

BRENT

Safeguarding Adults



ANNUAL REPORT
2021-22

WE ALL HAVE A ROLE TO PLAY



OUR
WHYs



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

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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) 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 2021 – April 2022.

This year was the final year for Michael Preston-Shoot as SAB Independent Chair who handed over to Fran Pearson, the new Independent Chair for Brent SAB. The official appointment was made in April 2022, with the preceding months a period of handover.

FORWARD BY FRAN PEARSON

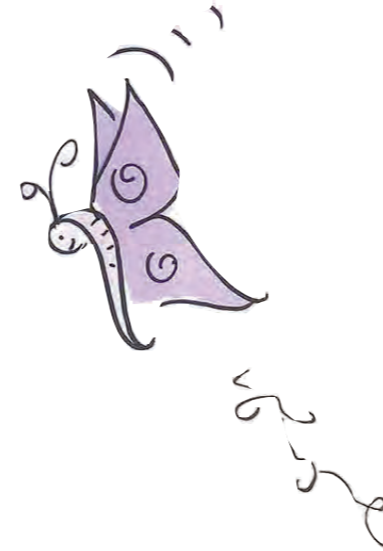
I am delighted to have been appointed as the Independent Chair of Brent Safeguarding Adults Board. I work, self-employed, as an independent chair of Safeguarding Adults Boards, and also as a reviewer of safeguarding incidents. Originally a social worker and social work manager, I then moved into NHS management including a secondment outside my usual area of work, into Public Health. Much of my employed career was in the north of Kensington and Chelsea, and the north of Westminster, so parts of Brent and a few colleagues and resources, are familiar.

One of my published Safeguarding Adults Reviews is that of Adult E in Brent. I very much wanted to come and work in the borough after gaining a little knowledge of adult safeguarding in Brent through that review.

I wanted to thank the outgoing chair of the Brent SAB, Michael Preston-Shoot. Michael is a well-known and respected academic in the field of adult safeguarding, and I can see from the work done and from what board partners have told me, how Brent SAB benefitted from his expertise and his commitment to those who were experiencing safeguarding, and how much he will be missed.



Fran Pearson
Independent Chair



2 WELCOME TO BRENT

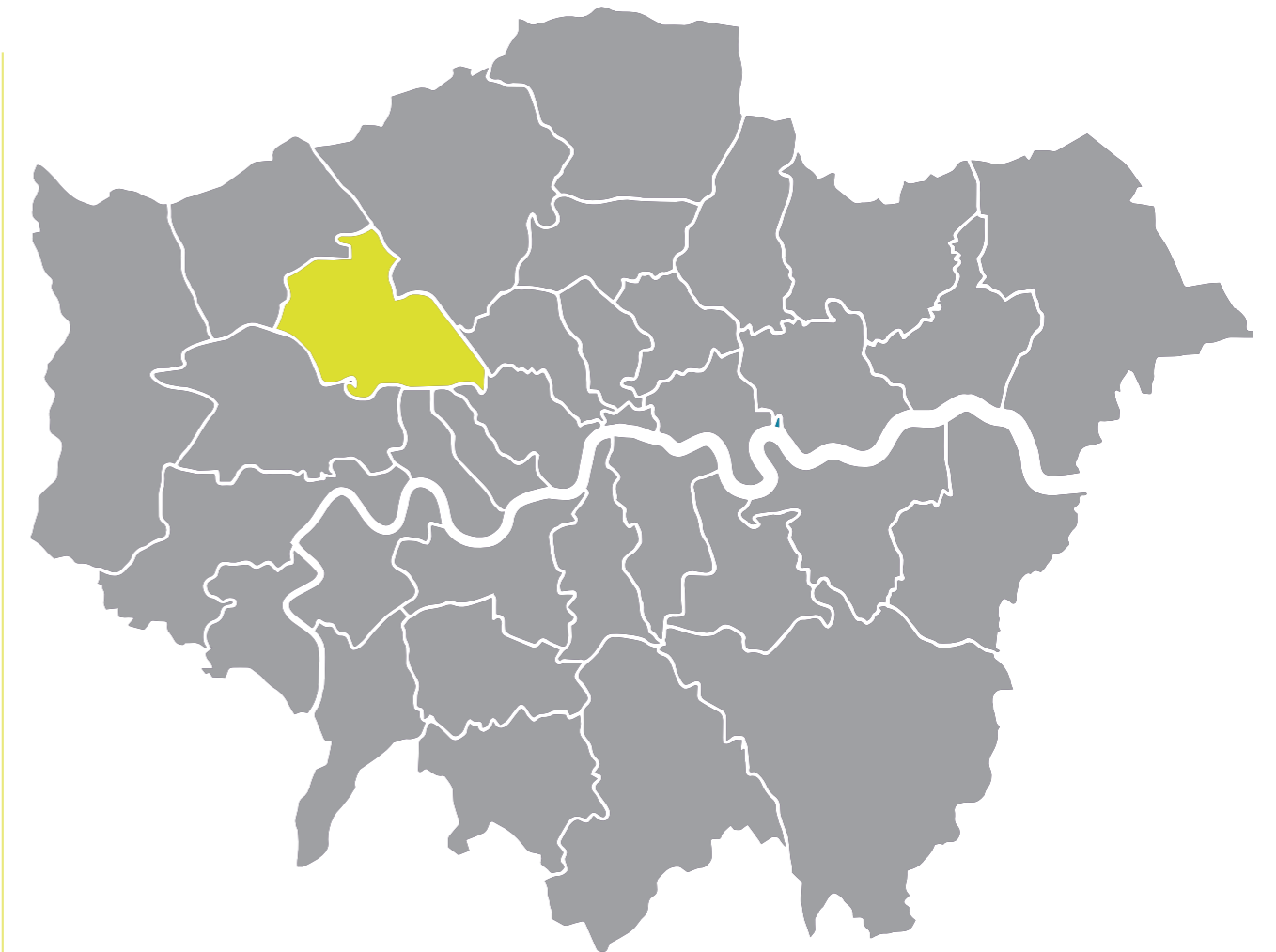
Population: 327,800 people live in Brent (population estimate)

Brent is one of the most diverse areas in London. Almost two thirds of the population are from Black, Asian and minority ethnic groups, the third highest in London after Newham and Redbridge. Brent is one of the most linguistically diverse areas in the country with around 150 different languages used.

