

BRENT Safeguarding Adults

GOOD PRACTICE in SELF NEGLECT

INTER AGENCY IT TAKES TIME

build a relationship

- 1 Get to know the person
- 2 balance intervention
- 3 bring your humanity

HOMELESSNESS + SAFEGUARDING

TRAUMA

SEE + UNDERSTAND THE BACKSTORY

WRAP AROUND MULTI-AGENCY CARE

ASSESS RISK (MCA)

LIBERTY PROTECTION

WHERE WILL THE ARRANGEMENT BE MAINLY CARRIED OUT?

NHS TRUST RESPONSIBLE BODY LOCAL AUTHORITY

RIGHT TO... INFORMATION CARE PLAN REVIEW

CAPACITY MEDICAL NECESSARY PROPORTIONATE CONDITIONS

ADVOCACY CHALLENGE

ALCOHOL ABUSE

Chronic alcohol dependency

HELLO AGAIN

KEY RISK INDICATOR

MULTI-AGENCY ASSERTIVE OUTREACH

EXECUTIVE CAPACITY

yes I want to do that...

what someone is telling you vs. balance

objective reality

PROBE CLARITY

EXPLAIN WHY + SHOW YOUR WORKING OUT!

Leadership starts with ... YOU

legal literacy is important

it is complex many interfaces

CANDOUR

INDEPENDENT ADVOCACY

Wishes Feelings

CAPACITY

SAFEGUARDING DOESN'T HAPPEN IN A VACUUM

WE ALL BRING VALUE

Capacity?

- 1 Are you unable to make a decision?
- 2 Do you have an impairment to your brain?
- 3 Is this impairment the reason you can't decide?

TRAUMA

MENTAL HEALTH DIFFICULTIES SELF NEGLECT

Loss Abuse War Catastrophy

Reaction - subtle - massive

CHANGES how I SEE and EXPERIENCE the world around me.

THOUGHTS → FEELINGS → BEHAVIOURS

Do we focus on the right thing?

BE CLEAR

thorough risk assessment robust recording

OUR WHYs

- To protect life
- protect from degrading treatment
- protect physical + mental integrity
- protect liberty

I HAVE REASON TO BELIEVE... CAPACITY CAN BE FLUCTUATING

RISK posed by circumstance or by others

COURT OF PROTECTION

You are there to ASSIST the court to make the RIGHT decision... not to WIN

WE ARE ALL PART of a DIVERSE SYSTEM

WE ARE BETTER TOGETHER

ANNUAL REPORT 2019-20



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WE ARE ALL PART
of a
DIVERSE SYSTEM

1 INTRODUCTION BY THE INDEPENDENT CHAIR OF BRENT SAFEGUARDING ADULTS BOARD

Welcome to the Brent Safeguarding Adults Board (SAB) 2019-2020 annual report. The annual report is one of the statutory responsibilities of the SAB within the Care Act 2014. This report covers the period April 2019 – April 2020. As you will be aware, the early months of 2020 was a time when the seriousness of Covid-19 escalated and a national lockdown followed. This report will make reference to the Covid-19 pandemic. However, as the pandemic began during the end of the time-period reported on, a detailed analysis will not take place within this report. A full analysis on Covid-19 and its impact on adult safeguarding will be covered in next year’s annual report 2020-2021.

Given that the Covid-19 Pandemic and the resulting impact on services, this year’s annual report is a streamlined version. This is an intentional change with the view to allowing the SAB partners time to focus on urgent and pressing operational matters. Therefore, the partner contributions are limited in this year’s report and what follows is a concise report which allows the SAB to communicate its achievements with the public, albeit in a shorter format.

This has been an extremely busy year for Brent SAB. During late 2019 the SAB held a ‘board development day’ where it invited operational agencies who provide a service to adults at risk of abuse or neglect to come and present to the board particular practice areas that in their view, needed strategic improvements to be made. The presentation brief was kept loose intentionally to ensure that agencies were given the freedom to present what was pertinent to them. Three themes came out of the presentations and subsequent discussions and these areas were used to inform the new strategic plan. Publishing a strategic plan is another of the SAB’s statutory responsibilities under the Care Act 2014. More information about the strategic plan in Brent can be found within this annual report.

Shortly before the national lockdown was imposed, the SAB held its third annual adult safeguarding conference. The conference provided the SAB with an excellent opportunity to begin working on achieving the new strategic plan. There were keynote presentations and workshops presented and facilitated by well-respected professionals in their field. There were plenary presentations on; ‘The Care Act

and Interfaces with other Systems’; ‘The Court of Protection, the High Court, Safeguarding and Self-Neglect’ and finally, ‘Mental Health with a focus on Self-Neglect and Assessing Capacity’. There were also professional workshops on ‘Executive Capacity’, ‘Learning from Safeguarding Reviews Where Adults At Risk Abuse Alcohol’, ‘Homelessness and Safeguarding’, ‘What Works In Practice With People Who Self-Neglect Drawing On Research and Good Practice’ and ‘The Liberty Protection Safeguards’. The conference was well attended by professionals in Brent and the feedback received was extremely positive.

Another statutory responsibility of the SAB required by the Care Act 2014 is to commission Safeguarding Adult Reviews where the criteria are met. During 2019/2020, the Board finalised the SAR on Adult C. However, after careful consideration it was agreed by the board that this review would not be published. 7 minute briefings have, however, been prepared to share learning from the review. The Board is finalising Safeguarding Adult Reviews in the cases of



Adult D and Adult E and commissioned two new reviews; Adult F and Adult G. A summary of these cases are described in this annual report. Neglect, self-neglect, mental health and managing risk in the community all feature within these reviews.

