REPORT FOR:	**Health & Social Care Scrutiny Sub-Committee**
Date of Meeting:	7 July 2014
Subject:	Harrow Local Safeguarding Adults Board (LSAB) Annual Report 2013/2014
Responsible Officer:	Bernie Flaherty Director, Adult Social Services
Scrutiny Lead Member area:	Councillor Chris Mote, Policy Lead Member & Councillor Kiran Ramchandani, Performance Lead Member
Exempt:	No
Wards affected:	All
Enclosures:	Harrow Local Safeguarding Adults Board Annual Report 2013/14

Harrow COUNCIL
LONDON

Section 1 – Summary and Recommendations

This report provides Scrutiny Committee Members with an overview of the Local Safeguarding Adults Board (LSAB) Annual Report for 2013/14 which summarises safeguarding activity undertaken in that year by the Council and its key partners. It sets out the progress made against priorities, analyses the referrals received and outlines priorities for the current year (2014/15).

Recommendations:
Scrutiny Committee is requested to note the work that has taken place in 2013/14 and the action plan for 2014/15.

Section 2 – Report

2.1 Introduction

This is the seventh Annual Report of the Local Safeguarding Adults Board (LSAB) and a copy is attached as an appendix for information.

Safeguarding vulnerable adults is a responsibility placed on health and social care through the 'No Secrets' guidance (Department of Health 2000) which is issued under Section 7 of the Local Authority and Social Services Act 1970.

Through this mandatory guidance, statutory health and social care organisations have a duty of partnership to work together to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigations of abuse and ensure people are given an opportunity to access justice.

The 'No Secrets' guidance gives Harrow Council a leadership and co-ordinating role to ensure that all those who provide services for local people work together to address the safeguarding agenda in the borough.

The LSAB oversees the work of the Council and its key partners in protecting vulnerable adults at risk of harm.

2.2 Management Information/statistics

The full sets of statistical information for safeguarding, Independent Mental Capacity Advocate (IMCA) and Deprivation of Liberty Safeguards (DoLS) services are at Appendix 1 of the attached report.

Headline messages – safeguarding adults

This is the third year where it has been possible to compare Harrow's performance against the national data. This section therefore provides a comparison with both the 2012/2013 local figures and the most up to date national figures available.

- 1,003 alerts compared to 657 in 2012/13 represented a growth of 53% locally. A growth in number is positive and suggests that briefing sessions, publicity and training events are being successful in raising awareness of the issues. However this is a very large increase and it therefore remains important to continue to ensure that only appropriate alerts are being taken forward as referrals – see next bullet point below

- 62% of Harrow alerts were taken forward as referrals (621 referrals), compared to 70% in 2012/13. The national figure is 63%. It is difficult to be sure what percentage of alerts should meet the threshold for investigation, although it certainly would not be 100%. 2013/14 is the first year where a formal threshold decision making tool was used by the Safeguarding Adults Service with all incoming alerts. The statistics suggest that in Harrow progress continues to be made at identifying the most relevant cases to be taken forward for investigation. As reported previously, both internal and external file audits check that appropriate alerts are being taken forward to the referral stage
- repeat referrals in Harrow decreased slightly from 11% in 2012/13 to 10% in 201314. The national figure was 18%, so Harrow continues to perform well in this area. As stated in previous reports, too high a figure suggests that work is not being done correctly or thoroughly first time around, so this is an important indicator and one the Board will want to continue to monitor closely
- completed referrals in Harrow decreased from 110% in 2012/13 to 92% in 2013/14 which continues to suggest that cases are progressing to a conclusion and are not "drifting". Last year's figure of over 100% represented completion of a number of cases not concluded in 2011/12. Last year's local performance is also good in comparison to the national figure of 81%
- in Harrow the female: male referral ratio at the end of 2013/14 was 62:38 which almost exactly mirrors the national position of 61:39
- referrals for older people remained high at 62% (63% in 2012/13), so they continue to be the most at risk service user group and the Harrow position exactly mirrors the same national figure
- for adults with a physical disability the figure in Harrow last year was 66% compared to 56% in 2012/13. It is important to note that in the statistics (as required by the Department of Health/ NHS Information Centre), service users (for example) who are older but also have a physical disability are counted in both categories. It is therefore quite difficult to form a view about risks to younger adults whose primary disability is physical or sensory. The national figure was 51%
- due to the high overall increase in alerts, the percentage of mental health referrals was lower (at 13% compared to 17% in 2012/13), however it's important to note that the service dealt with slightly more cases - 81 last year, compared to 77 in 2012/13. The national figure was 24%
- in Harrow the referral figure for people with a learning disability in 2013/14 was slightly lower at 15% compared to 18% in 2012/13, although with the overall increase in numbers there were more people (92 compared to 81 in 12/13) referred. Harrow's position is slightly lower than the national figure of 19%
- analysis of London comparisons released separately by the Information Centre (in respect of referrals from ethnic minority groups) and presented to the LSAB in March 2013 had suggested that Harrow was performing well (41% of all referrals) in relation to other London Boroughs. However as reported quarterly over the last 12 months at LSAB Business meetings, the figure for alerts was 34% for 2013/14 – a reduction of 8% on the 2012/13 figures. Therefore it remains a high priority for the LSAB to reassure itself that all sections of the community know how to raise a concern