Compared with other areas, Brent residents are more likely to have a religion: 82% had a religion compared with 71% across London and 68% nationally – the fourth highest rate in England.

Around a third of households in Brent live below the poverty line, once housing costs are taken into account.

(Based on 2011 Census data)



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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 and to commission Safeguarding Adult Reviews where the criteria are met. The Care Act 2014 outlined that Safeguarding Adults Boards should hold partner agencies to account for how they work together to protect adults from abuse and neglect.

TYPES OF ABUSE

Physical abuse, Domestic abuse, Sexual abuse, Psychological or Emotional abuse, Financial or Material abuse, Modern slavery, Discriminatory abuse, Organisational or Institutional abuse, Neglect and acts of omission and Self-Neglect (Care and support statutory guidance).

SECTION 42 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).

SAFEGUARDING ADULT 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. Section 44 of The Care Act 2014 states that the purpose of a Safeguarding Adult Review is to ensure that lessons are learned.

MAKING SAFEGUARDING PERSONAL

Mental capacity to make decisions is one of the key differences between safeguarding adults and safeguarding children. An adult has autonomy to make decisions about the way they wish to live their life. Any Enquiry should include an attempt to gain the views of the adult at risk as to what they would like to happen, providing any necessary support such as an advocate. This is called 'Making Safeguarding Personal'. If the adult at risk has the capacity to make a decision, their wishes must be

respected. However, this view must be balanced with an assessment of the risks and an agreement reached between the person and professionals as to how these risks will be monitored and managed.

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

If a person needs protective measures to be put in place to keep them safe, and is assessed as having lost capacity to make decisions about that particular area, either the Local Authority or the Court of Protection, depending on the circumstances, can authorise a DOLS. This gives the service or individual who provides care to a person legal authority to restrict their liberty in a specified way in order to keep them safe. There are strict criteria as to what is appropriate when putting such measures in place. This area currently sits within safeguarding adults in the Local Authority. The DOLS legislation is due to be replaced by the implementation of Liberty Protection Safeguards. The planned implementation date was due to be April 2022 but in December 2021 a letter was published by the Department of Health and Social Care formally delaying its implementation. Expect more information in relation to this in next year's annual report.

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PRINCIPLES OF ADULT SAFEGUARDING

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

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

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

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

Protection: Support and representation for those in greatest need.

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

Accountability: Accountability and transparency in safeguarding practice.

WE ARE BETTER
TOGETHER

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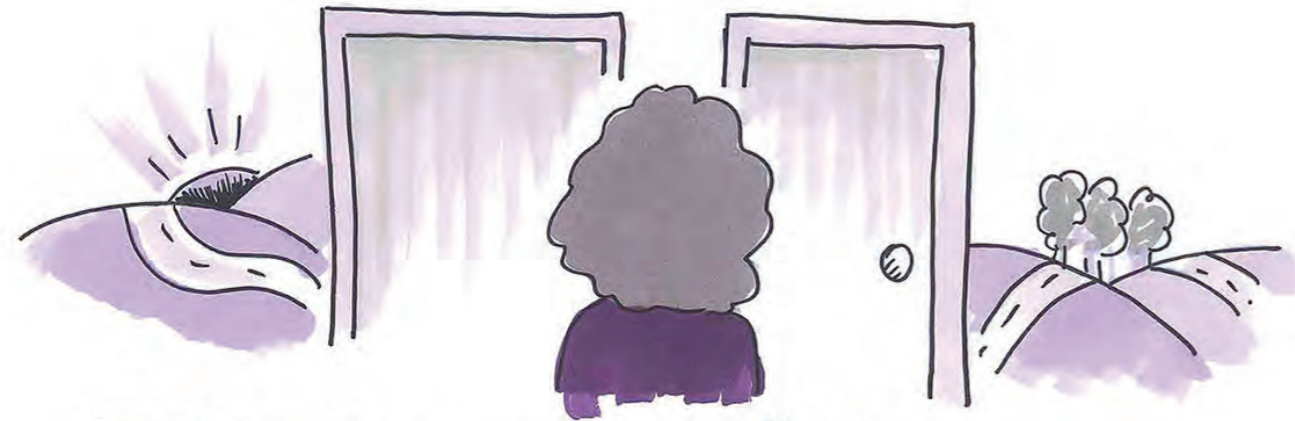
HOW TO REPORT ABUSE IN BRENT

The Safeguarding Adults Board is multi-agency strategic partnership board. The Safeguarding Adults Board is not responsible for progressing operational safeguarding concerns. This is carried out by Adult Social Care within Brent Council. The mandate of the Safeguarding Adults 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/adult-social-care/protecting-adults-from-risk-of-abuse#howtoraise

If you have any trouble completing the form please contact the duty safeguarding 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.



THERE IS NO
WRONG DOOR!

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REPORT FROM THE HEAD OF ADULT SAFEGUARDING,
BRENT COUNCIL

During 2021/22 the Safeguarding Adults Team (SAT) continue to embed a framework to provide consistency in how the partnership responds to concerns of abuse.

