Protection of Vulnerable Adults in Brent

Multi-agency Policy and Procedures

ADDENDUM 1

Brent NHS
Teaching Primary Care Trust

Protection of Vulnerable Adults in Brent

Multi-agency Policy and Procedures

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The Protection of Vulnerable Adults: Multi-agency Policy and Procedures was endorsed in October 2003 by a range of statutory and voluntary agencies in Brent. Since then there have been a number of legislative changes and advice on good practice that must be incorporated.

This addendum should be attached to the Policy and Procedure file and referred to, as appropriate.

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1 Brent Adults and Social Care Department

Update of *Policy 8* (page 7).

As from 4 July 2005, reference to Brent Council Social Services department should read as Brent Adults and Social Care department

2 Commission for Social Care Inspection (CSCI) and Healthcare Commission (Commission for Healthcare Audit and Inspection – CHAI)

Update of *Procedures – 2.10* (page 29)

These two bodies were set up on 1 April 2004. CSCI – brought together the work previously undertaken by the Social Services Inspectorate, the SSI/Audit Commission joint review team and the social care functions of the National Care Standards Commission. The functions include:

- local inspections of all social care organisations (public, private and voluntary) against national standards
- register services that meet national minimum standards

CHAI – encompass the work of the Commission for Health Improvement and the Mental Health Act Commission, the national NHS value for money work of the Audit Commission and the independent healthcare work of the National Care Standards Commission. The functions include:

- inspect the management, provision and quality of health care services
- carry out investigations into serious service failures
- encourage improvement in the quality and effectiveness of care

3 Strategy Meeting

3.1 Change of Circumstances

Addition to *Procedures – new 10.9* (page 50)

If there is a sudden change in circumstances so that some decisions made at the Strategy Meeting may no longer be appropriate, the care manager or lead person allocated must immediately inform all relevant parties and ensure this is followed up in writing.

3.2 Attendance

Addition to *Procedures – 10.7* (page 50)

a If there is an allegation of abuse of a vulnerable adult living in or attending an establishment that concerns that establishment, the manager and staff of that establishment will not normally be invited to the Strategy Meeting. The exceptions may be (a) if the Police deem it appropriate (b) the manager is from the 'holding company' and not directly responsible for the day-to-day management of the establishment. Consideration should be given as to whether to hold the Strategy Meeting in two parts, bringing in the manager for the second part.

b Normally the person who has referred an allegation of abuse of a vulnerable adult, should be invited to the Strategy Meeting, unless he/she is directly involved in the matter.

3.3 Feedback

Addition to *Procedures – 10.7* (page 50)

At the Strategy Meeting and subsequent Case Conference, a standard agenda item should include:

- What information will be fed back to relevant parties (including person who has made the referral and the victim and their family)
- Name of person(s) responsible for relaying that information

3.4 Reconvening of Strategy Meeting

Addition to *Procedures – 10* (page 50)

a If concerns have not been substantiated following investigation and assessment, the Team Leader should arrange a reconvened Adult

Protection Strategy Meeting for all relevant parties. The meeting should be minuted and minutes sent to all attending, as well as all those involved in the original Adult Protection Strategy Meeting. The need for awareness and on-going monitoring of the situation should be emphasised to all.

b If substantial concerns have been indicated by the investigation ie

- confirmation that the vulnerable adult is being abused
- investigation indicates continued risk
- risk of suicide or attempts to cause deliberate harm to him/herself
- concerns that the vulnerable adult is likely to be abused eg where a known abuser joins the family or household
- a catalogue of suspicious incidents

c A Manager from the SSD/joint SSD/Health team will call a reconvened Adult Protection Strategy Meeting and arrange for someone from the team to record the meeting and an 'independent' chair if necessary.

d Attendance at the meeting should include those who had previously attended the Adult Protection Strategy Meeting but could include others who may contribute information and assist in the monitoring and protection of the vulnerable adult.

e Purpose of the Reconvened Adult Protection Strategy Meeting:

- share information – social, medical, psychological
- assessing risks
- formulate/monitor a protection plan and make specific recommendations to agencies who have agreed to monitor the vulnerable adult
- recommend to agencies with statutory powers whether statutory action needs to be taken
- identify key personnel to take responsibility for tasks
- agree when to reconvene if appropriate

4 Death of a Vulnerable Adult

Addition to ***Procedures***

Attention should be paid to the circumstances that result in the death of a vulnerable adult eg if there are concerns about the quality of care the vulnerable adult was receiving prior to death then the Adult Protection procedures should be followed. Liaison with the Police, The Coroner and CSCI may be necessary.

