of her husband, Joanna developed diabetes and suffered a cognitive decline. She was later diagnosed with dementia. Her frailty increased and she increasingly relied on her son (Son A) to do her shopping, escort her to medical appointments and assist her with toileting and hygiene. Son A did not live at the family home but visited regularly.

Joanna's health declined and she was admitted to hospital. Discharge planning took place. An initial safeguarding referral was sent by hospital staff in relation to concerns around self-neglect. Following a home visit, there were concerns over the cleanliness of the home and Joanna reluctantly agreed for her home to be deep cleaned by specialist cleaners to enable her discharge home. A care package was arranged to support her aimed at preventing the self-neglect. After a period of time this care package was later cancelled by Son A, stating that he would provide the care required in future.

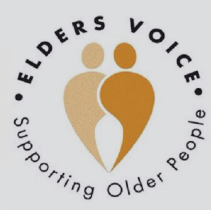
The relationship between her two sons had deteriorated to a great extent following the death of their father. Over time, son A began exerting control over the family home and began refusing entry and contact between son B and Joanna. Son A also developed a mistrust of professionals. After her discharge from hospital, Joanna initially attended her appointments with the GP, diabetes monitoring appointments and appointments at the memory clinic. All agencies reported that she was escorted by her son (A). This was monitored by the Safeguarding Adults Team through effective communication with the GP Practice which was able to monitor NHS records and report back. However, son A began refusing to allow any professionals into the home. A number of joint visits were arranged with the Safeguarding Adults Team and the GP but access could not be gained to the family home.

Whilst her attendance at appointments was being monitored, the Safeguarding Adults Team observed that Joanna began failing to attend appointments and son A continued to refuse entry to professionals when visits had been arranged.

After a period of time, a joint home visit was arranged with uniform Police Officers, the GP and the Safeguarding Adults Team. Due to the Police presence, son A allowed entry to professionals. The GP carried out tests on Joanna in the home and called London Ambulance Service, recommending immediate hospitalisation; stating that Joanna was close to a diabetic coma. She was immediately taken to hospital where her physical health improved. However she continued to suffer cognitive decline.

Due to the facts that had been gathered regarding her lack of care at home, the cancelled care package, her health issues on admission and the concerns about the control being exerted by her son, there was multi-agency involvement to discharge planning and a detailed assessment took place. This was a holistic assessment testing Mental Capacity and gathering evidence about Joanna's likely care and support needs on discharge from hospital. A Best Interest Meeting took place and a care home was found for Joanna. Due to her cognitive decline, an application was made to the Court of Protection for Deprivation of Liberty Safeguards so that measures could be put in place to keep Joanna safe. She continues to reside at a care home where she is being cared for.

14 Partner Organisation Contributions



Brent Clinical Commissioning Group

NHS Brent Clinical Commissioning Group (CCG) is clinically-led, which is responsible for planning and commissioning of health care services in Brent.

The CCG has key responsibilities towards safeguarding adults which are set out in the NHS Safeguarding Assurance and Accountability Framework (2015), to ensure safeguarding systems and processes in place to safeguard adults at risk from abuse and neglect. The CCG has responsibility for commissioning the majority of local health services and has a duty in assessing the health needs for patients and to assure themselves that the services they commission are of appropriate quality. The CCG are responsible for ensuring that those providing the healthcare needs of our population do so safely and are performing according to recognised and evidenced best practice.

NHS Brent CCG is a statutory member of the Brent Safeguarding Adults Board (SAB) following the implementation of the Care Act 2014. Safeguarding adults at risk has remained high priority for both commissioners and providers of NHS services during year 2017/18. The CCG have established LeDeR programme within the borough and also has developed a Steering Group. This aims to drive improvement in the quality of health and social care service delivery for people with Learning Disabilities (LD). Learning from the LD reviews will be collated nationally and locally, with local learning being reported to the Safeguarding Adults Board, and the Local Authority.

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 undertakes quality assurance visits in our provider organisations. This is to reinforce each provider's responsibility 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 areas of concerns in safeguarding adults and recommendations to promote improvement.