The Brent Adult Social Care department has continued to embed a new model, where a dedicated safeguarding team will triage safeguarding concerns and attempt to fast-track intervention to protect adults at risk. In order to reduce the number of cases which progressed to s.42.2 Enquiries, the safeguarding team engage with adults about their wishes and supporting them to develop alternative ways of managing risk. Concerns which require longer term intervention, the agency/team best placed to take the lead on Section 42(2) Safeguarding Enquiry works in partnership to support residents and their support networks in order to keep them safe.

Overall, the data this year shows that the number of concerns remains higher than pre-pandemic levels. However, it is right to say that there has been a slight drop in the number of concerns received compared to last year. This reflects safeguarding activity in other London areas. In order to ensure that services in Brent continue to raise concerns as they are currently,

Adult Social Care have planned a programme of awareness raising sessions for next year, to ensure that agencies remain attentive of their responsibilities in this regard.

The safeguarding data, which became available at the end of the reporting period of this annual report shows a fall in many categories of abuse. There has been a very small increase in 'Psychological / Emotional abuse' and 'Pressure Ulcers'. Regular audits of safeguarding activity are in place to provide continued assurance that agencies are working together to protect adults at risk of abuse of these categories. With regards to the location of abuse, people's own homes remains the highest location of abuse at 60% of all concerns which is similar to previous years. Other variations are continuing to be monitored. Extra Care and Sheltered Accommodation placements have seen a slight increase in the number of concerns raised. Extra Care and Sheltered accommodation placements support people to have more choice over the care received and allows individuals to live as independently as possible. The increase in Extra Care and Sheltered Accommodation reflects that there has been an increase in the number of people taking up

offers to be placed in those schemes.

Where a person has capacity, agencies have a responsibility to consider the desired outcomes of an adult at risk and work with them to achieve those outcomes. In terms of the outcomes of Section 42(2) Enquiries, 89% of all Enquiries result in the person's wishes being achieved or partially achieved. As Head of Safeguarding I will be working with agencies to ensure that we keep striving to help people achieve their desired outcomes in relation to Safeguarding Enquiries.

Evelyn Amedoda
Principle Social Worker and
Head of Safeguarding

7 SAFEGUARDING ACTIVITY IN BRENT

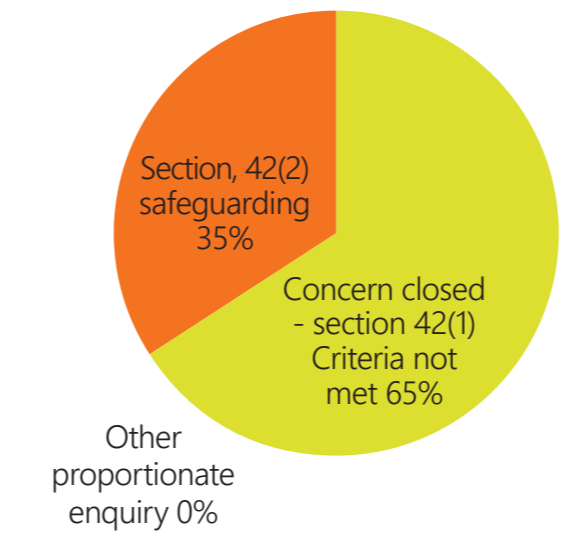
TYPE OF ABUSE (CONCERNS)	1921-21/22	TYPE OF ABUSE (CONCERNS)	2019-20/21
Neglect	537	Neglect	559
Psychological / emotional	449	Psychological / emotional	420
Physical	330	Physical	320
Financial	206	Financial	262
Self Neglect	229	Self Neglect	213
Self Harm	55	Self Harm	61
Organisational	20	Organisational	15
Pressure Ulcer	40	Pressure Ulcer	10
Domestic abuse	44	Domestic Abuse	70
Sexual Abuse	44	Sexual Abuse	64
Cuckooing	25	Cuckooing	13
Radicalisation	11	Radicalisation	5
Hoarding	21	Hoarding	19
Modern Slavery	8	Modern Slavery	7
Sexual Exploitation	4	Sexual Exploitation	14
Hate Crime	5	Hate crime	4
Forced Marriage	2	Forced Marriage	2
Discriminatory	1	Discriminatory	3
FGM	2	FGM	2
		Honour based Violence	1
		Mate Crime	6

The total recorded concerns for 2021-2022 was 1921 concerns. This represented a slight decrease from the previous year where the total recorded concerns was 2019. A recorded concern may include more than one type of abuse. Therefore, when the different abuse types are individually added together, the number is greater than the total of 1921 for 2021-2022 and 2019 for 2020-2021.