- statistics showing where the abuse took place in Harrow remain broadly similar to 2012/13 with the highest percentage being in the service user's own home (56%) and 23% in care homes (long term and temporary placements). The national figures are 39% and 37% respectively. It is pleasing that there has been a slight reduction in referrals from care homes and at the time of writing this report there is only one embargoed home in Harrow – with the restriction on admissions due to be lifted shortly

- allegations of neglect (at 25%) have become the most common referral, a rise of 9% in comparison with the 2012/13 figure and is likely to be due to the high numbers of grade 3 and grade 4 pressure sore alerts made during the year which were recorded under this category. The national statistic is 27% and is likely to be high for the same reason

- physical abuse (18%), financial abuse (18%) and emotional/psychological abuse (18%) are the other significant figures with the statistics being reasonably in line with or lower than the national figures of 28%; 18% and 16% respectively
- in Harrow, social care staff e.g. "domiciliary care workers" (25%); "other family members" (30%) and "partner" (5%) were the most commonly alleged persons causing harm. For Harrow it is of note that there has been a reasonably significant statistical increase in the numbers of allegations about family members – from 15% in 2012/13 to 30% last year. The national statistics are: social care staff 32% and family (including partner) 23%
- given the numbers of training and briefing sessions undertaken in recent years, it is always interesting to look at the source of alerts. Last year the highest number (19%) were from social workers/care managers. The other sources were: primary health care staff (14%); residential care staff (10%); family (10%); secondary health care staff (9%); mental health staff (9%); Police (3%) and family/friend/neighbour (12%). The previous year's figures are unavailable for direct comparison, however recognition should be given to what appears to the Safeguarding Adults Service to be an overall and positive rise in the numbers of alerts raised by NHS staff which are better in Harrow than the national performance of 10% for primary care; 8% for secondary care and 5% for mental health. Given the amount of publicity targeting communities/neighbourhoods it is also positive to note that 12% of referrals from neighbours/family exceeds the national performance of 9%
- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action compared to the 2012/2013 statistics of 6% have improved in 2013/14 at 10% (compared to 6% nationally). This indicates that the focus given to this area by the safeguarding adults team supported by the Police is positive, however work will need to continue in 2014/15, as access to justice is known to be the wish of the majority of victims
- outcomes for the adult at risk remain similar to previous years with the highest statistic being "no further action" at 36%. The other outcome areas include: increased monitoring (14%); community care assessment and services (13%); moved to different services (7%); referral to MARAC (1%); referral to advocacy (1%); application to Court of Protection (1%)

Headline messages – Independent Mental Capacity Advocate (IMCA) services

Harrow accesses IMCAs through a West London contract with the organisation POWhER and is able to compare local activity against similar London boroughs using the same provider.

- IMCAs were accessed in 44 cases last year (the average number of cases across all areas using the POhWER service was 25.3) and most were for people with dementia (14 cases); 11 for people with a learning disability and 10 for people with mental health difficulties
- source of referral to the IMCA service was: adult social care team (16); safeguarding adults and DoLS service (8); NHS services (8); mental health services (2)
- in relation to the ethnicity of cases referred to POWhER, 27 were white British; 5 were black Asian/Asian British and 2 were black African/Black British

Headline messages - Deprivation of Liberty Safeguards (DOLS)

This is the second year that the LSAB Annual Report has included a full set of statistics for the use of Deprivation of Liberty Safeguards (DoLS). The use of these safeguards is important in the Board's oversight of the prevention of abuse and as they are relevant for some of the most vulnerable people known to local services (and those that are placed out of borough), the LSAB needs to be reassured that they are carefully monitored.