5 Inter-Authority Investigation into Abuse of a Vulnerable adult

Addition to ***Procedures – roles and responsibility*** (page 25)

The Association of Directors of Social Services agreed, on 24 February 2004, a 'protocol for inter-authority investigation of vulnerable adult abuse'

5.1 The authority where the abuse occurs will have overall responsibility for co-ordinating the adult protection arrangements (the host authority).

5.2 The placing authority (i.e. the authority with funding/ commissioning responsibility) will have a continuing duty of care to the vulnerable adult.

5.3 The placing authority should ensure that the provider, in service specifications, has arrangements in place for protecting vulnerable adults and for managing concerns, which in turn link with local policy and procedures set out by the host authority.

5.4 The placing authority will provide any necessary support and information to the host authority in order for a prompt and thorough investigation to take place.

5.5 The host authority will make provision in service contracts, which refer to this protocol, outlining the responsibilities of the provider to notify the host authority of any adult protection concern.

5.6 Responsibilities of host authorities:

a The authority where the abuse occurred should always take the initial lead on referral. This may

include taking immediate action to protect the adult, if appropriate, and arranging an early discussion with the police if a criminal offence may have been committed.

b The host authority will also co-ordinate initial information gathering, background checks and ensure a prompt notification to the placing authority and other relevant agencies.

c It is the responsibility of the host authority to co-ordinate any investigation of institutional abuse. If the alleged abuse took place in a residential or nursing home, other people could potentially be at risk and enquiries should be carried out with this in mind.

d The Commission for Social Care Inspection should always be included in investigations involving regulated care providers and enquiries should make reference to national guidance regarding arrangements for the protection of vulnerable adults.

e There will be instances where allegations relate to one individual only and in these cases it may be appropriate to negotiate with the placing authority their undertaking certain aspects of the investigation. However, the host authority should retain the overall co-ordinating role throughout the investigation.

5.7 Responsibilities of Placing Authorities

a The placing authority will be responsible for providing support to the vulnerable adult and planning their future care needs.

b The placing authority should nominate a link person for liaison purposes during the investigation. They will be invited to attend any Adult Protection strategy meeting and/ or may be required to submit a written report.

5.8 Responsibilities of Provider Agencies

a Provider agencies should have in place suitable adult protection procedures to prevent and respond to abuse which link with the local inter-agency policy and procedures set out by the host authority.

b Providers should ensure that any allegation or complaint about abuse is brought promptly to the attention of Adults and Social Care, the Police, and / or the Commission for Social Care Inspection in accordance with local inter-agency policy and procedures.

c Provider agencies will have responsibilities under the Care Standards Act 2000 to notify their local CSCI area office of any allegations of abuse or any other significant incidents.

d Provider agencies who have services registered in more than one local authority area will defer to the CSCI area office relevant to the area in which the abuse took place.

6 Referrals to Other Agencies

Addition to ***Procedures: Section 7*** (page 38-40)

If there are concerns about an individual who carries a conviction for a relevant violent or sexual offence, a referral should be made to Brent's Multi-Agency Protection Panel (MAPP) – *see The Criminal Justice and Courts Services Act 2000.*

7 Establishment Concerns

Additions to ***Procedures: Sections 22 and 23*** (page 65-66)

7.1 Definition

For the purpose of this section, 'establishment' means provision of services to vulnerable adults, and includes:

- Residential care home
- Nursing care home
- Hospital including day hospital
- Day care services including luncheon clubs
- Home care provision

7.2 Following an Adult Protection Strategy Meeting, there may be serious concerns about providers of services to vulnerable adults. The procedures set out in this section should be used to progress an investigation, when:

a serious, non-client specific, concerns are raised about a provider

or

b the investigation of specific concerns reveals wider issues about a provider

and

c these cannot be resolved by local negotiation with the manager

and

d these need a co-ordinated approach between different sections of the Department.