Safeguarding Adult Training is a mandatory requirement for all members of staff within the CCG. CCG in its duty to support improvements in the quality of Primary Care and its safeguarding function provides e-learning at levels one and two, and delivered face to face safeguarding adults level three training to CCG staff, General Practitioners, and other health providers in the Borough. This is to ensure a consistent approach in safeguarding adult practice across all teams and services in the borough. The CCG receives regular monitoring reports from providers on safeguarding adults within their services, including evidence of training compliance, and reports on safeguarding performance in general.

The Designated Nurse for Safeguarding Adults attends and contributes significantly to the Brent Safeguarding Adults Board and its five sub groups: She also supports work in relation to the following fields: Prevent Delivery Group, Channel Panel, Violence against women and girls delivery group meeting, and Multi-Agency Risk Assessment Conferences.

Central North West London Health Trust

CNWL PRIORITIES IN 2017-18

- Monitoring staff awareness of, and knowledge about safeguarding adults
- Embedding Making Safeguarding Personal (MSP) in practice
- Ensure service users are provided with information that will support them to prevent harm
- Improve mental capacity assessment recording across the Trust
- Improve the consistency of the Deprivation of Liberty (DoLS) trackers to ensure individuals are protected and not unlawfully deprived of their liberty
- Ensure training figures for Prevent meet the Trust compliance figures
- Ensure staff training is compliant with Intercollegiate document and Skills for Health Core Skills Training Framework

During 2017-18, we:

- Carried out a Trust wide survey of staff on safeguarding including questions on Female Genital Mutilation (FGM) and Domestic Abuse.
- Ensured MSP is embedded in training and the development of the new clinical system
- Developed a Keeping Safe leaflet on Financial Abuse following on from the Sexual Safety leaflet the previous year. This is currently with the printers.
- Developed a streamlined mental capacity assessment template that will go live with the new clinical records system.
- Rolled out a new DoLS tracker on inpatient wards
- Provided sufficient training for Prevent to achieve 85% compliance for clinical staff
- Updated e-learning packages, strengthening the assessment process at the end of the workbook. 95% of all Trust staff are compliant with mandatory training.
- To raise awareness and understanding of safeguarding adults. Our survey contributed to raising awareness and understanding amongst our workforce
- Continuing to work together to understand and meet the challenges of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Our work on developing templates for mental capacity assessments and the DoLS trackers improves practice and implementation of the Mental Capacity Act. By making the MCA Essential to Role it has further raised its profile within the Trust.
- Training and Workforce Development. Our updated e-learning packages support workforce development and include slides on Making Safeguarding Personal and the Mental Capacity Act
- Further develop understanding of the Mental Capacity Act by establishing the Essential to Role training programme. Embed the MCA template in practice.
- Roll out making routine enquiries for Domestic Abuse
- Complete and launch the Safeguarding pages on the new clinical system – embedding Making Safeguarding Personal.
- Embed new Safeguarding Adults Training Strategy in practice
- Develop 2 new Keeping Safe leaflets – Domestic Abuse and one on Self Neglect The continued focus on the Mental Capacity Act and Making Safeguarding Personal meets the priorities outlined above in improving staff awareness, understanding and approach to safeguarding and person-centred approaches.
- The continued development of Keeping Safe leaflets provides information to service users and carers. In the Kingswood Centre, an Easy Read Safeguarding presentation was developed and a Carers event was held on the 20th March 2018.

London Fire Brigade (LFB)

PRIORITIES 2017-18

- Aligning our Safeguarding Adults Policy and related policies with the Care Act 2014
- Developing and rolling out safeguarding training for all staff
- Embedding the information sharing project with the London Ambulance Service (specifically to address fire risk and hoarding behaviour) into core business
- Undertaking the second part of an independent audit by MOPAC to review our adults safeguarding practices