There were 14 requests for authorisations last year (an increase of 1 from the previous year) of which 9 were granted.

The main change is that there were 5 requests from hospitals compared to none in 2013/2013. The remaining 9 were from registered care settings, primarily nursing homes.

- 5 authorisations were for 18 – 64 year old adults and 9 were for older people
- 9 authorisations were for men and 5 were for women
- the 14 referrals were across a range of disabilities: 6 for people with a physical disability; 3 for people with a mental health difficulty; 3 for people with a learning disability and 2 for people with more than one disability (LD/MH and sensory)

On 19 March 2014, the Supreme Court handed down its judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council". The judgment is significant (in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty) and has brought significantly higher numbers of people into eligibility for a DoLS assessment. At the time of writing this report Harrow has dealt with 15 cases in the first 2 months of the new financial year, a figure which already exceeds the total number for last year.

The consequences for resources are significant and are still being quantified – see comment at section 3 below.

Summary/Actions Required

In the majority of the safeguarding statistics the Harrow position mirrors the national picture and in some important areas e.g. repeat referrals and completed referrals, local performance last year was better than the national average.

There are 4 main areas arising from this section of the report for further action and LSAB monitoring: high prevalence in abuse of older people, percentage of (adult/under 65) mental health referrals being below the national average, access to the criminal justice system for victims; alongside the Board's ongoing commitment to ensure that all sections of the community/user groups are able to obtain information/raise alerts.

The action plan in the annual report (year one of the LSAB Strategic Plan 2014 – 2017) includes objectives to address the key messages from the statistical analysis.

2.3 Making a Difference – (progress on objectives for 2013/2014)

This section of the annual report looks at what difference the work of the LSAB made last year by reviewing progress on the priorities agreed for 2013/2014, as set out in the annual report for 2012/2013.

Winterbourne View

The LSAB first considered the Winterbourne View documentary at its Annual Review Day in June 2011 and the subsequent actions were embedded in the LSAB's 3 year Business Plan and therefore reviewed as a standing item (in the exception report) at every meeting in 2013/14. The issues at Winterbourne View were very much focused on NHS commissioned services and local improvements are being overseen by NHS London. The NHS Self Assessment Framework for safeguarding adults (which included the Winterbourne requirements) was presented by Harrow's NHS providers at the LSAB in December 2012 and priorities for each organisation will be taken forward in the Board's new Strategic Plan for 2014/2017.

An in-depth (independent) review of Harrow's multi-agency post Winterbourne View work is being carried out at the time of writing this report and any recommendations will be reported to the LSAB during 2014/2015.

Theme 1 - Prevention and Community Involvement

The LSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow

A new prevention strategy titled "Promoting Dignity and Prevention of Abuse" was developed by the Board in 2013 and formally agreed at the business meeting in March 2014.

The focus of the information in last year's Council Tax leaflet (sent to every household in the borough) was about "being a good neighbour" with a plea to let vulnerable older or disabled people know if it seems that there might be unscrupulous doorstep salesmen or similar operating in the area. Linked to the briefings for 220 Neighbourhood Champions; joint work with the Fire Service for free home fire safety checks and further action to reduce ATM thefts targeting older people, these activities were aimed at broadening the approach to the prevention of adult abuse.

The Best Practice Forum held on 17th June 2013 for World Elder Abuse Awareness Day focussed on tackling financial abuse and was attended by 65 staff from a range of organisations. The event included presentations from the Police (Economic Crime Unit); Trading Standards; NatWest Bank and the Office of the Public Guardian. There was a strong prevention focus to the day which had been set up in response to staff reporting that this was a growing area of work which was difficult to deal with.

Outcomes:
There were 14 alerts raised by friends/neighbours last year and 57 by family – and it is hoped that the increase (and slightly better than national performance) were achieved as a result of the above activities.
There were 38 more reported cases of financial abuse in 2013/14 compared to the previous year. This indicates growing awareness of the topic. Staff have also indicated slightly improved confidence in dealing with allegations of this type which has been confirmed by the external case file auditor in his independent review of casework.