This year, the SAB took part in an ADASS ‘Peer Review’. The focus of the Peer Review was on the operational effectiveness of the SAB partners. The review was not an inspection but rather strategic and operational practitioners and managers from other organisations attended the London Borough of Brent as reviewers to seek assurance around adult safeguarding operationally, as well as forming a view of the strategic oversight by the SAB. This was a valuable experience for all who took part and a number of positive areas were identified as well as areas for improvement. Further information on the Peer Review can be found within the annual report. The outcomes of the review have also informed the board’s strategic plan.

I have attended scrutiny meetings to inform elected members of the work of the SAB. I attended scrutiny to present the Adult B SAR to elected members and to report on the ADASS



Peer Review in Brent as well attending to report on last year’s annual report. Next year I will attend scrutiny to present the SAR on Adult E.

Finally, I would like to record my appreciation for the work of Daniel Morris, Meenara Islam, Janine Georgias and Hannah O’Brien, who have managed and supported the work of the Board. Thank you also to Graphic Change. The images that they drew during the SAB conference 2020 are used throughout this annual report and

capture the professional discussions during the conference.

I hope you enjoy reading this year’s annual report.

PROFESSOR MICHAEL PRESTON-SHOOT
INDEPENDENT CHAIR

2 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.

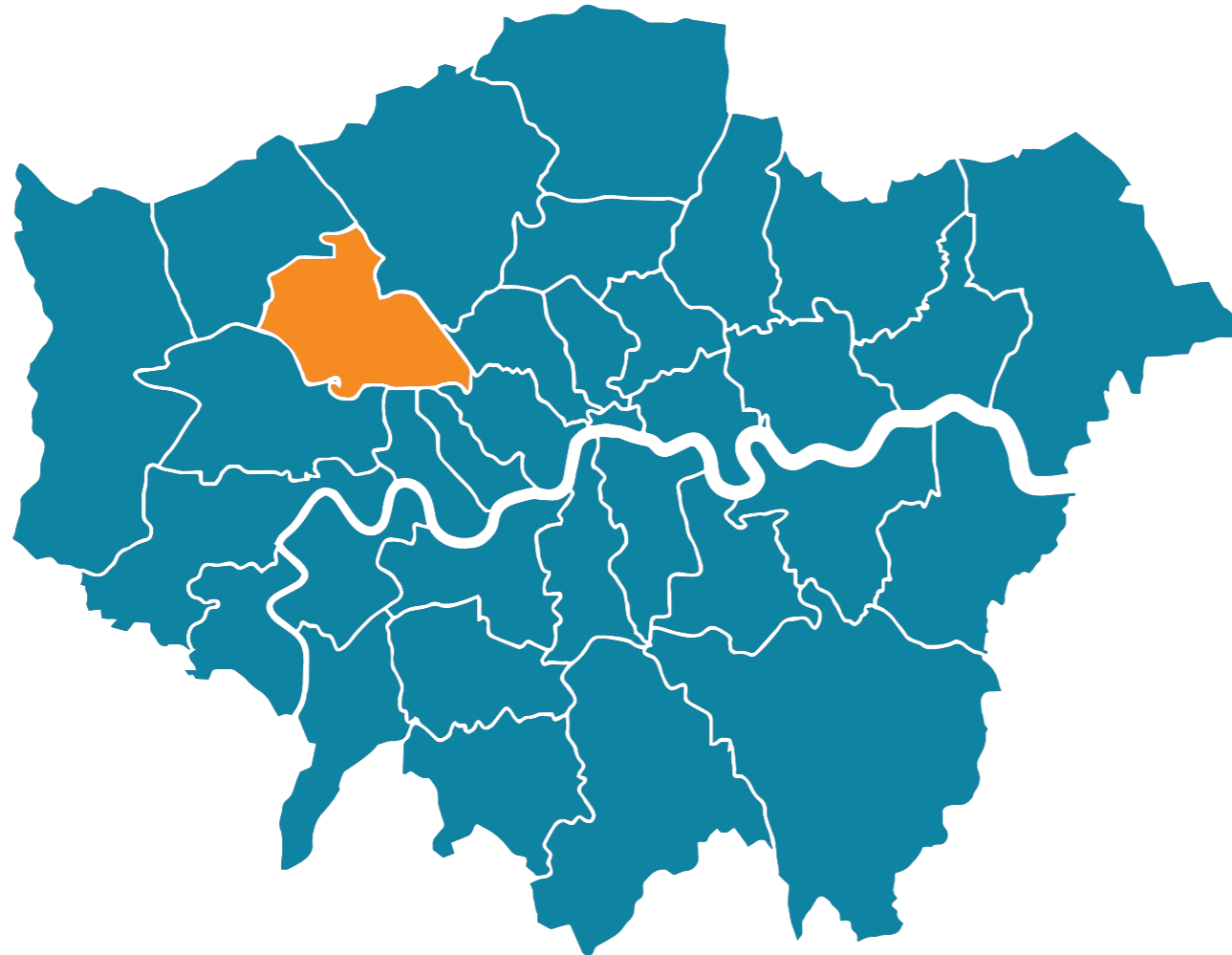
Population: 334,700 people live in Brent - we are the 6th largest borough in London.

53% of residents were born abroad which is the 2nd highest in London.

35% of the population of Brent identify as white (16% identify as white other), 34% identify as Asian, 18% identify as black, 6% mixed and 7% other.

37% of the population of Brent do not speak English as their first language.

At the time of writing, during the period April 2019 – April 2020 there were 32,104 recorded offences within the London Borough of Brent (this can change over time). This equates to a crime rate of 95.5 offences per 1,000 population. This is below the average for London (107.9). Brent was the 16th highest borough in London for crime.