WHAT WE DID

- The Brigade has reviewed the internal Safeguarding Adults policy and updated this in line with the London multi-agency adult safeguarding policy and procedures, to incorporate the particulars of the Care Act 2014. The updated policy references the Mental Capacity Act 2005 and the Prevent strategy and is available to all staff via the internal intranet.
- S015 Counter Terrorism from Met Police has run two sessions on Prevent in particular for our youth/health and fire safety regulation staff. In addition, an article on Prevent/Radicalisation and what staff need to be aware of/action to be taken has been pulled together and published on our Intranet to raise everyone's awareness on the topic and related responsibilities.
- The Hoarding policy has also been reviewed to signpost the issue (hoarding) as requiring a 'self-neglect' referral to Social Services Departments. The policy outlines the immediate steps which should be taken to protect the adult and preserve the scene (when appropriate).
- Delivering the information sharing project with the London Ambulance Service to provide Home Fire Safety Visits to high risk hoarders, has been embedded into core business.

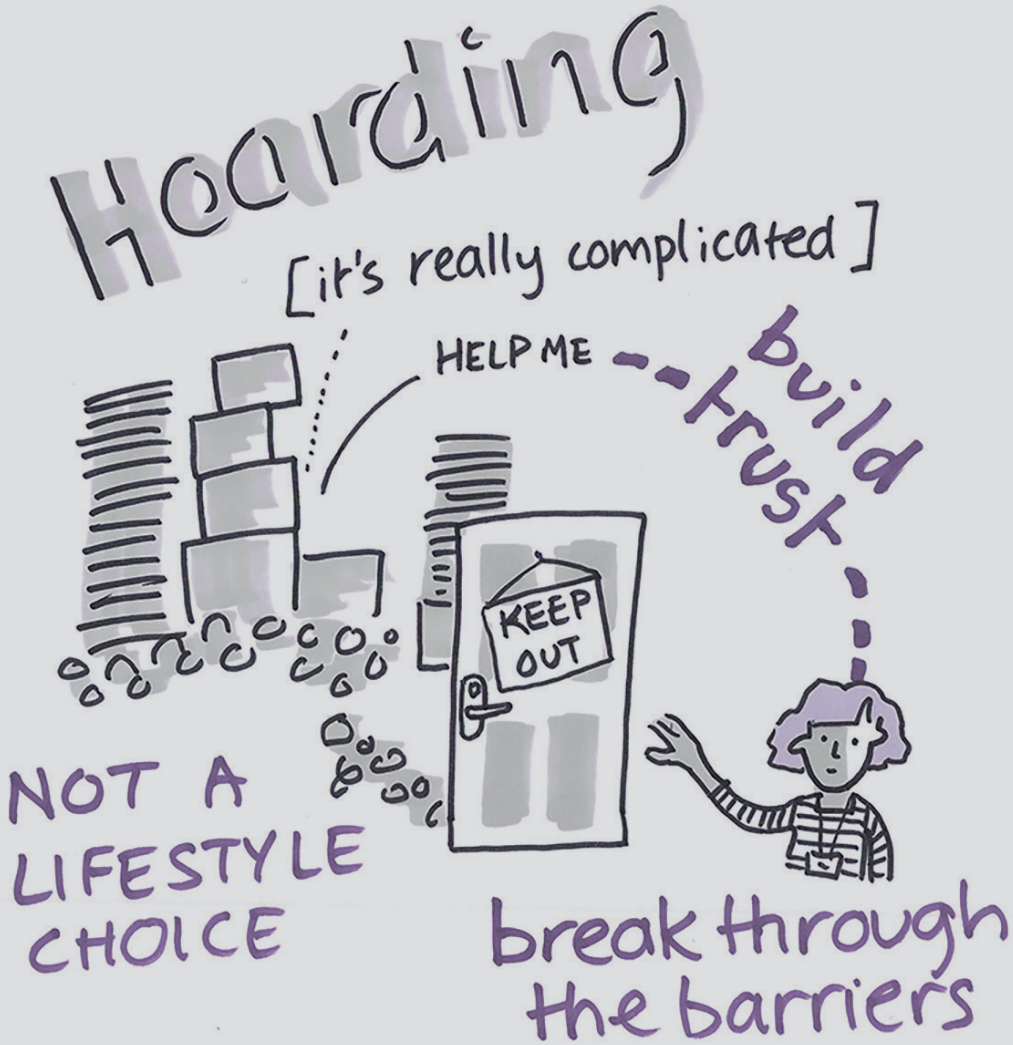
LFB TRAINING

The Brigade has developed a safeguarding training package for all personnel to increase awareness and improve consistency and improve partnership working. This package has been delivered in stages and rolled out to station-based staff. The training complies with both the Care Act 2014 and London Multi-Agency Policy and Procedures 2016, and will ensure all Brigade personnel are aware of the importance of ensuring people feel supported and empowered to make their own decisions and informed consent. To this end, the package will also provide staff with an understanding of the Mental Capacity Act. The Brigade has undertaken the second part of an independent audit by MOPAC to review our adult safeguarding practices. The Brigade 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 wellbeing and safety. The project with the London Ambulance Service resulted in 884 LAS referrals being raised across London in 2017/18. Of these, 70% resulted in Home Fire Safety Visits being booked. Such visits provide individuals at risk with tailored fire safety advice to reduce the risk of fire. When an individual is found to have additional care and support needs, is at risk of abuse or neglect by a third party, or falls under the self-neglect category, we immediately report the concerns to the relevant agency to ensure the protection of the individual, and that the risk was addressed before it escalated. We also provided and installed arson letter boxes to victims of crime, in particular those related to domestic violence. Overall, the Brigade has contributed to LSAB's development of information sharing and referrals pathways to ensure a multi-agency approach to Londoners' safety and wellbeing. Furthermore, it has voluntary contributed £1,000 in total to the Safeguarding Adults Board and the Safeguarding Childrens Board to help the Boards meet their priorities.

London Fire Brigade Changes