Ensure effective communication by the LSAB with its target audiences

Information about abuse and how to report it was included in the packs sent out to 4,500 family carers in May 2013.

A session was run for the Harrow "Rethink" support group in February 2014 with a range of information provided to attendees. A focus on briefings for mental health related services was agreed by the LSAB for last year given the relatively low number of alerts received the previous year.

The LSAB created a bi-monthly newsletter in 2013 aimed at keeping all relevant individuals and organisations up to date with its work and any key issues that needed to be highlighted. Four editions have been published to date (September and November 2013; January and March 2014) which included topics such as: making safeguarding personal; statistical information; safe place schemes; mental capacity and training information.

The Safeguarding Adults Service attended a wide range of community based events last year to raise awareness. This included the carer's "Shopping Road Show" during Carer's Week 2013, several Safer Streets days, 3 sessions with Age UK in the Town Centre, white ribbon day (international day of domestic violence) and the LD Big Health Day.

Outcomes:
On receiving the third edition of the LSAB's newsletter, the staff at a local Neighbourhood Resource Centre discussed the idea of a Harrow Safe Place Scheme with service users who were very keen on the idea and wanted to help. As a result, workers have supported service users to visit shops and other businesses in their area to sign them up for the scheme. This is a very positive first step in getting a fully established scheme in the borough (an LSAB priority for this year).

After attending the "Shopping Road Show" and visiting the safeguarding adults stall (where they collected an application form to request a free home fire safety check), two older carers received a visit from the fire service resulting in the fitting of new smoke alarms and advice about fire safety. During this visit the couple made the Borough's Fire Commander aware of a young disabled child living next door who had oxygen breathing apparatus fitted all around the home. This was seen by him as a possible fire risk, so he took the time to call in on the neighbours and advise them about free home safety checks, offering them a priority visit within 24 hours.

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence

Briefing sessions have been held for 200 of the borough's Neighbourhood Champions who are the "eyes and ears" of the community on their individual street. A simple fact sheet was developed to give to the Champions which also included information about support for carers.

60 vulnerable older people were referred by the Safeguarding Adults Service to the Fire Service to get free home fire safety visits, where fire-fighters have checked their home for any risks.

Outcomes:
One elderly man had been falling asleep in bed whilst smoking cigarettes - following the home fire safety check the fire service gave him fire retardant bedding and a new smoke alarm, vastly reducing his risk of harm from a fire. Another woman was a well known hoarder and following the referral, fire officers were able to ensure that she had an escape route from her property. Through the same project, two people living in a sheltered housing block were able to have domestic sprinklers fitted - the first in Harrow.

There is evidence that the Harrow LSAB's work is influenced by user feedback and priorities

The independent social worker (who interviews randomly selected service users after the safeguarding investigation is concluded) continued last year to ask whether people knew how to report abuse and understood what would happen next. She reported that service users were unclear about the process – resulting in production of new easy to read information developed with the assistance of service users. This publication follows on from the original leaflet about "safeguarding adults from abuse in Harrow is everyone's business" which had been well received.

Service users attended the LSAB Annual Review Day for the first time last year. This positive development by the Board aims to ensure that the views of victims of abuse or those that represent possible victims are directly heard by the LSAB and that actions are taken as a result. There were a number of clear messages from the user representatives, including a wish for people with a learning disability to have more information about fire safety.

Outcomes:
Production of a new publication "what happens after I report abuse?" which is now given to all clients who are involved in a safeguarding adult's investigation. The effectiveness of the information being given out will be monitored by the independent social worker in her interviews with service users in future.

The borough's Fire Commander visited some of the Neighbourhood Resource Centres to discuss fire safety, promote home fire safety checks and stress the importance of smoke alarms.

Theme 2 – Quality and Performance Review

The LSAB oversees effective practice and ensures continuous improvement

Performance management reports were presented to the LSAB at all of its meetings in 2013/14. A section on Provider concerns (e.g. care homes having been embargoed) is due to be added to future reports so that important information can be shared amongst the LSAB's member organisations.