3 WHAT IS ADULT SAFEGUARDING?

The Care Act 2014 gave adult safeguarding in England its first legal footing. The Act formally created Safeguarding Adults Boards (SABs) and laid out what the duties were of SABs, namely: 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 neglect. The Act requires partner agencies and services to work together to protect adults at risk of abuse and neglect.

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

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). The Act specifies that local authorities have a duty to undertake an Enquiry where there is a concern that an adult with care and support needs is unable to protect themselves when experiencing or at risk of abuse or

neglect. If the criteria are met, then the local authority must conduct an Enquiry and decide on any action under section 42(2).

REVIEWS

Where the strict criteria are met, Section 44 of the Care Act states that Safeguarding Adults Boards must arrange a Safeguarding Adult Review. A Safeguarding Adult Review is completed by a suitably qualified person, independent of the local authority and its partners. The purpose of a Safeguarding Adult 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 adults at risk in future. Further information regarding the current status of Brent's Safeguarding Adult Reviews can be found later in the annual report.

MAKING SAFEGUARDING PERSONAL

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. The DOLS legislation is due to be replaced by the implementation of Liberty Protection Safeguards. At the time of writing the annual report there have been indications that this change will be delayed until April 2022.

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)

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4 PRINCIPLES OF ADULT SAFEGUARDING

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.

WE ARE BETTER TOGETHER

5 HOW TO REPORT ABUSE IN BRENT

The Safeguarding Adults Board is a strategic board. The Board is not responsible for progressing operational safeguarding concerns. This is carried out by Adult Social Care within Brent Council. The mandate of the Board is to seek assurance that adult safeguarding is effectively managed by all services within the Borough.

If you wish to raise a safeguarding concern there is a 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 and they will help you. Alternatively, you can contact the safeguarding adult team on **020 8937 4098** or **020 8937 4099 from 9am-5pm**, Monday to Friday.



6 FORWARD BY THE TEAM MANAGER OF THE SAFEGUARDING ADULTS TEAM AND SAFEGUARDING ACTIVITY IN BRENT

This has again been a challenging year for the Safeguarding Adults Team. New ways of working and recording were developed and embedded with an increased focus on providing intensive intervention as soon as is practicable. The Safeguarding Team now gathers and interprets more data than previous years, which enables us to monitor emerging trends more effectively.

Neglect continues to be the main category of abuse but there has been increasing number of concerns raised due to issues around self-neglect. This is now a significant proportion of our work in Brent. The location of abuse in most cases in Brent remains in the person's own home.

We continue to develop our relationships with partners, operational and strategic boards to ensure a multi-agency response is provided to Safeguarding Concerns. Of particular

focus has been developing partnership working in relation to domestic abuse. This will continue to be an area of focus over the coming weeks and months.

At the time of writing, the Safeguarding Adults Team are carrying out an increasing number of visits due to the pandemic. The full impact of which we will report on in the next annual report.



BRENT LOCAL AUTHORITY SAFEGUARDING TOTALS FOR 2019-2020				
Safeguarding Concerns	Section 42 Safeguarding Enquiries	Other Safeguarding Enquiries	Total Enquiries	Conversion rate % Enquiries/Concerns
1411	835	5	840	60%

CONVERSION RATE CHANGES IN BRENT FROM PREVIOUS YEARS:

2019/20	Current conversation rate is 60%
2018/19	1,493 concerns received, 72% meeting S42(2)
2017/18	1,675 concerns received, 42% meeting S42(2)
2016/17	1,712 concerns received, 37% meeting S42(2)

LONDON AVERAGES FOR THESE PERIODS WERE AS FOLLOWS:

2018/19	1,435 concerns received, 43% meeting S42(2)
2017/18	1,350 concerns received, 43% meeting S42(2)
2016/17	1,225 concerns received, 45% meeting S42(2)

During 2019/20, a new framework was implemented on making decisions to carry out safeguarding adults enquiries. This framework focused on S42(1) as the statutory criteria for

decision making, and S42(2) where the duty is triggered under the Care Act. As a result of these changes and additional capacity in the local authority 'front door', the safeguarding team have improved the initial response to safeguarding and a conversion rate lowering in line with the rest of London.

TYPE OF ABUSE FOR CONCERNS RAISED		
Abuse Type	Number	Percentage
Neglect / Acts of Omission	447	31%
Physical	285	20%
Financial / Material	222	15%
Psychological/Emotional	214	15%
Self-neglect/Hoarding	123	8%
Not recorded	50	3%
Sexual Abuse	46	3%
Domestic abuse	33	2%
Self-harm	9	1%
Organisational	8	1%
Radicalisation	5	1%
Sexual Exploitation	4	1%
Forced Marriage	3	1%
Modern Slavery	3	1%
Discriminatory	2	1%



LOCATION OF ABUSE FOR CONCERNS RAISED		
Own Home	Number	Percentage
Care Home (Residential & Nursing)	447	31%
Other	285	20%
Hospital - Acute	222	15%
Not recorded	214	15%
In the Community (excluding community services)	123	8%
Hospital - Mental Health	50	3%
In a Community service	46	3%
Service within the community	33	2%
Hospital - Community	9	1%



7 STRUCTURE OF THE SAB AND ITS SUB-GROUPS

SAFEGUARDING ADULTS BOARD (SAB)

The Board is a partnership made up of statutory and non-statutory partners. The statutory partners are; The Police, Clinical Commissioning Group and the Local Authority. Non-statutory partners can be anyone invited by the SAB to become a partner. Brent SABs non-statutory partners can be seen in the graphic in section 12. The Board meets on a quarterly basis. There are 3 Sub-Groups that assist the SAB in carrying out its duties. These sub-groups meet when required other than the Executive Sub-Group. Each has different aims and objectives linked to the Safeguarding Adults Strategic Plan.