The updated Safeguarding Adults and Hoarding policies alongside the safeguarding training package have been increasing staff awareness of the six statutory safeguarding principles and developing a more consistent approach across our organisation and with our partners.

- The development of a new Person at Risk form to improve the efficiency and security of our referral process and information
- sharing, and enable easier monitoring of our safeguarding concerns at both local and organisational levels.
- The sharing of information with partner agencies and the retention of personal data on the safeguarding database will also
- be reviewed considering the new General Data Protection Regulation (GDPR) requirements.
- A review of staff training will take place to highlight areas of strength and weakness. These will be discussed with the
- Brigade's training provider to ensure it is being delivered to the required level.
- Addressing any gap in our safeguarding procedures identified in the MOPAC review.
- Data protection legislation is often quoted as a barrier to information sharing and an explicit duty to share risk information and a more comprehensive approach is required not only to increase access to data, develop and maintain cooperation across agencies; but to develop the strategic and coordinated intelligence necessary, in particular to tackle the increasingly systematic exploitation of vulnerable people, e.g. modern slavery.



London North West University 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:

- Northwick Park Hospital
- St Mark's Hospital
- Community services across Brent, Ealing and Harrow
- Urgent Care Centres
- Central Middlesex Hospital
- Ealing Hospital

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 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.

2016-17 brought an increase in safeguarding adult activity at the Trust. Adult safeguarding referrals increased by 25% on the previous year and there was a significant increase in Deprivation of Liberty referrals. During 2016-17 LNWHT focused on further embedding a safeguarding culture across the 8000 strong workforce. A particular focus has been on PREVENT training which has resulted in the Trust being above the target set by the Home Office PREVENT training trajectory.

In addition to its commitment to training and development and the increased safeguarding culture the Safeguarding Adults Team progressed a number of other work streams in the past year. Firstly domestic abuse awareness has been firmly incorporated into the training provided to Trust staff with two Independent Domestic Violence Advocates (IDVA's) employed in the Emergency Rooms at both Ealing and Northwick Park Hospitals. The IDVAs provide support to patients attending the hospital and act as a crucial resource for front line staff delivering care. Secondly Modern Slavery and Human Trafficking abuse was also incorporated into adult safeguarding Training. Staff across Children's and Adult Safeguarding Service have completed the London ADASS & NHS England "Train the Trainer: Human Trafficking and Modern Slavery Multiagency Awareness Raising Training

LNWHT safeguarding adult alerts, notified by staff, have increased by 31% during 2017/18. The increase demonstrates that a safeguarding culture exists at the Trust and that the focus on training has had 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.