7.3 It needs to be clear who takes the lead, who should be involved, actions to take and systems to follow. The purpose of this process is to ensure a co-ordinated approach at a senior management level, to a complex situation that may involve a number of units in Adults and Social Care, other Brent Council departments, Health, CSCI, Police and possibly other agencies outside the borough. It does not replace other processes. Where it becomes clear, for example, that legal action needs to be taken via the CSCI, this takes precedence.

7.4 Once concerns about a provider of a service to vulnerable adults become wide-ranging and serious, the Service Unit Manager or Assistant Director should take the lead on deciding the strategy for investigation and action, supported by the Adult Protection Co-ordinator who will take lead role for co-ordination. This would normally involve the Team Leader, CSCI, Adults and Social Care and PCT Contracts Unit and Policy and Performance Units, other teams with clients placed in the establishment, and may become necessary to involve the Council's solicitors (Legal Department), PCT and Hospital.

7.5 While the CSCI cannot volunteer information on concerns they have about a service, they are able to share information about risk to individual clients of the Department. The CSCI should themselves be informed of any concerns, even if they do not appear serious in themselves.

7.6 There may be clients of other authorities receiving a service about which there are concerns. There is a tension between wanting to act responsibly and notify those other authorities of our concerns, and the need to act within the law in terms of not injuring the proprietor's ability to trade by expressing generalised concerns. A standard letter has been approved by Brent Council's Legal Department, and is available from the Adult Protection Co-ordinator.

6.7 The chair of the Adult Protection Strategy Meeting triggers this serious concerns process by advising the Adult Protection Co-ordinator and the relevant Service Unit Manager or Assistant Director.

7.8 Where wider concerns have arisen from accumulated complaints about a service, the Complaints Manager will alert the relevant Service Unit Manager or Assistant Director that they feel this process needs to be instigated. Where it becomes apparent to a Team Manager that accumulated concerns should be followed up, they will notify the Complaints Manager, and determine who will instigate the process. Depending on the circumstances of any particular case, the CSCI may need to be copied into complaints that relate to regulated services. Where wider concerns have arisen through contract monitoring, the Contracts Manager should contact the Service Unit Manager or Assistant Director.

7.9 The usual starting point for this process would be a meeting at which those with relevant information would share it, agree an action plan with clearly allocated tasks and time-scales, and a review date. The Manager leading the meeting would take decisions in consultation with the participating units of Adults and Social Care. Likely elements of an action plan would be a review of all Brent clients within the service; and recommendation to other local authorities and Health providers to do the same. The Adult Protection Co-ordinator has a standard letter that can be sent Director to Director of Adults and Social Care.

7.10 When the alleged perpetrator is also a vulnerable adult, and a serious offence has occurred in an establishment, a full Adult Protection investigation should be carried out, in addition to the need for an Adult Protection Strategy Meeting. If the establishment is a residential or nursing home, the CSCI must be involved. In all cases, the care manager, care co-ordinator or link/key worker representing both victim and abuser must be informed immediately and be closely involved at all stages.

7.11 Staff should be reminded of the 'whistleblowing' policy and procedures to report concerns about poor practice.

7.12 Staff are reminded of the definition of **Neglect and acts of omission** (paragraph 2.7 of *No Secrets*):

Neglect and acts of omission, include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

8 Young People and Vulnerable Adults Facing Forced Marriage

New guidance *Practice Guidance*

8.1 Introduction

8.1.1 The following is based on *Young people and vulnerable adults facing forced marriage: practice guidance for social workers* policy issued in March 2004 by the Foreign & Commonwealth Office, Association of Directors of Social Services, Home Office, Department for Education and Skills, Department of Health. It was compiled through consultation at local level and with relevant non-governmental organisations.

8.1.2 The guidance requires that a vulnerable adult who is or may be a victim of a forced marriage be referred to the multi-agency adult protection policy and procedures. A person under the age of 18 year should be referred to the child protection policy and procedures.

8.1.3 Although *Protection of Vulnerable Adults in Brent* provides the basis for guidance to agencies in the Borough, there are a number of significant issues and differences in practice that must apply in responding to and investigating forced marriage. This addendum highlights those matters.