CASE REVIEW SUB-GROUP

The Case Review sub-group is a multi-agency and multi-disciplinary group. It considers referrals for Safeguarding Adult Reviews (SAR). Where the criteria are met, it commissions and manages mandatory Safeguarding Adult Reviews. In addition, the Case

Review Sub-Group commissions and oversees discretionary Safeguarding Adult Reviews and 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 and acted upon, and impact is assessed.

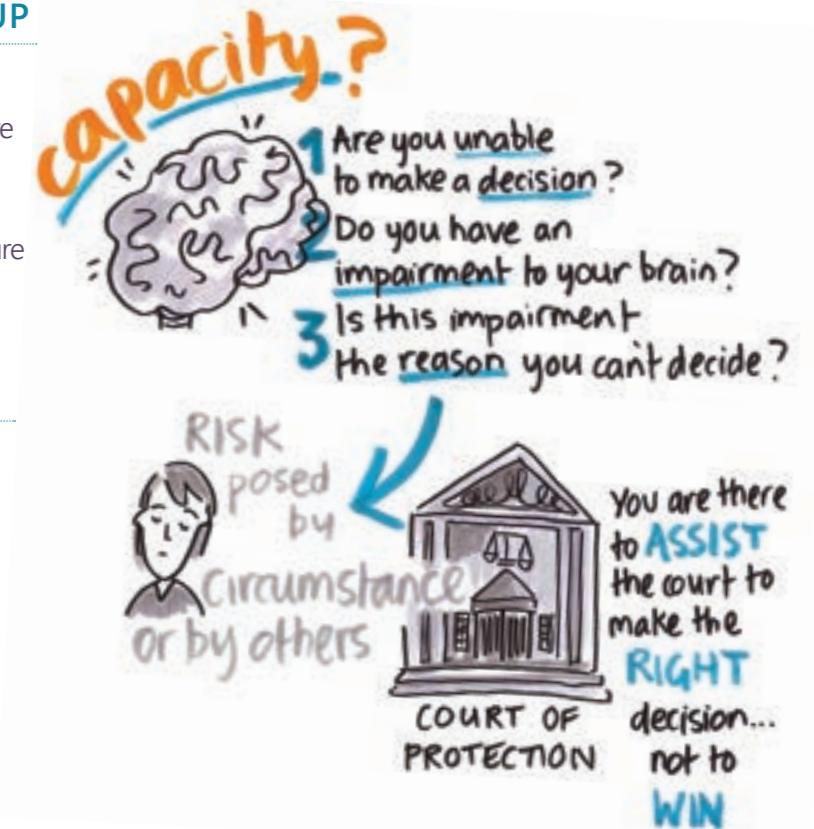
PROVIDER CONCERNS SUB-GROUP

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 has been reformed and will now be a bi-annual meeting of the Statutory Partners,

The Chief Executive of Brent Council and the Independent Chair of the SAB. This meeting will have a focus on governance.



8

EVENTS & BOARD ACTIVITY



ADULT SAFEGUARDING CASE AUDIT

The Safeguarding Adults Board commissioned an independent auditor to undertake sixteen case audits to evaluate the quality of safeguarding practice in the London Borough of Brent. This audit examined areas such as: decision making, making safeguarding personal, application of the Mental Capacity Act, professional curiosity and use of advocacy. The auditor attended the SAB to present a paper summarising the audits in late April 2019. The findings were encouraging. Positive areas of practice were identified as well as areas for future development.

JOINT ADULTS AND CHILDREN'S SAFEGUARDING SURVEY

The Safeguarding Adults Board and the Safeguarding Children Board in Brent undertook a joint online survey. This was a survey across the Safeguarding partners to gather an awareness of safeguarding amongst all staff within the partnership. The survey also attempted to ascertain what learning and development opportunities were required within the Borough. The results of the survey were presented at the SAB and fed into the development of the learning and development plan and the new strategic priorities.

BRENT, BARNET AND HARROW COMBINED LEARNING EVENT

Brent SAB took part in a three-borough event in order to improve cross-borough multi-agency working for the future. Following The Metropolitan Police moving away from the Borough based Policing model to the 12 Basic Command Units (BCU's), Brent, Barnet and Harrow now have a Senior Police leadership team that operates across the three boroughs. This event was a first step towards trying to support that transition and forge closer links. The theme of the event was the Mental Capacity Act. The Police, the local authorities and colleagues in mental health teams each explored the Act. Michael Preston-Shoot presented information from national and regional Safeguarding Adult Reviews that had involved the emergency services and raised learning in relation to the Mental Capacity Act.

PEER REVIEW

Mid 2019, Brent took part in an ADASS 'Peer Review'. A Peer Review is the agreed methodology to monitor the effectiveness of adult safeguarding across England. It is not an inspection. It is a review carried out by leaders from other local authority areas that visit the Borough and undertake case file and data analysis, interviews and workshops. They also evaluate documentation sent to them and use

all this information to form a view as to whether the system is working as it should. The subject matter of the review focused on 'the Operational Links Between the Partners of the Safeguarding Adults Board'. As with all Peer Reviews, there were an equal number of positive areas of practice and opportunities identified for further development. However, the areas of strength were regarded as a strong indicator of good performance within the London Borough of Brent. The Peer Review therefore provided assurance about prevention and protection of adults from abuse and neglect. The feedback received was also presented at the 'Board Development Day' (see below) and was used to inform the board's strategic priorities.