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 Metropolitan Police in Brent

OUR PRIORITIES IN 2017-18

- Tackling violent crime and especially knife crime affects young people across London.
- Countering terrorism and reviewing our strategy, tactics and resources in light of the threat.
- Protecting children and developing a robust approach to tackling child sexual exploitation.
- Transforming the Met to become a modern police service, using technology and data, skills and engagement to fight crime more effectively.
- In addition, the Metropolitan Police Service (MPS)'s Vision is to provide a consistent set-up on all Boroughs, which has effective IT, office space and training for officers and staff. Protecting the public, providing a quality service to victims of crime and supporting our officers by providing relevant training and a supportive working

WHAT WE DID

- Increased and more effective publicity raising the profile of Safeguarding as a whole throughout the organisation.
- The publication of up to date and relevant 'tool kits' across all areas of Safeguarding to provide officers and staff with the information they need to improve and maintain the police and multi-agency response.
- The development of a Safeguarding Dashboard across MPS so Boroughs can begin to evaluate and compare performance, better understand trends and recognise areas of improvement. This addresses both Child and Adult Safeguarding.
- Closer and more effective working relationships across the Brent Crime Wing as a whole and increased recognition of threat risk and harm to ensure more effective short-term responses and support partners in this along with the provision of ongoing support in the medium and longer-term.
- The Metropolitan Police supported and continue to support staff in attending both centrally and locally held training including a new Missing Person training course, abuse and neglect of vulnerable adults, mental health, drug and alcohol dependency, suicide prevention and missing people. harmful practices, domestic abuse, stalking and harassment, hate crime, young offenders, child sex exploitation, criminal exploitation of children, modern slavery, human trafficking, sex workers, rape, sexual offences and child protection online.

PRIORITIES FOR 2018-19

The MPS safeguarding priorities for 2018/2019 must be integral to the Mayor Of London's Police and Crime plan 2017-2021. Three priorities are detailed namely;

- Violence against women and girls
- Keeping Children and Young People Safe
- Hate Crime and Intolerance

In conclusion it is clear within the new and developing Basic Command Unit structure that the Safeguarding of Children and Adults remains a top priority (only behind Counter-terrorism). The integration of previously separate and specialist roles within Child abuse and serious sexual offences with locally held officers is designed to provide a high quality and effective police response from the outset.

London Ambulance Service (LAS) NHS Trust Safeguarding Statement 2017-18

2017-18 has been another busy year for the London Ambulance Service NHS Trust. We have seen an increase in incidents and an increase(15%) in safeguarding concerns raised by our staff, we raised 22,198 concerns – 4841 adult safeguarding concerns, 8050 adult welfare concerns and 8382 child safeguarding referrals .