Peer Review

The Care Quality Commission (CQC) no longer inspects Councils, other than any in-house residential services that they provide. Their expectation is for senior managers and Councillors to ensure that internal processes for continuous learning, quality assurance and improved outcomes for users are in place. Peer Review challenge (by relevant senior professionals from other Councils) is one method that can be applied to support self evaluation and service development.

The Peer Review challenge was commissioned by the Council with the full support of the Local Safeguarding Adults Board.

***What was the Harrow process*?**

The Peer Review challenge team were in Harrow for 3 days, (18-20 November 2013) and the formal process followed the Local Government Association methodology. The Team that carried it out was: Cathy Kerr (Director of Adult and Community Services, LB Richmond); Stephen Day (Director of Adult Services, LB Ealing); Gill Ford (Head of Performance and Quality Assurance, LB Richmond); Mary Stein (Head of Service Transformation, LB Brent) and Cathie Williams (for London Councils and also the lead for Adult Safeguarding, Local Government Association).
It should be noted that all members of the Team were social care professionals i.e. there were none from the other statutory sectors including the NHS and the Police. The methodology was:

- completion of a self assessment;
- reading by the Peer Review Team of the self assessment/evidence portfolio (prior to the 3 days on-site work); and
- interviews/focus groups/observation on site

The evidence portfolio was extensive and the interviews/focus groups included a wide range of LSAB members and partner organisations across the statutory sectors (NHS, Fire Service, Police); third sector (Harrow Mencap/Age UK Harrow/Mind in Harrow etc) and private sector care homes and agencies. Elected members (the Portfolio holder and shadow portfolio holder); front line staff and relevant managers were also interviewed.

There were six specific outcome areas examined by the Team: (i) the council demonstrates improved safeguarding outcomes alongside wider community safety improvements; (ii) the council has fully engaged people who use services in the design of its services; (iii) there is recognised and active leadership by the council on Adult Safeguarding (iv) the council has robust and effective service delivery that makes safeguarding everybody's business; (v) services are held accountable through performance measures, including quality measures, towards the outcomes for people in the strategy; and (vi) there is multi-agency commitment to safeguarding.

The Peer Review Team's findings (highlights)

i. Practice:

They found that there is impressive safeguarding adult's practice which is overseen by strong leadership and commitment by senior officers and elected members.
There is also a real strength in the practice at all levels with a range of forums/activities in place to develop the skills of staff and clear evidence of a learning cycle. They also found that staff are giving high priority to placing users at the centre of the safeguarding process and to working with them to achieve the outcomes they want. They also noted that the LSAB has produced good literature and that other materials and awareness raising activities have had a positive impact.

Recommendations (for Practice):

The Peer Review Team said that gaining access to justice for victims in Harrow (in common with the national picture) is a challenging experience, and the LSAB must continue to do what it can to make it easy for people to report issues.

They found that getting through the “front door” of Access Harrow can be difficult.
They advised the LSAB to consider how it exerts a preventative function to ensure people are not harmed by poor health, care or police responses.

ii. *Governance*:

The LSAB is well established with a high level of commitment from most partners. There is also strong leadership from the Council with evidence of inter department working practices, including strong links with Children’s Safeguarding and wider community safety work. There is also evidence of innovative activities that reach some citizens who would not otherwise get any support.

Recommendations (for Governance):

They asked the Council to consider how it brings strategic leadership and commitment from key partners into owning safeguarding (rather than seeing it as Council business they are helping with).

iii. Quality Assurance:

There is evidence of the Council proactively seeking feedback from service users and acting on the feedback. There is evidence that there is an effective learning loop from the practice through audit response and review. There is also a broad and innovative system of risk management in place.

Recommendations (for Quality Assurance):

They identified scope to address care quality issues more systematically. This would involve partnership work between NHS Commissioners, the Care Quality Commission, the Quality Surveillance Group, along with the council. This will encourage Providers to engage more proactively with their own learning and development. They also identified a need for more focus on outcomes in reporting to the LSAB, assisted by systematically capturing the outcomes that people wanted and whether they have been achieved.

Conclusion

In conclusion the Peer Review Team stated that they found an openness to try new approaches and that the Council is in a strong position for the challenges that are coming and to continue the journey.