TRANSITIONS LEARNING EVENT

Late 2019, The Safeguarding Adults Board arranged a full-day multi-agency learning and development event jointly with the Safeguarding Children Board focussing on 'Transitions'. This event was relevant to both Boards as it focused on when children who have received statutory services move into adulthood. Evidence suggests that this is a high risk time and one which can be challenging for professionals, young people and young adults. Guest speaker Dez Holmes facilitated and presented an interactive session, passionately identifying research findings and

encouraging professionals to explore some of the challenges of working with this group.

BOARD DEVELOPMENT DAY

One of the duties of Safeguarding Adults Boards as defined by the Care Act 2014 is to publish a strategic plan. The previous plan had been in place since 2016 and therefore it was an appropriate time was for the Board to reflect on the landscape and re-evaluate its priorities. In October 2019, the Board undertook an event to refresh its strategic plan, which it called 'The Board Development Day'. Operational Services were given a brief to present to the Board for ten minutes to explain pertinent operational issues that required strategic input. The SAB members then picked out themes from these presentations and together formed the strategic priorities.

AUDIT OF COMMISSIONED SERVICES

To seek assurance around the use of 'extra care' accommodation in Brent, which is a particular model of accommodation combined with care provided on-site, the SAB commissioned an independent audit. The auditor was asked to examine a sample of recent placements into extra care to seek assurance that the model was being

used appropriately. The auditor was asked to return to Brent and conduct an audit of cases to seek assurance that, within extra care placements where there was increasing risk due to poor health or decline in cognition, the risks were being managed effectively. Both audit reports were presented to the Safeguarding Adults Board. The findings were positive and although there were some areas identified for further improvement the results suggested that extra care was being used appropriately in Brent and risks being managed during the time of the audit.

THE SAFEGUARDING ADULTS BOARD ANNUAL CONFERENCE

This year's annual conference provided the SAB with an excellent opportunity to begin working on the new Strategic Plan. To support learning around 'Legal Literacy', the SAB managed to secure keynote presentations from Tim Spencer-Lane and Alex Ruck-Keene, legal experts in their field, to speak about 'The Care Act and interfaces with other systems' and 'The Court of Protection, the High Court, safeguarding and self-neglect – which court and what can you ask for?' The third and final speaker, Patrick Hopkinson, spoke about 'Mental Health with a focus on Self-neglect and

assessing capacity', ensuring that self-neglect was an area of particular focus. In order to ensure that learning was disseminated to delegates at the conference, the SAB secured input from a range of well-respected speakers namely; Suzy Braye, Michael Preston-Shoot, Adi Cooper and Mike Ward. In addition to legal workshop sessions by Alex Ruck-Keene and Tim Spencer-Lane. These workshops focussed on areas all relevant to the strategic plan and common areas of challenge in cases of self-neglect namely; 'Executive Capacity', 'Learning from Safeguarding Reviews Where Adults At Risk Abuse Alcohol', 'Homelessness and Safeguarding', 'What Works In Practice With People Who Self-Neglect Drawing On Research and Good Practice' and 'The Liberty Protection Safeguards'. The conference was a huge success, was well attended by professionals in Brent and the feedback received was extremely positive. Present throughout The Safeguarding Adults Board Conference was a skilled artist capturing the discussions in graphic form.

LEARNING AND DEVELOPMENT

Over the last year Brent SAB has undertaken a number of multi-agency learning dissemination

events in relation to the Adult C SAR, domestic abuse, making safeguarding personal, hoarding and self-neglect, The Mental Capacity Act and safeguarding awareness raising with charities and volunteers.



9 THE SAFEGUARDING ADULTS BOARD STRATEGIC PLAN 2019-2021

During late 2019, The Safeguarding Adults Board held a 'Board Development Day' event. Presentations to Board members were made by operational agencies who provide a service to adults at risk of abuse and neglect in Brent. The purpose of the presentations was to give services the chance to tell the SAB what they felt the Board should focus on strategically over the next 2 years. Feedback from the ADASS Peer Review was also incorporated into the day's discussions as well as using information obtained by the audits commissioned by the SAB. Following the presentations, Board members came together for group discussion to identify themes. At the following SAB meeting the Strategic Plan was agreed and later published on the Safeguarding Adults Board website;

PRIORITY 1 – SELF NEGLECT

The Care Act 2014 statutory guidance (DH, 2020) defines self-neglect as: "A wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding." The Brent SAB aims to ensure strategic development of working with people who self-neglect. The Brent SAB aims to do this by:

- Development of multi-agency self-neglect policies and procedures
- Learning dissemination events
- Multi-agency learning and development sessions

PRIORITY 2 – LEGAL LITERACY

Legal Literacy is knowledge and awareness of the legal options open to practitioners in order to safeguard adults at risk from abuse and neglect. The Brent SAB aims to empower practitioners in Brent with knowledge as to the options open to them and develop systems in order that this informs decision-making. It aims to do this by:

- Development of understanding of legal duties in relation to adult safeguarding
- Audit of use of legal rules in cases
- Multi-agency workforce development
- Learning from outcomes of judicial reviews and Ombudsman reports

PRIORITY 3 – INFORMATION DISSEMINATION

Some of the feedback is that information sometimes does not reach those who need it most. The Brent SAB reflected on this and agreed to undertake:

- Two professional conferences to ensure practitioners who work in Brent can come together for multi-agency learning and development
- At least one community conference to reach smaller organisations and the public
- Official Launch of the Safeguarding Adults Board Website as a vehicle to disseminate learning and information

10 PARTNER ORGANISATION CONTRIBUTIONS



BRENT CLINICAL COMMISSIONING GROUP

NHS Brent Clinical Commissioning Group (CCG) continues to play an important role in shaping and ensuring that Brent Safeguarding Adult Board (BSAB) implements its strategic objectives. The principal role of the CCG is to ensure that both its own internal adult safeguarding structures and processes, and those within NHS commissioned services comply with relevant legislation and guidance. Safeguarding adults is a statutory requirement and the responsibility of all. The CCG provides expertise, support and challenge to raise awareness and make improvements in safeguarding across the Health economy.