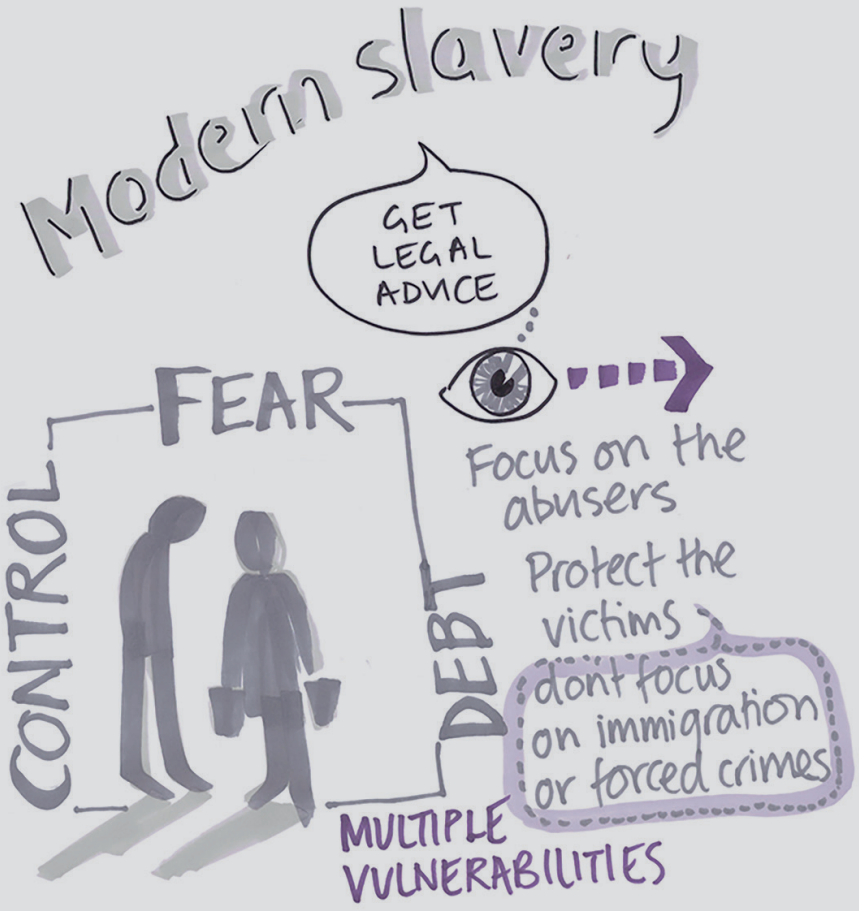
Safeguarding is a priority for the Trust and we have this year recruited a full time administrator to assist with the increased workload.

During the year, we have introduced two new policies: Safeguarding supervision and Chaperone policy. We continue to provide annual safeguarding training to clinical staff which this year was delivered via e learning and reflected learning from Safeguarding Adult Reviews, Serious Case Reviews or audits undertaken.

The trust has undertaken a number of quality audits throughout the year these include:

- Auditing knowledge and retention of staff learning
- Quality of concerns/referrals raised
- Quality of training delivery
- Modern slavery referrals
- Child sexual abuse and child sexual exploitation
- Adult sexual abuse
- Child female genital mutilation

Full LAS safeguarding governance and assurance can be found in our annual report for 2017/18 which will be published on our website when agreed.



London Community Rehabilitation Company

Our focus in 2017/18 in relation to safeguarding has been twofold: first to strengthen our visibility across the partnership and, secondly, to ensure staff are skilled in the recognition of and responsiveness to, any safeguarding concerns.

WHAT WE DID

In respect to strengthening our visibility and partnership working, five Contracts and Partnerships Managers have been deployed across the specific LCRC areas with this as their strategic focus. They are tasked with attendance at Safeguarding Adult Boards and engagement with Safeguarding Adult Reviews, along with building relationships with our key stakeholders.

LCRC have also developed a new case recording and assessment tool, REACTA, that specifically focuses on risks posed by the service user to any identified children or vulnerable adults. London wide training has been delivered to our operational staff in the use of REACTA to increase our organisational responsiveness to the needs of vulnerable adults through thorough assessment, timely actions and managerial oversight. It is our intention that with the imposition of a new case recording and assessment approach, REACTA, all our Offender Managers will be able to provide a thorough and thoughtful analysis of the risks presented to any vulnerable adults in contact with Service Users and for robust actions to be implemented in order to safeguard them or the Service User themselves. With this, the envisaged impact will be a reduction in unnecessary checks causing local authorities undue strain as well as an uplift in quality referrals and multi-agency working. The effectiveness of this approach will be measured over the next 12 months.

LCRC have an internal Safeguarding Board that is chaired by our Chief Executive and has representation from our strategic and operational heads. The Board's remit is to monitor quality and performance within our operational team and to have oversight to our wider safeguarding action plans which incorporate learning from Safeguarding Adult Reviews and borough based priorities.

WHAT WE WILL DO

London CRC will continue to strengthen our management of Service Users in the community through increased managerial support, increased partnership working and the development of evidence based interventions reflective of our Service Users' needs. This ambition is present across our organisation and will continued to be the focus of our work in the future. Furthermore, London CRC are committed to strengthening our operations and strategy around vulnerable adults, given the large proportion of our Service User population who meet the criteria for 'Adults at Risk'.