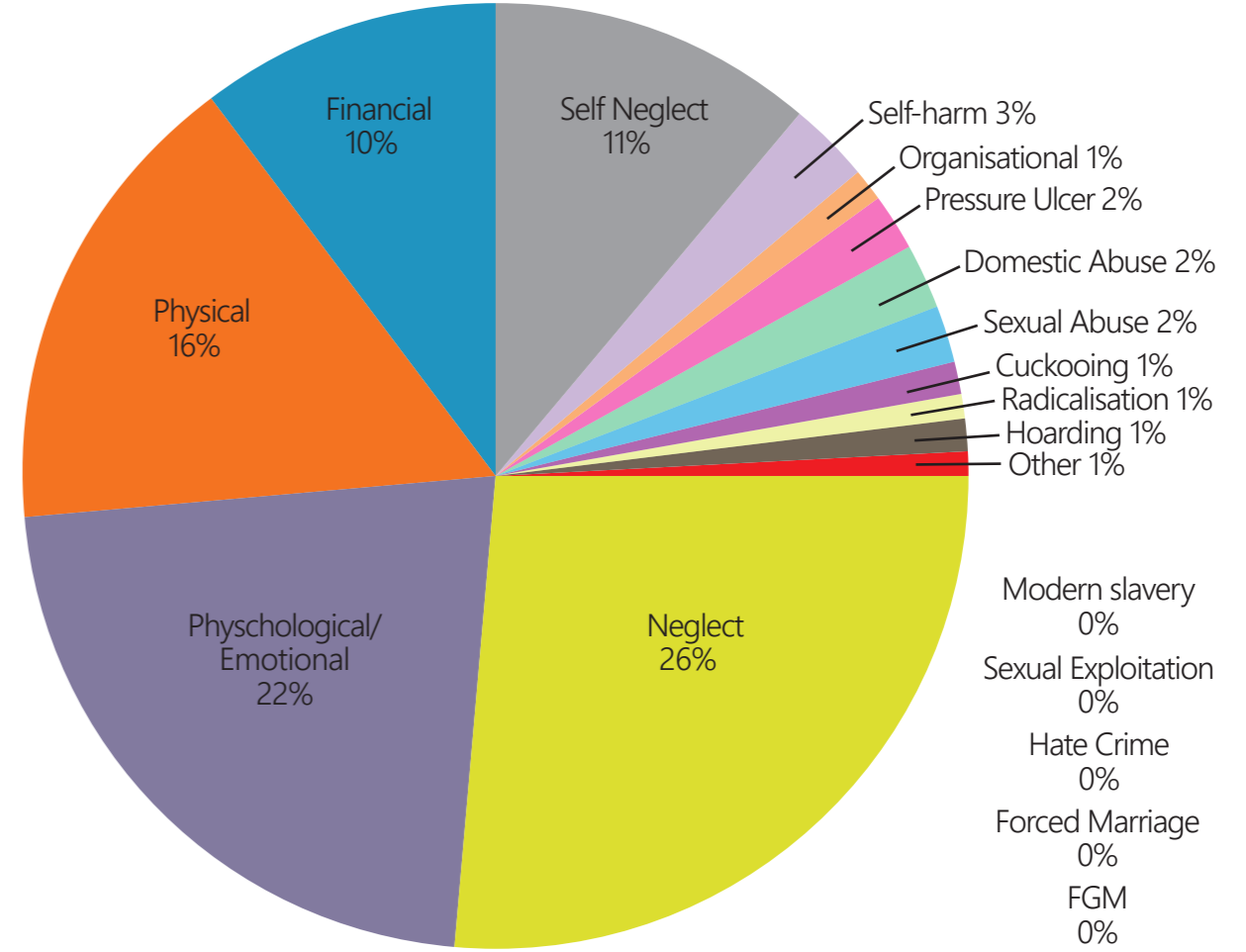


BRENT LOCAL AUTHORITY SAFEGUARDING TOTALS FOR 2021-2022				
Safeguarding Concerns	Section 42 Safeguarding Enquiries	Other Safeguarding Enquiries	Total Enquiries	Conversion rate % Enquiries/Concerns
1921	668	4	672	35%