The Designated Nurse for Safeguarding Adult attends and contributes to Brent SAB and its sub groups. The CCG also supports work in relation to the following areas: Prevent; Violence Against Women and Girls; Female Genital Mutilation (FGM) and Multi-Agency Risk Assessment Conferences. The CCG updated the Safeguarding Adult Cards, which are used as a quick guide to support all professionals in their practices across North West London (NWL). The quick reference cards can also be used to look up Local Authorities and Safeguarding Designated Professional contact details across North West London CCGs.

During the last year, NWL CCG delivered training aimed to provide information on the new Mental Capacity (Amendment) Act 2019. This training was hosted by NHS Brent CCG to provide advice on the application of the Liberty Protection Safeguards. The training was well attended and the feedback obtained showed it added value to the system. NWL CCGs also held a safeguarding conference, attended by over 200 people from the partnerships across the eight Boroughs. The conference provided an excellent opportunity to learn together to better improve outcomes for children, young people and adults. The conference was highly evaluated. Attendees reported feeling confident and equipped to recognise and respond to safeguarding issues. Over 90% stated they would take the learning back to their organisations to improve their safeguarding practices.

The Safeguarding Designated Nurse continuously examines potential areas of risk in relation to its statutory responsibilities and has provided clinical advice to NHS providers. This includes ensuring learning from Safeguarding Adult Reviews and other reviews, both local and national, is disseminated and lessons are learned and embedded in local practices. The Safeguarding Designated Nurse also provides safeguarding

supervision to Safeguarding Named professionals within NHS providers. This strives to ensure safeguarding adult activities are firmly embedded as part of everyday practices.

The CCG monitors compliance within providers using a standard template, the North West London Safeguarding Health Outcome Framework (SHOF), which includes clear safeguarding standards and key performance indicators. During 2019/20, NWL CCGs reviewed its Safeguarding Health Outcomes Framework. This ensured a consistent reporting framework for providers to enable a clear picture of safeguarding adults across North West London and provided assurance for the CCGs, NHS Trust Boards, and Local Safeguarding Boards.

The CCG continues to undertake quality assurance visits in health providers. These visits are a learning opportunity which helps each NHS provider to meet their duties to safeguard adults at risk and promote the welfare of those identified to be at risk of abuse or neglect.

NHS Brent CCG continues to explore how to support and empower people at risk of harm to resolve the circumstances that put them at risk. The CCG supports NHS providers to develop safeguarding responses to strengthen the

understanding and realisation of outcomes people want /need. This utilises good person-centred practice from the outset in trying to achieve the resolution that people want, including introducing different ways to enable resolution.

The CCG coordinates the Learning Disability Mortality Review (LeDeR) programme in Brent. This aims to drive improvement in the quality of health and social care service delivery for people with Learning Disabilities (LD). The CCG was also recognised as the first CCG in England to have completed all outstanding LeDeR reviews within the financial year. The CCG hosted an event for families, carers and professionals, to share the learning from LeDeR reviews. These raised awareness about the LeDeR programme and developed the local 'learning into action' strategy. In combination with the Local Authority, the CCG held a 'Big Health Check 2019' to raise awareness of physical health issues amongst people with a learning disability and their families and carers.

The Safeguarding Team delivered safeguarding training to health staff in the CCG and the wider local health economy. This aims to improve 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 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.



LONDON AMBULANCE SERVICE (LAS) PRECIS OF ANNUAL REPORT 2019-20

The London Ambulance Service is commissioned by Brent CCG. Brent Safeguarding Adults Board is currently the only London Safeguarding Adults Board the LAS attend and oversight over this service is via the Brent SAB. Therefore, although not a statutory partner, a contribution from the LAS is included in this annual report.

6031 Safeguarding concerns were raised by LAS across London which represented a slight decrease compared to last year of 1.6%. Brent is the 13th highest borough in London in terms of referrals by the LAS.

The majority of LAS referrals are in relation to self-neglect, closely followed by neglect.

LAS has observed an emerging increase in safeguarding concerns as the Covid-19 pandemic has become more severe. The LAS will report on this to a greater extent in next year's annual report.

The priorities for LAS for the next 12 months are:

- To rebuild the Safeguarding Team post Covid 19. Consider new Safeguarding practice, opportunities and requirements post Covid 19.

- To recruit new members to the Safeguarding Team to enable outstanding safeguarding practice across the Trust.
- Introduce a new safeguarding referral process with the Trust moving to Electronic Patient Care Record (EPCR).
- To continue to improve the quality of Safeguarding Governance and Assurance.
- Work with partners to: develop contextual safeguarding arrangements following pilot; improve safeguarding response to Prisons

- and referral process; improve feedback from referrals/ concerns.
- Provide a varied safeguarding educational program across the Trust as well as Safeguarding Specialists delivering training at a variety of levels in line with intercollegiate documents and trajectory agreed with commissioners.
- Embed new legislation and best practice. Particularly Domestic Abuse, Liberty of Protection Safeguards & Child Death processes.



THE METROPOLITAN POLICE

As reported on in the previous annual report, The Metropolitan police has moved from a Borough based Policing model to a cluster based Basic Command Unit. Brent is now clustered with two other London Boroughs namely Harrow and Barnet. This report is an overview of safeguarding adult activity over the three Boroughs. Within the clusters, The Metropolitan Police have developed three particular areas and report on these under the three headings; domestic abuse, contextual safeguarding and mental health. The other areas of development are grouped under the heading 'other safeguarding activity'.