We will look to strengthen our partnership work through on-going engagement with the Safeguarding Adults boards across London via our Contracts and Partnerships Managers.

15 Safeguarding Adult Reviews

Adult B

This review focusses on an adult with a learning disability who has lived almost their entire life in care settings. The focus of the review is to ensure that residents in care settings are safe and appropriately looked after. The SAB intends on publishing the SAR, its findings and its recommendations mid-September 2018 and therefore a detailed write-up will not be included in this report. The Board will be offering learning and service development seminars in the Autumn of 2018 exploring the findings and recommendations of the SAR. The Board will be seeking reassurance that lessons from this case have been learned.

Adult C

The review on Adult C focusses on an adult with mental health problems and learning difficulties. The review will span a number of years but will primarily focus on the multi-agency response to concerns raised since Adult C became an adult. The review will focus on the role of mental health, health and safeguarding adult responses to concerns raised in the past regarding mental wellbeing and possible deprivation of liberty and/or abuse or neglect at home, and make recommendations to ensure that lessons are learned. The review is due for completion towards the end of 2018.

Adult D

This review focuses on an older adult with a history of mental health problems and self-neglect who died at home and was not found for a couple of months. The review is focusing on the most recent episode when Adult D was being treated in hospital for mental ill-health and how well the arrangements for his after-care worked once he was discharged home. In particular the review is focusing on the care and support that was offered to Adult D and how professionals and their organisations responded when he increasingly rejected their efforts to meet his care and support needs. A reviewer for this case has been appointed, agencies have provided a chronology of their involvement and a learning event is planned. It is planned to conclude this case by the end of 2018.

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 had passed away 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.

These safeguarding adult reviews are shining a light on adult safeguarding systems in Brent. The Board is responsible for seeking reassurance that adult safeguarding systems are working effectively, namely that agencies are working collaboratively together, and for taking corrective action to improve policies and practice where necessary. This includes raising awareness of different types of abuse and neglect, ensuring that staff receive training, and reviewing and/or developing new guidance.