8.1.4 This policy and procedures on forced marriage has been agreed by:

Brent Multi-agency Adult Protection Committee (October 2004)

Brent Council Executive Committee (September 2004)

Brent Health and Social Care Partnership Board (December 2004)

8.2 Definition

8.2.1 A **forced marriage** is defined as:

One or both spouses ***do not consent*** *to the marriage and some element of duress is involved. Duress includes both physical and emotional pressure.*

A forced marriage is not the same as an **arranged marriage** in which the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangement remains with the couple to be married.

8.2.2 A **vulnerable adult** is a person aged 18 years or older *who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation* ('Who Decides?' - Law Commission Green Paper 1997).

8.2.3 In these circumstances, **'harm'** should incorporate all forms of ill treatment including physical, sexual and emotional abuse. It should include any ill treatment that leads to the impairment of, or avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioral development.

8.2.4 **Domestic violence** has been defined by the Crown Prosecution Service as *any criminal offence arising out of physical, sexual, psychological, emotional or financial abuse by one person against a current or former partner in a close relationship or against a current of former family member.*

8.3 Context

8.3.1 Some forced marriages take place in the UK, while others involve a partner coming from overseas or a British citizen being sent abroad.

8.3.2 Forced marriage cannot be justified on religious grounds. Every major faith condemns it and freely given consent is a prerequisite of Christian, Jewish, Hindu, Muslim and Sikh marriages.

8.3.3 Families may have a range of motivates for engaging in a forced marriage eg belief they are upholding cultural traditions, protecting 'family honour', preventing 'unsuitable' relationships, assisting claims of residence and citizenship,

financial incentives. However, forced marriage should be recognised as a human rights abuse.

8.4 The victim

8.4.1 Although current statistics indicate that most cases of forced marriage involve young women, there is evidence to suggest that perhaps 15% of the victims are male. Older people and people with learning disabilities may be particularly vulnerable.

8.4.2 Vulnerable adults who are forced into marriage often become estranged from their families, may have been trapped into a cycle of abuse (eg may have suffered years of domestic violence), feel unable to leave because of their children, lack of family support, economic pressures and other social circumstances. They may have a physical or learning disability and be unable to challenge the situation. Isolation is one of the biggest problems facing victims of a forced marriage. If they leave, they can suffer without their family, friends and usual environment. They often live in fear of their own families who will go to considerable lengths to find them and ensure their return. Families may solicit the help of others (eg bounty hunters and members of the community) or involve the police by accusing the victim of a crime. Leaving the family may be seen as bringing shame on the honour of the victim, their family and the community which can lead to social ostracism and harassment from the family and community. The victim may suffer emotionally, often leading to depression and self-harm, including suicide.

8.4.3 Forced marriage places vulnerable adults at risk of rape and possible physical harm. Some cases have resulted in the reluctant spouse being murdered.

8.4.4 The needs of the victim of a forced marriage will vary widely. They may need help avoiding a threatened forced marriage, or help in dealing with the consequences of a forced marriage that has already taken place.

8.4.5 Forced marriage has many parallels with domestic violence and child abuse. For many vulnerable adults, turning to a statutory agency may be a last resort. Worries about a forced marriage may not be the presenting problem. The victim may face significant harm if their families become aware they have sought assistance from statutory or voluntary/community-based organisations.

8.4.6 Symptoms that a forced marriage has or is about to take place may include:

- Health – self-harm, attempted suicide, eating disorders, depression, isolation
- Family history – siblings or other relatives forced to marry, family disputes, domestic violence and abuse, running away from home, unreasonable restrictions eg 'house arrest'
- Employment – poor performance, poor attendance, limited careers choices, not allowed to work, unreasonable financial control eg confiscation of wages/income

8.5 Policy

8. 5.1 The adult protection procedures applies to a victim of a forced marriage who is 18 years or older, and ***"who is, or may be, in need of community care services by reason of mental or other disability, age of illness and who is, or may be, unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"***

('Who Decides?' 1977, Law Commission Green Paper).

8.5.2 Some individuals do not have the capacity to consent to the marriage, and some individuals may be unable to consent to consummate the marriage. Sexual intercourse without consent is rape. Compelling, inciting or facilitating a person with impaired capacity for choice to engage in sexual activity without consent is also an offence under the Sexual Offences Act 2003.