Outcomes:

It is important to note that some of the recommendations had already been identified by the LSAB and work is underway e.g. a new template is in place for capturing partner data for presentation at Board meetings; there are quarterly meetings with Access Harrow to discuss the pathway for safeguarding adults alerts; a legal update Best Practice Forum was held on 10th December 2013 as part of ongoing sessions to further develop staff’s understanding of relevant legislation and a new Prevention Strategy was agreed by the LSAB at its March 2014 meeting. Some of the recommendations relate to the function of the LSAB and the Board had already agreed to some independent challenge at its next annual review day in June 2014. This will provide an opportunity for further debate about membership, ownership and effectiveness.
The action plan developed from the Peer Review recommendations is in place and will be monitored at LSAB business meetings during 2014/15.

Statistical data improves understanding of local patterns enabling improved planning of responses to allegations

The LSAB has received statistical reports at each of its meetings, including the full year position for 2012/13 at its Annual Review Day. In addition, the new Strategic Plan for 2014 – 2017 includes trend analysis looking back over the previous 3 years and all reports include comparison with the national position.

Outcomes:
Ongoing analysis by the LSAB of relevant statistical information has enabled adjustments to be made to training events and also to briefing sessions. The most up to date comparisons with the national data shows a positive picture for the work in Harrow with 4 main areas identified for future work (see above).

Theme 3 –Training and Workforce Development

The LSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act

The LSAB Training Strategy was updated and agreed by the Board at its meeting in March 2014.
The contract for the multi-agency safeguarding adults training programme was formally retendered and following a challenging selection process the LSAB confirmed that the new contract for the next 3 years will be with Lowe Consultancy Services.
At the time of writing this report the training programme is being updated based on learning from file audits and case reviews and on analysis of attendee feedback about the previous year's sessions.

Multi-agency training remains a high priority for the LSAB. The existing programme is competency based. As a supplement to the formal training programme, the Safeguarding Adults Service also ran briefing sessions across a range of agencies, offering most at the organisation's premises. Full details of the training statistics are at Appendix 2 in the attached annual report.

Headline messages

- a total of 2176 people received some training in 2013/14 - this was an increase of 698 people from 2012/13
- 620 staff received formal training – this was the same level as in the previous year - the breakdown of formal training was: 177 Council staff (a decrease of 27 from 2012/13); 66 NHS staff (a decrease of 22 from 2012/13); 14 "other statutory" staff including the Police (an increase of 9 from 2012/13); 269 private sector staff (an increase of 43 from 2012/13) and 94 voluntary sector staff (a small decrease of 3 from 2012/13)
- a refresher was organised for elected Councillors and was attended by 12 individuals
- 1355 people attended sessions run by the Safeguarding Adults Service (an increase of 645 from 2012/13). It is very positive to note that there were a number of new or significantly increased areas last year including: 254 related to DoLS; 220 Neighbourhood Champions; 30 students at local colleges (on access to health/social care courses) and 169 service users

- a total of 208 staff attended 5 multi-agency best practice forums in 2013/14 on financial abuse; self neglect/hoarding; "think family" (joint with the LSCB); legal updates and safe place schemes
- 33% of individuals (302 people) booked on to formal training courses cancelled, a small decrease, but still leading as in previous years to difficulties about the viability of some sessions
- this was the second year for the new e-learning course which allows some front line staff to access training that they might otherwise not be able to e.g. GP trainees. A total of 201 staff (including 110 GPs/primary care staff) used the tool – an increase of 53 people from 2012/13 suggesting that this approach to training/development is being well received

Outcomes

The new programme for 2014/15 is being developed from the evaluation and experience of the 2013/14 sessions. It will also cover the areas that successive independent audits of safeguarding cases and the Peer Review suggested for further improvements in staff knowledge and/or confidence. These include the Mental Capacity Act; DoLS and making safeguarding personal/outcome focused.

The Councillors asked for safeguarding adults' wallet cards to be provided to all elected Members which was done in October 2013.

The well established file audit process continued in 2013/14 with both internal and external/independent scrutiny of safeguarding adults' work. The main findings were reported to the Board in September 2013 and the headlines are covered in the full report attached.