16 Brent Safeguarding Adults Board Budget, Income and Expenditure 2017-2018

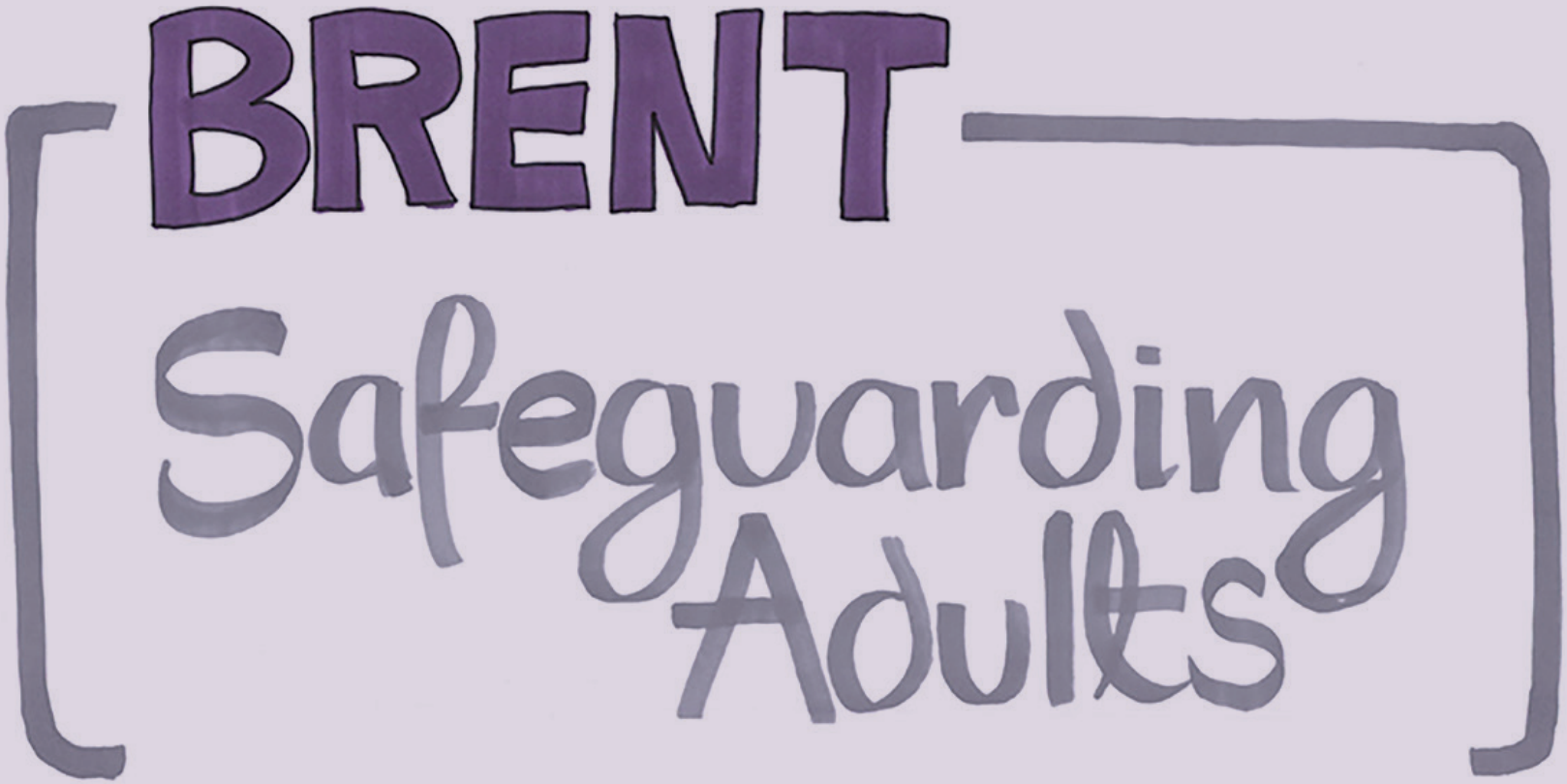
Contributor	Sum
The London Borough Brent	£137,400
Brent CCG £25,000	£25,000
MOPAC £5000, LFB £500	£5000
LFB	£500
TOTAL	**£167,900**

Expenditure	
Staff Costs April 2017-April 2018	£101,320
April-September 2017 Independent Chair's fees	£7,700
September-December 2017 Independent Chair's fees	£5,775
December-March 2018 Independent Chair's fees	£4,400
September-October 2017 SAR costs (Adult B)	£9,870
21 March 2018 SAB conference 21/03/18	£5,545
GRAND TOTAL	**£134,610**

During the period April 2017-2018, there was an underspend of £33,290. There are currently three Safeguarding Adult Reviews (SAR) in progress (please see section 15 for more detail). On completion, the expected costs of the combined SARs are likely to be met by this underspend in 2018-2019.

17 The Coming 12 Months and Future Learning Events

- Currently, Brent has four Safeguarding Adults Reviews at various stages of completion. 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.
- Lunch 'n' Learn Sessions focusing on topical issues will be scheduled throughout the year and advertised on the Safeguarding Adults Newsletter and Safeguarding Adults Board Website. These will include information-sharing, mental capacity and risk assessments, working together, and Making Safeguarding Personal.
- The Safeguarding Conference will take place in Spring 2019 and will focus on key areas of safeguarding practice identified by the board, its sub-groups and the current Safeguarding Adult Reviews.
- Development of a tri-borough multi-agency learning event.
- Conduct audits of safeguarding enquiry decision-making, Making Safeguarding Personal, and risk and mental capacity assessments.
- Safeguarding Awareness Training to raise the profile of adult safeguarding across the workforce.
- The Board will undertake a development day scheduled early 2019 to discuss its progress against the strategic plan and develop a new plan for the years 2019-2021.
- Ensure that Making Safeguarding Personal is embedded into policy and practice and improve how the Board gathers and obtains the views of adults at risk and those who support them.



BSAB ANNUAL REPORT 2017-18

Brent