OUTCOME OF CONCERNS

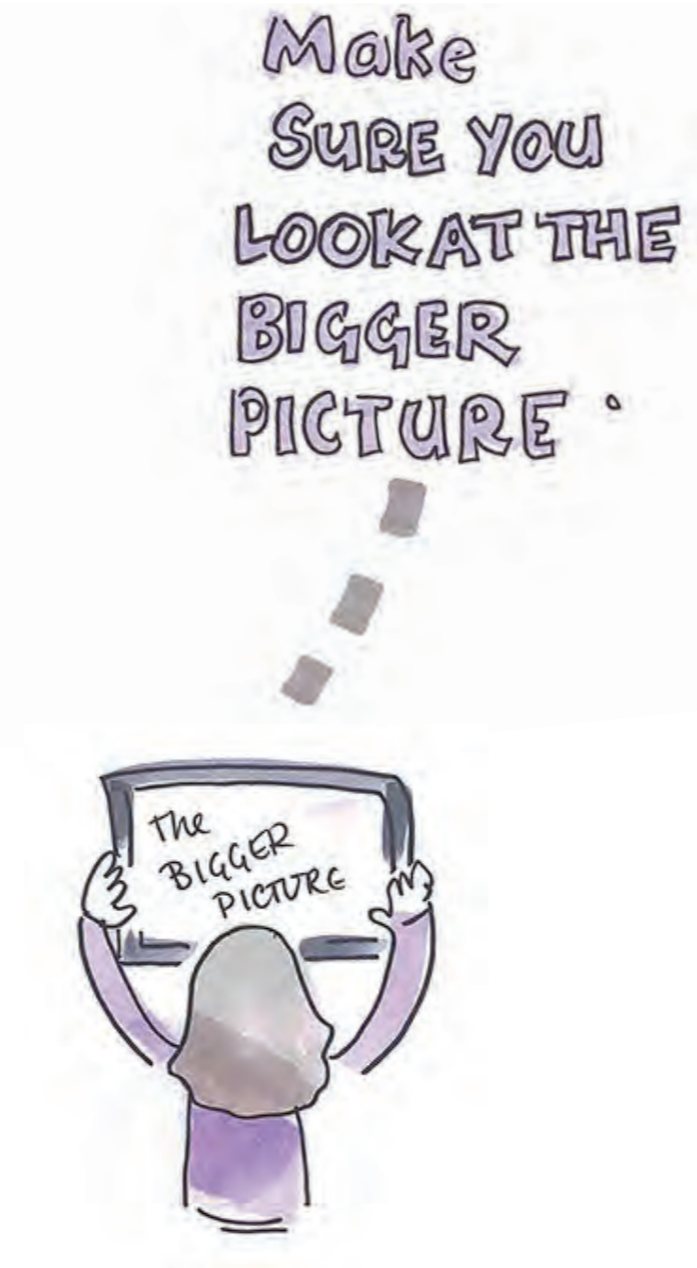


CONCERNS IN PERCENTAGES

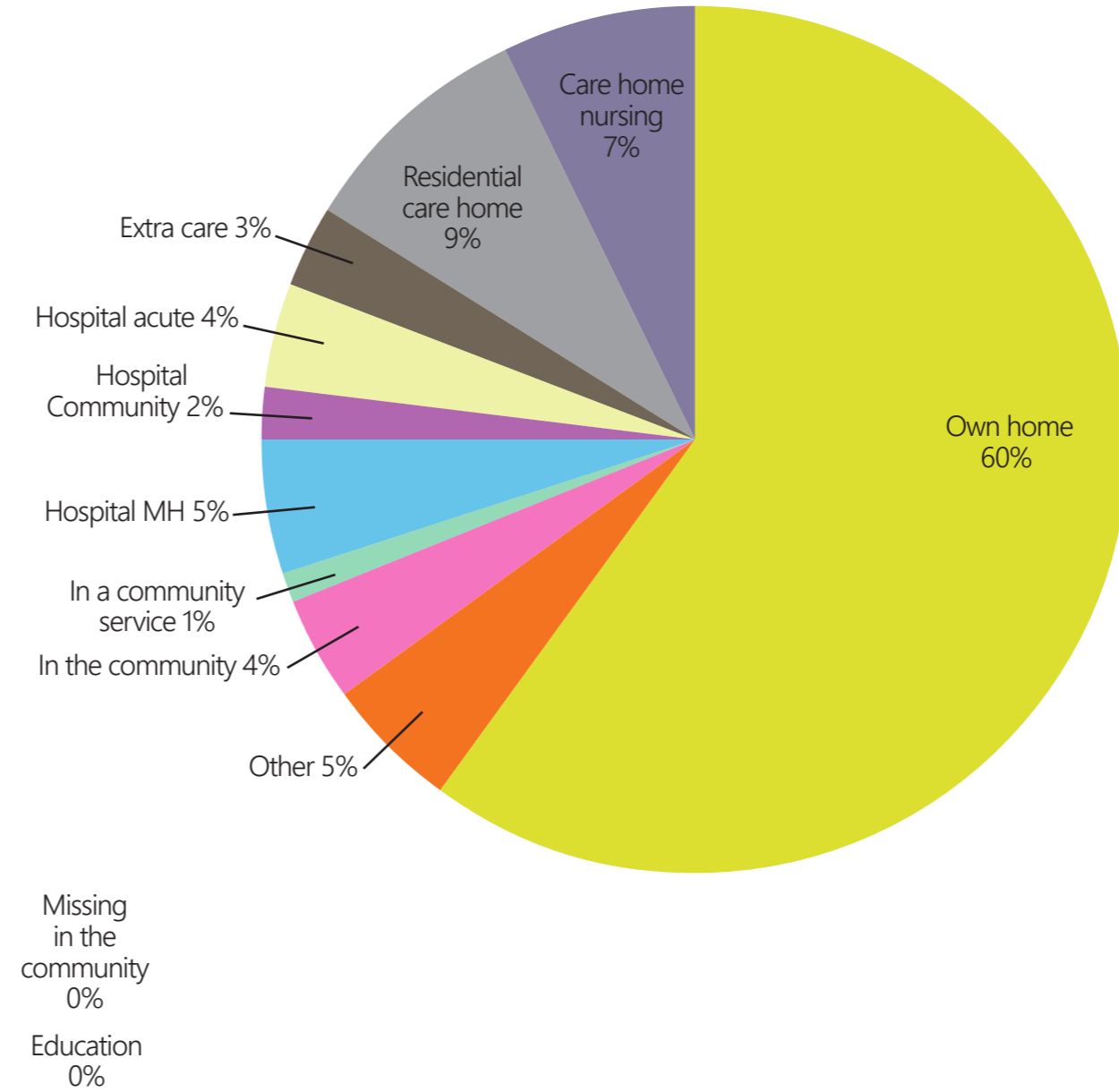


Please note, due to rounding of figures into whole percentages, the total number percentage points may not add up to exactly 100%.

CONCERNS LOCATION OF ABUSE 21-22	CONCERNS LOCATION OF ABUSE 20-21
Own Home 1183	Own Home 1275
Other 104	Other 113
In the Community 81	In the Community 83
In a Community Service 22	In a Community Service 50
Hospital MH 98	Hospital MH 79
Hospital Community 40	Hospital Community 33
Hospital Acute 76	Hospital Acute 57
Extra Care 61	Extra Care 11
Education 1	Education 0
Residential Care Home 173	Residential Care Home 156
Nursing Care Home 132	Nursing Care Home 117
Missing in the community 5	
Total 1976	Total 1974



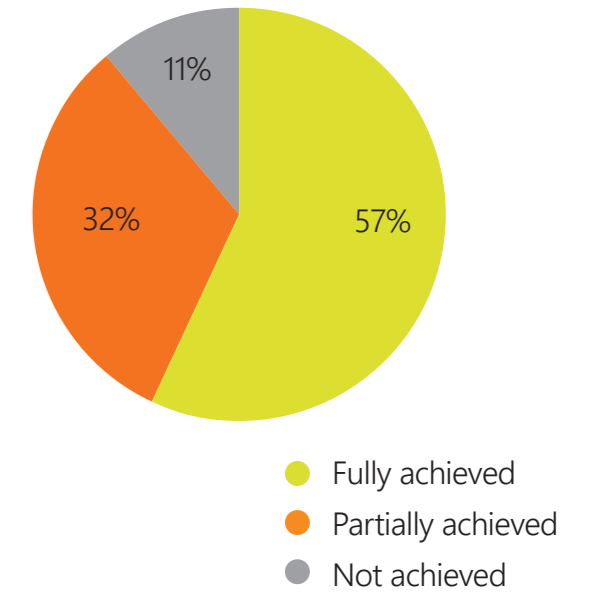
LOCATION IN PERCENTAGES 21-22



MAKING SAFEGUARDING PERSONAL

Individuals, or their representatives if unable to communicate or contribute, are asked about the extent to which their desired outcomes were met and if they felt safer. As these are not mandatory, not everyone responds and data may be excluded where a person has died. For those able to respond, 57% felt their desired outcome were met. The remainder was partially met (32%) and not met (11%).