DOMESTIC ABUSE		
<p>Achievements</p> <ul style="list-style-type: none"> Streamlined IDVA referral pathway created. Increased use of Body Worn Video and 999 call recordings improve outcomes. Suspect guilty pleas preventing protracted court cases for vulnerable victims. Successful implementation of 'virtual' MARAC held every two weeks. Increased referrals for Non-crime domestic incidents attended by police officers through the design of a new template referral process. 	<p>Challenges</p> <ul style="list-style-type: none"> High demand area for policing. Mostly low risk offending but requires high levels of resourcing from initial response through to prisoner processing. Training - Young inexperienced workforce requires close supervision and monitoring 	<p>Development Needs / Opportunities</p> <p>New roles created Predatory Offender Unit – focus on high harm offenders, in particular domestic abuse. (launch late 2020)</p> <p>Dedicated roles to support</p> <ul style="list-style-type: none"> Domestic Violence Prevention Orders Stalking Protection Orders Domestic Violence Disclosure Notices

CONTEXTUAL SAFEGUARDING		
<p>Achievements</p> <p>Q4 training delivered to 1200 officers, highlighted:</p> <ul style="list-style-type: none"> Vulnerable adolescents. Vulnerability Assessment Framework Domestic abuse investigation. <p>Refreshed referral process for low-level domestic abuse cases including family members resulted in increased referrals.</p> <p>A Central Mental Health Team lead and in turn a NW MH Liaison Team lead for Children and Young Persons Mental Health (CYPMH) have been recently appointed to progress work in this area.</p> <p>The MH Liaison Team are members of Dementia Support Group and disseminate info as appropriate.</p> <p>The MH Liaison Team organised a series of presentations by "Treat Me Right" regarding learning disabilities to the SNTs and new officers.</p>	<p>Challenges</p> <p>COVID-19 pandemic resulted in significant staff numbers remote / agile working. IT compatibility issues have mostly been resolved.</p> <p>Police response is fractured between initial response, reporting via MASH, s.135 of The Mental Health Act assessment support, problem solving and criminal investigation.</p>	<p>Development Needs / Opportunities</p> <p>Proficiency in virtual platforms Info sharing agreements Revised terms of reference to support virtual meetings and information sharing.</p> <p>Develop closer relationships with Care Home Partnerships and Care Quality Commission vulnerable adult panel</p>

MENTAL HEALTH

<p>Achievements A Central Mental Health Team lead and in turn a NW MH Liaison Team lead for Children and Young Persons Mental Health (CYPMH) have been recently appointed to progress work in this area.</p> <p>The MH Liaison Team are members of Dementia Support Group and disseminate info as appropriate.</p> <p>The MH Liaison Team organised a series of presentations by "Treat Me Right" regarding learning disabilities to the SNTs and new officers.</p>	<p>Challenges Mental Health - Police response is fractured between initial response, reporting via MASH, s.135 of The Mental Health Act assessment support, problem solving and criminal investigation.</p>	<p>Development Needs /Opportunities The aim for the CYPMH lead is to initiate joint working across the MPS, between the MH Teams, and other MPS commands (e.g. Missing Persons, Gangs Unit, DV, custody) alongside external partners in order to draw up clear communication as to procedures and protocols that should be adhered to when it comes to Mental Health and Young people.</p>
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OTHER SAFEGUARDING ACTIVITY

<p>Achievements The NW Safeguarding portfolio has thematic areas, with a Lead Responsible Officer for each area. This ensures there is a subject matter expert for each theme, responsible for training and staff development, supporting partner meetings, quality assurance and audit for the NW BCU</p>	<p>Challenges Awareness of: s.42 / MCA / LPS / multi-agency enquiries in parallel with criminal investigation.</p>	<p>Development Needs /Opportunities The MPS will continue to train all frontline and custody staff to recognise people who are ill, vulnerable or in crisis; signposting them to help through the Adult Coming to Notice (ACN) referral process, or MERLIN for cases of missing, exploitation, vulnerability or involved in crime. Regular engagement with awareness campaigns and partner training helps to equip police officers and staff with the right skills to recognise illness and vulnerability, such as; dementia, modern slavery, criminal exploitation and mental illness.</p>
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BRENT COUNCIL – ADULT SOCIAL CARE

Brent Council’s Adult Social Care has a lead role in safeguarding adults. Under the Care Act 2014, we have a legal duty to carry out what is termed an enquiry for certain adults in our area. Preventing and responding to abuse is a core part of what we do and rooted in our belief that everyone has the right to live safely, free from abuse and neglect. Although these have been challenging times in adult social care, our focus remains on ensuring every change we make to how we work, such as our systems or practice, only improves how we respond to abuse of adults in our area.

Adult Social Care continues to be committed to partnership work and collaboration with the members of the Safeguarding Adults Board. We have taken part in and submitted audits of our practice, reflecting our open approach. The department has engaged, reflected and learned from the findings of Safeguarding Adult Reviews and ensures its staff are active participants in SAB learning and development opportunities and the annual conference. Adult Social Care was a lead partner in the ADASS Peer Review of safeguarding, helping to coordinate and set out a programme of audit that was open, transparent and sought to



learn from the peer review team. In adult social care we set out an action plan to improve areas following this peer review. This action plan included changing our recording to reflect how vulnerable adults are supported and involved in safeguarding, reviewing the structure of our teams to support more effective working together, and more training opportunities for staff.