8.5.3 The rights of the victim of forced marriage must include consideration of:

- The wishes of the vulnerable adult
- Personal safety and level of risk to the vulnerable adult – it may not be in their best interest to remain in the family home
- Confidentiality
- Accurate information about rights and choices

8.5.3 Adults and Social Care will refer to the police if there is any suspicion of a crime having taken place. It will not send a vulnerable adult

back to their family home against their wishes.

8.5.4 In applying the guidelines, agencies in Brent will not discriminate against any persons on the basis of sex, race, colour, language, religion, political or other opinion, national or social origin, association with national minority, property, birth, or other status as defined under Article 14, European Convention on Human Rights.

8.5.5 As this is a sensitive and complex area of work, social workers dealing with such cases should seek advice from a specialist social worker who has had specific training in handling the issues raised. Close continuous consultation and supervision with such a person should be subsequently offered.

8.8 Procedures

8.8.1 If there is a disclosure or suspicion of a forced marriage, the standard adult protection policy and procedures will vary in the following ways:

a Referral - the matter must be referred to Adults and Social Care (duty senior) and/or the Police (Community Safety Unit) **immediately**. The Police must be informed, even if the vulnerable adult does not want any action taken.

b Investigation - the investigation will be undertaken by Adults and Social Care and/or the Police – and by no other agency.

c Strategy Meeting – the vulnerable adult will be invited to the Strategy Meeting and involved in discussions with relevant professional agencies.

d Disclosures – **do not** attempt to contact or share any information with anyone other than Adults and Social Care and/or the Police investigators, and do not attempt to act as a mediator between the vulnerable adult and their family.

9 Protection of Vulnerable Adults Scheme (POVA)

Update of **Appendix 1: 7.2** (page 105)

The Protection of Vulnerable Adults (POVA) scheme, as set out in the Care Standards Act 2000, is to be implemented on a phased basis from 26 July 2004.

In July 2004, the Department of Health issued a practical guide that includes changes to the requirements for Criminal Records Bureau Disclosures in certain circumstances.

The guidance sets out what is required of providers of care, employment agencies and businesses and other stakeholders in respect of:

a care workers employed by registered providers of care homes, including workers supplied by employment agencies and businesses to such providers, who are employed in care positions that enable them to have regular contact in the course of their duties with care home residents; and

b care workers employed by registered providers who carry on domiciliary care agencies, including workers supplied by employment agencies and businesses to such providers, who are employed in care positions concerned with the provision of personal care in their own homes for persons who by reason of illness, infirmity or disability are unable to provide it for themselves without assistance.

c Adult placement carers who come within current Care Home regulations and are regulated as care homes.

Other groups of staff will be covered in due course, including NHS staff but in the meantime, from early 2006 all eligible new recruits into the NHS must undergo mandatory Criminal Records Bureau checks.

The guidance sets out the steps for checks against the POVA list as part of pre-employment appointment, and how to refer someone to the POVA list.

Legal and/or HR advice is recommended if in any doubt.

Further information: see Department of

Health website – www.dh.gov.uk (and type in search box 'vulnerable adults').

10 The Sexual offences Act 2003

New **Appendix**

The Sexual Offences Act 2003 is designed to protect the public from sexual crime. It sets new parameters for care workers looking after people who have a mental disorder. Any sexual activity between a care worker and a person with a mental disorder is prohibited whilst that relationship of care continues.

This paper focuses on those aspects of the Act which relate to vulnerable adults.

The Act uses the same definition of 'mental disorders' as the Mental Health Act 1983 ie *mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of the mind'*. This includes learning disabilities.

A 'relationship of care' is defined as where one person has a mental disorder and another person is regularly involved or is likely to be involved, face to face in their care, where that care arises from the mental disorder. It applies to people working on either a paid or voluntary basis, and includes staff such as:

- Doctors
- Nurses
- Social workers
- Medical receptionists
- Cleaning staff
- Advocates
- Voluntary helpers
- Workers who provide complementary therapy
- Anyone who provides any care or assistance, including family members or friends

and workers in all settings, including:

- Care home
- Community home
- Person's own home
- On outings or trips

and range of employment arrangements, including:

- Workers who provide services through the NHS or a private medical agency or independent clinic or hospital
- Workers who provide services in the home or for a body or agency which brings them into, or could bring them into, regular face-to-face contact with people with mental disorders
- Volunteers

In each case there is a requirement that the care worker must have regular face to face contact with the complainant – or that the carer would be expected to have such contact. This is to restrict the scope of the offences to those carers who are in a position of responsibility/trust towards the person.