PEOPLE SUBJECT TO S.42 ENQUIRIES ASKED WHETHER DESIRED OUTCOMES MET



8 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 Metropolitan Police, North West London Clinical Commissioning Group (soon to become Northwest London NHS Integrated Care System) and Brent Council. There are many non-statutory partners who provide a valuable contribution. The Safeguarding Adults Board meets on a quarterly basis. There are three sub-groups that assist the SAB in carrying out its duties. These sub-groups meet when required other than the Executive Sub-Group which meets twice-yearly. Each sub-group 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

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 multi-agency 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.

This is a planned area of change and will be reported on in next years annual report.



9 EVENTS

The Safeguarding Adults Board continued to offer virtual learning and development opportunities which was open to all professionals who work or volunteer with adults at risk in Brent.

The learning topics offered are chosen in response to learning needs identified by practitioners and managers, the objectives in the strategic plan as well as feedback from evaluations.

SAB MULTI-AGENCY TRAINING PROGRAMME SUMMARY 2020/21

- 12 learning topics delivered
- 15 occurrences
- 197 training places accessed

TOPICS INCLUDED

- Making safeguarding personal – Patrick Hopkinson
- Applying The Mental Capacity Act In Relation To Housing and Homelessne – Mike Ward
- Safeguarding Vulnerable Dependent Drinkers – Mike Ward
- Responding to Self-Neglect and Hoarding – Heather Matuzzo
- Transitional safeguarding – Dr Adi Cooper and Dr Christine Cocker
- Safeguarding, Homelessness and Self-Neglect – Susan Harrison
- Safeguarding, Homelessness and Self-Neglect – Professor Michel Preston-Shoot
- Learning dissemination Adult D – Professor Michel Preston-Shoot
- Learning dissemination Adult D – Professor Michel Preston-Shoot

The transition to virtual sessions has seen a rise in bookings, a 61% increase in total places booked.

For the first time the Safeguarding Adults Board ran two virtual sessions aimed at members of the public;

- Recognising Domestic Abuse and Older Abuse – SafeLives (public event)
- Financial Scams, Fraud, Abuse and Coercion – Professor Keith Brown (public event)

The Safeguarding Adults Board only runs multi-agency safeguarding learning and development sessions that are agreed by the partnership.

Sessions were attended by the following organisations:

- Adults Services (Day/Support Centre) 3
- Brent CCG 6
- Brent Council 38
- Central London West Community Healthcare Trust 22
- Central North West London Health Care Trust 26
- London North West Healthcare NHS Trust 2
- London Ambulance Service 5
- NHS England 23
- Probation 6
- Voluntary Organisations 52
- Education 12
- Faith Settings 2

10 BOARD ACTIVITY

Over the period 2021 – 2022, The Safeguarding Adults Board (SAB) focussed on ensuring that safeguarding systems have continued to work effectively.

One of the ways the Safeguarding Adults Board did this was by asking partners to complete the regional Safeguarding Adults Partnership Audit Tool (SAPAT) over the summer weeks of 2021. The purpose of the audit was to seek assurance over the work of the partnership and individual partner organisations. The SAPAT comprised of four different sections, each exploring a different area.

Section A asked the partnership about achievements and challenges of the past, present and future. Partners indicated strongly that the challenges consisted of the pandemic, changing landscapes, changes to legislation and organisational change. Partners noted burn-out amongst operational staff caused by a range of factors to include the pandemic and there was continued concern about these areas for the future. Partners noted the incredible efforts of frontline staff in continuing to recover from the impact of the pandemic and how organisations had used learning from the partnership to make positive change to ensure

that adults at risk are better protected.

Section B asked how each organisation gathers the views of service users and what the oversight arrangements were in relation to this area. Partners reported that they ensure that service user wishes are monitored through management sign-off over assessments, audits, use of complaints and improved monitoring over data. Partners highlighted an ambition to have greater levels of service user contact in future, possibly developed through the partnership.

Section C asked partners to report on emerging trends post Covid-19 and organisation plans to mitigate future risks. The partnership reported that they had seen no decrease in the number of safeguarding concerns from the previous year suggesting that higher reporting of neglect and abuse is likely to continue. Organisations reported responding by increasing resources as a response and putting systems in place for more effective partnership working to avoid duplication and problem solve more effectively.

Finally Section D asked the partnership about learning from Safeguarding Adult Reviews. Partners reported that they had

made changes to training programmes and Reviews had been discussed in supervision. Where recommendations had been made to an organisation directly, then internal changes had been made and embedded. Partners of the SAB expressed an energy to continue to explore how we can best learn from Safeguarding Adult Reviews as a partnership.

*DONT allow yourself
to EVER BE
DESENSITISED*

THE SAFEGUARDING ADULTS BOARD MET QUARTERLY DURING THE YEAR 2021-2022.

April 2021 At the Safeguarding Adults Board meeting April 2021; the SAB scrutinised safeguarding data within Brent for the previous financial year. Brent Adult Social Care presented updates to the partnership in relation to commissioning oversight arrangements and a new service aimed at engaging people who lived chaotic lives (SMART Service). A discussion took place regarding current Safeguarding Adult Reviews. Finally a discussion took place regarding learning from deaths of people with learning disabilities and an update from Healthwatch regarding their activity locally.