The number of concerns received into adult social care are similar to the previous year and a focus has been on having the right conversations

with adults at risk of abuse early on, to understand what they want to happen next. This is part of Making Safeguarding Personal, helping people to recover and improve their resilience after abuse. Our data shows that there has been an increase in reports of self-neglect and hoarding. Self-neglect can be raised under safeguarding and adult social care contributed to the SABs development of a Self-Neglect and Hoarding Policy and Toolkit. Internally, we found that adults who self-neglect and hoard may need time to build a different type of relationship of trust with practitioners. We have worked with the

adult at risk to slowly remove items and make homes habitable, while linking them with mental health or other types of support. We work closely with partners, such as the London Fire Brigade, to reduce risk of fire for example. This will continue to be an area of focus for us over the coming year.

At the time of writing this, the Covid-19 pandemic continues to affect those already known to adult social care, and is bringing more people to our attention for support. Adult social care, in the widest sense of safeguarding residents, continues to respond to make sure people have access to the right services and that we are supporting, preventing deterioration or managing the risk of abuse linked to isolation. The safeguarding adults team have undertaken an increased number of welfare visits to make sure people are safe in the community and in care homes, doing so in a way that seeks to minimise any transmission of the virus. Those experiencing domestic abuse continue to have support to keep themselves safe and move to places of safety when needed.

ALCOHOL ABUSE



The energy and commitment from adult social care to continue to safeguard our most vulnerable has been recognised during this time, and the response during the pandemic will be

reported on to a greater extent in next year's SAB annual report.

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SAFEGUARDING ADULT REVIEWS

Adult C

This review was completed and agreed by the SAB but was not published to protect the subject. 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. Multi-agency learning dissemination events were undertaken and learning briefings were disseminated to professionals. The learning identified in relation to Adult C is that professionals should have made greater and more consistent attempts to check the welfare of Adult C, considering practice evidence in relation to 'transitions' and reflecting on patterns of behaviour in relation to how his family engaged with professionals. Agencies should have been more effective in sharing information, building evidence that could be used to explore legal options. Further, agencies should have adopted a joined up approach to managing risk.



Adult D

Adult D died in his early 70s. He had a diagnosis of depression in later life with suicidal thoughts. He had health problems, which impacted on his mobility. He began severely neglecting himself which led to him being hospitalised. He was discharged home with a care package arranged to support him. In time he began refusing entry to carers. Due to his non-engagement the care package was cancelled. Adult D was later found dead in his home. The SAR has been provisionally completed but is awaiting a report from family members and full approval by the SAB. The learning identified in this case was around a lack of multi-agency working and a failure to share information effectively when the risks began to increase. The case highlighted lack of understanding about Making Safeguarding Personal and its relationship with the Mental Capacity Act. As a result of the case of Adult D, the SAB partnership developed a new self-neglect procedure to ensure a multi-agency approach to this type of abuse in future. Dissemination events are being planned for the coming year.

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. This review is nearing completion. The review will focus on how agencies could have worked better to better protect Adult E. It will also explore the balance between allowing a person's freedom and imposing restrictions to keep people safe. This review is still its completion stages. The learning identified in this case will be reported on in next year's annual report.

Adult F

A reviewer has been chosen and this report is in the very early stages of completion. This report focuses on an adult who self-neglected and refused medical intervention for conditions impacting upon his health. This report will examine whether agencies could have worked better to protect the adult at risk. This review is also still its completion stages. The learning identified in this case will be reported on in next year's annual report.

Adult G

A reviewer has been chosen and this report is in the very early stages of completion. This report will focus on the care provided by a care home, how the care home were supported by specialists and how the care provided was monitored. The report will also focus on the hospital discharge process and how agencies work with families. This review is also still its completion stages. The learning identified in this case will be reported on in next year's annual report.



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BRENT SAFEGUARDING ADULTS BOARD BUDGET, INCOME AND EXPENDITURE 2019-2020

INCOME 19/20	AMOUNT
Clinical Commissioning Group	£25000
Brent Council	*£37400
MOPAC	£5000
LFB	£500
Total	£67,900

ITEM	EXPENDITURE 19/20 (ROUNDED COST)
February 2019 SAB conference	£6000
February 2020 SAB conference	Deferred until 20/21
SAB learning and development (rolling costs)	£700
SAR: Adult C	£4500
SAR: Adult D	£13,000
SAR: Adult E (not yet completed)	£4,500
Independent Chair Fee's	£16500
Safeguarding ASC case audit	£2200
Safeguarding audit commissioned services	£5050
Design Costs for promotional material	£500
Board presentation BMG research	£500
Website Development	£2000
Joint Survey (SAB contribution)	£3500
Transitions Event Room hire	£500
Catering costs for board meetings	£500
Annual Report Costs	£1000
Printing costs	£100
Board Development Day	£1000
Total	£62,000

*In addition to the above, Brent Council contribute £100,000 to staffing costs to fund a strategic partnerships lead, a share of a learning and development officer and line management of these roles.

13 THE COMING 12 MONTHS

Currently Brent is finalising Safeguarding Adult Reviews in the cases of Adult D and Adult E and commissioned two new reviews; Adult F and Adult G. The SAB will also continue to consider new referrals, which may be sent in by either professionals or by members of the public.

At the time of writing, due to the Covid-19 pandemic, Brent SAB is redesigning its learning and development plan to move towards a virtual

multi-agency learning and development offer. This will set out how the SAB plans to achieve its strategic plan and disseminate learning. Once agreed, it will be published on the SAB website and will be reported on within the next strategic plan.

Again, due to the Covid-19 pandemic, the Board has sought assurance regarding how well partners are working together to safeguard

and promote the wellbeing of adults with care and support needs who are at risk of abuse and/or neglect.



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