DOLS arrangements (including for health funded services and facilities) are effective

The full set of Deprivation of Liberty Safeguards (DoLS) statistics are shown at Appendix 1 in the attached annual report.
The first independent audit of DoLS work has recently been undertaken by the external file auditor and will be reported to the LSAB at its business meeting in September 2014. As explained above, there has recently been a very significant increase in the number of DoLS referrals following the Supreme Court ruling in respect of the "Cheshire West" legal case. The implications for Harrow will be reported to the LSAB and summarised in next year's Annual Report.
A significant number (254) of briefing sessions about the DoLS arrangements have been held with local providers of services e.g. nursing homes which assisted in increasing the referral numbers in 2013/14 compared to 2012/2013.
Informal peer review/audit with another London Council has been agreed in principle with that borough, however implementation has been delayed due to the very large influx of cases in all Council areas.

Outcomes:

An increase in referral numbers last year suggests that work carried out to improve awareness of the safeguards has started to have a positive impact. There were 5 requests for DoLS assessments from local hospitals last year compared to none the previous year, which is a very positive change.

Theme 4 - Policies and Procedures/Governance

Ensure production of the LSAB Annual Report

The LSAB Annual Report 2012/13 was agreed formally by the Board at its annual review day in June 2013. This report for 2013/14 will be discussed at the same event in June 2014. Subsequently the report will be presented to the Council's Scrutiny Committee, the Health and Wellbeing Board and partner agencies' Executive meetings or equivalent.

Outcomes:

Following discussion by the LSAB last June a "key messages for staff" version of the report was produced for the first time and an easy to read version was put on the Council's website – aiming to ensure that the Board's work is as accessible as possible to both staff and the public.

Ensure that the LSAB Annual Report is presented to all relevant accountable bodies

Following its formal agreement at the LSAB annual review day on 28th June 2013, the report was presented to the Council's Scrutiny Committee in July, the Health and Wellbeing Board in August and subsequently to all partner agencies' Executive meetings or equivalent.

The general public is aware of safeguarding issues and the work of the LSAB

In 2013/14 the safeguarding adults' website was refreshed and now includes (for example) the notes from LSAB meetings which had not previously been available there.

Outcomes:

As stated earlier in this report an additional easy to read leaflet "what happens after I report abuse" was developed with the involvement of service users as feedback from vulnerable adults by the independent social worker was primarily that they didn't understand the terminology or process that had been followed even though they were happy with it and the outcome.

The LSAB (jointly with the LSCB) takes a "family first" approach to its work

A full set of joint protocols were developed in 2013/14 by the LSAB/LSCB (Local Safeguarding Children's Board) sub-group and were formally launched by the chairs of the 2 Boards in October 2013. A joint LSCB/LSAB "think family" best practice forum was subsequently held for 50 staff across adults and children's services which included use of the protocols as well as a focus on the importance of working together and sharing information to ensure positive outcomes for both vulnerable adults and vulnerable children.

The LSAB/LSCB work programme for 2014/15 includes a review of the joint protocols one year after their formal launch.

Outcomes:

The independent/external file auditor reported that the safeguarding adults team were demonstrating growing confidence in a "family first" approach, with all the relevant (audited) cases being appropriately referred to Children's Services.

The LSAB has strategic oversight of local safeguarding adults work

During 2013/14 the LSAB developed a new Strategic Plan for 2014 – 2017 having overseen the successful implementation of the previous Business Plan which expired in 2013. The new Plan was formally adopted by the LSAB at its Business meeting in March 2014 and the action plan for the first year is shown at the end of the attached annual report.

Theme 5 – Partnership with the Local Safeguarding Children's Board (LSCB)

Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC

Close work continued in 2013/2014 between the LSAB and LSCB primarily through the joint sub-group which reports to both Boards.

The "think family" joint best practice forum looked at lessons from the serious case reviews which followed the death of a child (e.g. baby Peter) with a particular focus on the responsibilities of staff working with the adults in a family where there are concerns about a vulnerable child. A key focus of the event was on the "toxic trio" of factors that can be present in some cases i.e. an adult with mental health issues, a substance misuse problem and the presence of domestic violence - and the impact on ability to parent. Adult Services staff were given advice about completing Common Assessment Framework (CAF) forms and also on taking cases to MARAC (multi-agency risk assessment conference – for domestic abuse).

Outcomes:

The independent file auditor commented on a growing confidence in the work of the safeguarding team in cases where there are also children present and reported that all appropriate (audited) cases were referred to Children's Services.