Such work provides access to vulnerable persons and therefore the potential for abuse by unscrupulous individuals. These care worker offences put on a statutory footing, restrictions on behaviour that previously was covered by Codes of Conduct. It is now a criminal offence to engage in activities that previously may have only been dealt with as a disciplinary matter. The 2003 Act seeks to balance two competing interests – protecting people with impaired mental functioning from sexual exploitation and giving maximum recognition to their sexual rights.

The relevant offences are covered by sections 38 to 41 of the Act:

S38 – Care workers: sexual activity with a mentally disordered person

This law covers all intercourse, other penetration or sexual touching of someone with a mental disorder. It includes sexual touching of any part of their body, clothed or unclothed, either with your body or with an object.

S39 – Care workers: causing or inciting sexual activity

This covers causing or persuading someone with a mental disorder to engage in any sexual activity, including sexual acts with someone else or making them strip or masturbate. This offence applies when someone has incited a person with a mental disorder to engage in sex, even if the intended sexual activity does not take place.

S40 – Care workers: sexual activity in the presence of a person with a mental disorder

It is an offence to engage in sexual activity when you know that you can be seen by a person with a mental disorder who is in your care, or you believe or intend that they can see, and where you do this in order to gain sexual gratification from the fact that they may be watching you.

S41 – Care workers: causing a person with a mental disorder to watch a sexual act.

It is an offence to intentionally cause a person with a mental disorder to watch someone else taking part in sexual activity. This includes looking at images such as videos, photos or webcams, for the purpose of your own sexual gratification. It is not intended that this should prevent care workers from providing legitimate sex education as part of an approved care plan.

Note:

- The sexual activity has to be done intentionally.
- Activity is 'sexual' if a reasonable person considers the nature of the activity is sexual eg sexual intercourse, masturbation.
- Or that the nature of the activity may be sexual, because of the circumstances or the purpose of the person in relation to it. This would include touching a person's thigh or an unnecessary examination of a patient by a doctor for sexual gratification.
- The Sexual Offences Act applies whether or not the victim appears to consent and whether or not they have the legal capacity to consent. For these offences, therefore, the apparent consent of the victim is only an issue in as much as it may absolve the defendant from non-consensual offence such as rape or sexual assault. If it is proved that the victim had a mental disorder then it is presumed that the care worker knew this, or could reasonably have been expected to know.

Care workers: Exceptions

The care workers' offences do not apply in the following situations:

Where the care worker was legally married to the person with a mental disorder and the latter is 16 years of age or older, or where it can be proved that the sexual relationship pre-dated the start of the relationship of care, as long as that sexual relationship was lawful. This would apply, for example, where someone who looks after his or her partner following the onset of a mental disorder continues to have a consensual relationship with them.

Policy and Practice

The Sexual Offences Act has implications for organisations working with people with mental disorders.

a Public sector

The government has issued guidance (see Home Office website)

b Private and voluntary sectors

All organisations working with people with mental disorders are expected to:

- Update their policies and guidelines on inappropriate sexual relationships between staff and vulnerable adults to ensure compliance with the Act.
- Take account of the Act when delivering training.
- Disseminate information about the offences affecting care workers and persons in positions of trust within their organisations.

It will be important to stress that people working with vulnerable adults are aware that they can continue to provide sex education, advice and contraception when part of an approved care plan.

11 Key Agencies and Useful Contacts

See *Section 5*

Police – Community Safety Unit (page 125)

Kilburn Police Station, Salusbury Road, NW6

Tel: 020 8733 3737/3742/3743

www.brent.gov.uk

Brent NHS
Primary Care Trust
Working with our partners for a healthier Brent

The Princess Royal Trust
Brent Carers Centre

Brent Association
for Voluntary Action

Advancing Local
Voluntary Action

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