June 2021 At the SAB held in June 21, a presentation was made by a senior leader in Brent Council outlining the Health and Wellbeing Strategy and the developments around Integrated Care Systems. Michael Preston-Shoot presented a National Analysis of Safeguarding Adult Reviews. The partnership received a presentation regarding the outcomes of the SAB Learning and Development Conference Week. There was an item exploring current Safeguarding Adult Reviews in Brent and revisiting partnership actions in previous SARs. The Safeguarding Adults Partnership Audit Tool was launched to

partners to complete over the summer months.

October 2021 At the Safeguarding Adults Board meeting October 2021, representatives from Children and Young People, Brent Council were present for an item on Transitional Safeguarding where Bridging The Gap Research Paper was presented and a follow-up discussion took place. Along with action planning for Brent SAR's, there was a presentation of a Norfolk SAR on three people with learning disabilities in out of borough placements from other parts of the country who had died. As part of this item, the Independent Chair asked for assurance

from Brent Adult Social Care and the Clinical Commissioning Group that placements they had made outside of Brent were safe and people were well monitored. Brent Safeguarding data was scrutinized and the brief findings from the SAPAT were presented to the SAB.

February 2022 The final Safeguarding Adults Board of the financial year in Brent focussed upon Adult F and Adult G Safeguarding Adult Reviews and associated action planning. The outgoing Independent Chair, Michael Preston-Shoot thanked partners for their contributions during his tenure as Independent Chair and introduced Fran Pearson who was to take over as the new Independent Chair of Brent Safeguarding Adults Board in April 2022.



11 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.

The development of a new Strategic Plan was postponed due to operational pressures on partners during the pandemic and due to awaiting the arrival of the new Independent Chair who would oversee the new Strategic Plan. The current plan will be refreshed and reported on in next year's annual report. The current plan is;

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." In order to work towards achieving this priority Brent SAB have:

- Monitored self-neglect data at the SAB and asked agencies to account for their response.
- Developed multi-agency self-neglect policies and procedures which are published on the Independent Safeguarding Adults Board Website (www.brentsafeguardingpartnerships.uk)
- Undertaken multi-agency learning dissemination events in relation to Adult D and Adult F throughout 2021 and 2022.
- Organised multi-agency learning and development sessions examining different aspects of self-neglect facilitated by:

- Michael Preston-Shoot
- Suzy Braye
- Susan Harrison
- Heather Mattuozo
- Mike Ward
- Patrick Hopkinson



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. In order to work towards achieving this priority Brent SAB have:

- Regular attendance of colleagues from the legal department to advise the Safeguarding Adults Board in relation to legal options.
- Learning and Development sessions in responding to particular forms of neglect or abuse.
- Completion of the SAPAT in order to ascertain if this remains an ongoing issue for the partnership.



PRIORITY 3 – INFORMATION DISSEMINATION

Some of the feedback at the Development Day was that information sometimes did not always reach those who need it most. In order to work towards achieving this priority Brent SAB have:

- Organised professionals conferences in 2019, 2020 and a virtual conference in 2021 to ensure practitioners who work in Brent can come together for multi-agency learning and development.
- As part of the Virtual Conference week, community sessions were arranged in relation to Financial Abuse and Domestic Abuse to reach smaller organisations and the general public.
- Launch of the Safeguarding Adults Board Website as a vehicle to disseminate learning and information and promote the independence of the SAB in Brent (www.brentsafeguardingpartnerships.uk)



12 PARTNER ORGANISATIONS



13 SAFEGUARDING ADULT REVIEWS

Safeguarding Adults Boards have a statutory duty to commission a Safeguarding Adults Review where the criteria laid out in the Care Act 2014 are met. The purpose of a Safeguarding Adults Review is to explore how agencies worked together to protect a person with care and support needs from abuse or neglect and identify the lessons to be learned. Safeguarding Adults Reviews are not about blame. They are reviews completed by a person independent of agencies involved. Safeguarding Adult Reviews are normally published on completion. Published reviews are available on the Brent Safeguarding Adults Board website <https://brentsafeguardingpartnerships.uk>

In the reporting year 2021-2022, Brent Safeguarding Adults Board had two Safeguarding Adults Reviews that had been formally commissioned and were in progress. In order to protect the person's identity, the person's name is not used in a Safeguarding Adults Review unless specifically requested by family members.

Adult E falls outside of the reporting period of this annual report. However, following a complaint made by Adult E's family, an update in relation to the Adult E SAR has been included overleaf.



Adult E

Adult E was published and reported on in the previous annual report and does not fall into the current reporting year. However, since the publication of the Safeguarding Adults Review, the family of Adult E wrote to highlight their distress at the time taken to complete the SAR, and that the family did not feel sufficiently updated by the Safeguarding Adults Board during the progress of the SAR. Brent Safeguarding Adults Board made an apology to the family of Adult E and wished to highlight this within the Brent SAB annual report for both the time taken to complete the review and also apologise with respect to the frequency of communication. Brent Safeguarding Adults Board have made a commitment that, if there are delays of a similar nature that occur in future, families will be informed at each point of postponement of the outcome of any discussions and involve families to a greater extent in relation to any decisions made on how to progress.

Adult F

The Adult F SAR has been completed and the initial action planning has been undertaken. The subject of the report is an older retired male who suffered long-term mental health problems. During his working life he required intervention and support in relation to his mental health but was able to manage work and home life. However, in his later life, health and social care professionals became concerned about how he was living and attempted to persuade him to accept support. His health deteriorated and professionals tried to support him but he refused intervention. He later died in hospital. The themes of this review are self-neglect, mental capacity and making safeguarding personal. This report has not yet been published. At the time of writing the Safeguarding Adults Board is due to meet with the remaining family member to discuss publication in the coming weeks. Further information regarding this review will be reported on in next year's annual report.