2.4 LSAB Objectives for 2014/2015

The LSAB's objectives for 2014/15 build on those established the previous year. The additional priorities include: establishing a "Safe Place" scheme for Harrow; full implementation of the Peer Review action plan; reviewing the joint LSAB/LSCB protocols and further developing the audit of local DoLS arrangements. Harrow Council's Safeguarding Adults Service is also considering taking part in the ADASS/Local Government Association sector led improvement project on "Making Safeguarding Personal" which aims to ensure that clients are always at the centre of the investigation/assessment process and that their desired outcomes are achieved. This project work will entail a self assessment with consequent work on local procedures, protocols and staff training.

In addition, the LSAB will need to address the implications of the Care Act 2014 which will put Boards on a statutory footing from April 2015.

Section 3 - Financial Implications

The revenue cost of the Safeguarding Adults Service (and related activities e.g. publicity) is outlined in the Annual Report at Section 2.3. The costs of increased activity during 2013/14 resulted in additional costs incurred by the safeguarding team, however this was contained within the overall adult social care budget.

The main financial implications arising from this report relate to the Supreme Court judgement in the DoLS work area. It has been estimated that subsequent to that judgment there is the potential for DoLS applications for a large percentage of Harrow clients placed in care homes. The following data gives an idea of the potential numbers:

- total out of borough residential/nursing clients = 195
- across all the out borough cases the client group breakdown is: 16 mental health and 60 learning disability which is arguably where the majority of DoLS work is likely to come from as they are primarily for the protection of people with complex and challenging needs

The remaining cases in residential/nursing home placements are in the borough and there are 427 of these – it is assumed a lower percentage of requests will come from in-borough homes as the clients' needs are less complex/challenging.

The main costs relate to the need to commission independent Best Interest Assessors or to pay travel costs for Harrow staff. For all DoLS cases there is a requirement to commission a private/independent section 12 psychiatrist. To date the average cost of each DoLS assessment is £360.

NB. It is important to note that there are statutory requirements to carry out DoLS assessments and the timescales in which they must be completed are set out under the DoLS framework i.e. that urgent referrals must be assessed within 7 days and standard authorisation requests within 21 days. There is consequently no option but to process the cases as soon as they are referred to the Council, including use of independent staff where required (psychiatrists) or to meet resource gaps (availability of Best Interest Assessors).

For 2014/15 the position will need to be closely monitored to assess the financial impact of the increased activity which may result from the supreme judgement in relation to the DoLs work area and contained where possible.

Any ongoing financial impacts post 2014/15 will need to be reviewed and considered within the demographic growth provision contained within the Medium Term Financial Strategy.

Section 4 - Performance Issues

The report is primarily concerned with performance and contains analysis of the Harrow LSAB statistics, both as they relate to the previous year and also to national data. The Peer Review was an independent challenge of Harrow's performance and its findings are also covered in this report.

Section 5 - Environmental Impact

There is no environmental impact arising from this report.

Section 6 - Risk Management Implications

Risk included on Directorate risk register? Yes

Separate risk register in place? No

Potential risks:
Failure to ensure local safeguarding adults' arrangements are robust could lead to a serious untoward incident e.g. death of a vulnerable person.

Section 7 - Equalities implications

The LSAB considers local safeguarding adults statistics at each Business Meeting and at its annual review, with particular emphasis on ensuring that alerts are being received from all sections of the community. The new Strategic Plan for 2014/17 has been developed such that the LSAB will monitor the impact of abuse in all parts of Harrow's community and will focus its awareness raising sessions in areas where low/no referrals have been received in the previous period. Safeguarding adults' work is already focused on some of the most vulnerable and marginalised residents of the local community.

Section 8 - Corporate Priorities

This report primarily relates to the Corporate priority of a safer borough:

"Safer: *A borough where residents feel safe to live and enjoy their lives. We will work with the police and other partners to make Harrow even safer"*

Section 9 - Statutory Officer Clearance

Name: Donna Edwards Date: 11th June 2014	x	on behalf of the* Chief Financial Officer
Name: Sharon Clarke Date: 28th May 2014	x	on behalf of the* Monitoring Officer

Ward Councillors notified:	**NO** - the report affects all Wards

Section 10 - Contact Details/Background Papers

Contact: Visva Sathasivam (Head of Adult Social Care)
(Direct Dial: 0208 736 6012)

Background Papers: Harrow Local Safeguarding Adults Annual Report 2013/14.