Adult G

The Adult G SAR is nearing completion and agreement by the partnership. The subject of the report was a male with cerebral palsy. During his younger life he resided with his parents in the family home but as his health, mobility and ability to communicate deteriorated and he was moved into a care home. Over time the care home began to struggle meeting his needs and he developed severe pressure ulcers. He had periods in hospital but returned to the same placement due to a range of factors but a large part was due to a belief by professionals that the care home was his home and that he did not want to move. He was diagnosed with a learning disability late in life and was eventually moved to a nursing placement once the funding arrangements were agreed. However, problems continued to occur and Adult G died in hospital. The report has highlighted a number of lessons around commissioning and monitoring of placements, working with other boroughs where safeguarding concerns are raised and pressure ulcer care in care homes and in hospital.

14**BRENT SAFEGUARDING ADULTS BOARD BUDGET, INCOME AND EXPENDITURE 2021-2022**

INCOME	AMOUNT
Clinical Commissioning Group	£25000
Brent Council	*£37400
MOPAC	£5000
Total	£67,500 Rounded Figure

ITEM	EXPENDITURE 21/22 (ROUNDED COST)
Adult F Safeguarding Adult Review	£7,000
Adult G Safeguarding Adults Review	£5,000
Virtual Conference Week	£7,000
Learning and Development Offer	£10,000
Annual Report Costs	£1000
Independent Chairs Fees (including handover to the new Chair)	£25,000
Total	£55,000

*In addition to the sum on the left, Brent Council pay for staffing costs to support the functioning of The SAB namely;

- One full time Strategic Partnerships Manager (portion of time)
- One full time Strategic Partnerships Lead
- One part time Strategic Partnerships Learning and Development Coordinator



© Brent Safeguarding Adults Board 2021-2022

15 THE COMING TWELVE MONTHS

The next 12 months will be a time of change for Brent SAB. A new Independent Chair, Fran Pearson has been appointed. It is likely that the new chair will have views on how the Brent SAB works, and may want to talk with partners about the possibility of doing things differently. The Chair will lead discussions around system changes as a result of the new priorities. The Chair will also oversee a new learning and development offer and will lead the SAB regarding changes in legislation from Deprivation of Liberty Safeguards (DoLS) to Liberty Protection Safeguards (LPS). There will also be organisational change towards Integrated Care Systems.

At the time of writing the Safeguarding Adults Board is in the process of setting its future priorities for 2022 – 2025. Future meetings will focus on scoping and planning the future priorities which are agreed as; Substance Misuse and Housing Need, Self-neglect and the continuing Safeguarding impacts of the Covid 19 pandemic.

Progress in relation to these areas will be a focus of next year's annual report.



BE VIGILANT

DON'T allow yourself to EVER BE DESENSITISED

Find the Person and Listen to her Voice
THERE IS NO WRONG DOOR!
We are all system leaders



LEARNING & DISABILITY IS A SPECTRUM & vulnerabilities depend on an individual's needs & abilities.



Homelessness & Safeguarding
LIFESTYLE
TRANSIENT CASE
SUPPORT
can be FRAGMENTED
SO DIFFICULT TO BUILD A CASE...



Hoarding
separate the person from the behaviour
happens without people even knowing
Human Kind BE BOTH!
understand the disorder

BE Continually Professionally Curious..



BALANCE
safety protection
choice autonomy

Consent Capacity = Lawful marriage

Transition
Gradual & Extended
Relationships Matter
PREPARATION PLANNING AFTERCARE SUPPORT
continuity safety ongoing
communicate

Housing & Safeguarding
don't just be task focused
Make SURE YOU LOOK AT THE BIGGER PICTURE
don't just fix the leaky tap
make every contact count

Rights based Risk Assessment
I can take risks
we have the same rights as every citizen
Professionals must NOT be risk averse.
Enabling... CAN DO CAN'T DO

BE BOLD

BALANCE

RISK
RESOURCES
RISK
LEGISLATION
RISK
CAPACITY
RISK
CHOICE

Domestic Abuse

DV doesn't discriminate
FEAR
FINANCES
CARING ROLE
MOBILITY
KNOWLEDGE
know your options
ID immediate safety needs
multi-agency approach

Hoarding

[It's really complicated]
HELP ME
trust
NOT A LIFESTYLE CHOICE
break through the barriers

Mental Capacity

capacity fluctuates
INVOLVE OTHERS
GET FAMILIAR
MENTAL CAPACITY ACT
not a one time assessment
MAY
DEC
JAN

WE ALL HAVE A ROLE TO PLAY...

Stay curious
Collaborate
VOICE

don't be a SWISS CHEESE
step back and review

SUPPORT
GUIDANCE
SUPERVISION

MSP
multi-agency
ENGAGE 1-1
ENGAGE
COMMUNITY ENGAGEMENT
ENABLE EMPOWER
Worker
Client
Manager

Modern slavery

FEAR
CONTROL
DEBT
Focus on the abusers
Protect the victims
don't focus on immigration or forced crimes
MULTIPLE VULNERABILITIES

Financial abuse

most common type of abuse
MOST OFTEN WITHIN FAMILIES
HIDDEN
ALWAYS A CRIME
can use CIVIL LAW
Look beyond the obvious

person-centred

MY HISTORY
courage
'family' view
engagement
collaboration
persistence

supervision
escalation
reporting
holistic
joined up

LIKELIHOOD x SEVERITY

RISK

context matters
Risk attitudes can become cultural
"No wardrobes allowed!"
I'm worried about you...
SHARE YOUR CONCERNS
LOOK BEYOND THE OBVIOUS
Can I talk to you about the food...
★ ★
★ ★
★

Adult Safeguarding Leadership

starts with us all....



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