& our Partners,

Committed to Safeguarding Adults

Harrow Safeguarding Adults Board (HSAB)

Annual Report 2018 - 2019

in partnership with:

Index **Page**

"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (HSAB Vision)

Foreword

This is the last time I will be writing the foreword to the Board's annual report, as I have decided to leave Harrow due to some caring responsibilities that I have taken for family members abroad. Thank you so much for all your support over the time that I have been the HSAB chair. I would also like to thank staff, volunteers, experts by experience, users and carers from all the many agencies who have contributed to safeguarding and dignity/respect work in Harrow over the last year.

I was very pleased to attend the third joint HSAB HSCB (Harrow Safeguarding Children's Board) annual conference on the 25th January 2019 and for the first time it was co-hosted with the Safer Harrow Partnership. The topic was "invisible chains – the trafficking of adults and children into slavery and exploitation" and was an inspirational event. There were excellent speakers and challenging workshops and it continued to develop the Board's commitment to "thinking whole family" as well as addressing a key priority around community safety. Look out for the fourth joint conference in early 2020.

In 2018/2019 the HSAB continued to tackle issues such as hate crime; scams; distraction burglary/doorstop crime; and home fire safety. Section 3 highlights the excellent work that has been done by partners in these areas over the last 12 months.

An excellent piece of joint work between the Police and the Council Safeguarding Team led to the successful prosecution (resulting in a custodial sentence) last year of a son who had systematically harassed his parents to give up both money and their home to him.

I think that once again this annual report demonstrates the difference that the Board's work has made to the lives of the most vulnerable people in the borough and hope you agree once you have read it.

As ever, everything the HSAB does is to achieve its vision – "*that Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business".* In that context, section 4 of this report covers the areas that the Board wants to work on this year (2019 - 2020) which includes a focus on supported housing with a learning event looking at best practice for Providers, and a continued focus on any areas that tackle the vulnerability of older people living in their own home e.g. scams.

Once again I am delighted to present this report to you and hope you will use it to raise awareness of adult safeguarding and to identify issues that you can take forward in your own organisation. A lot has been achieved, but we are not complacent – so I wish you all the very best for the future.

Visva Sathasivam (Chair of the HSAB)

Message from the new Chair of the Harrow Safeguarding Adults' Board

In May 2019 I was appointed by the HSAB to the post of independent chair, a role that I am delighted to take up. I have been the chair of the Harrow Children Safeguarding Board since 2017 and have been impressed during that time by the quality of the engagement that there is in Harrow among the statutory partners and between them and the voluntary sector.

This spirit of cooperation and engagement also is evident in the many transactions that there are between those whose work protects children and their peers who safeguard vulnerable adults.

Harrow's partners have decided from June 2019 onwards to move to a new safeguarding structure, which sees closer alignment between adults' and children's safeguarding work. This will lead among other things to some shared objectives, more crossover working groups and better alignment of data and intelligence sharing.

We have a lot to learn from each other and I believe that having one person chairing both boards will facilitate cohesion and shared learning. As the occupant of that role I am excited by the possibilities that it offers and am glad that I am surrounded by so many dedicated and knowledgeable professionals who will help me to ensure that our new structure will deliver safeguarding excellence.

(Chris Miller)

.....

SECTION 1 - INTRODUCTION

1. Introduction to the annual report

This is the 12th Annual Report published on behalf of Harrow's Safeguarding Adults Board (HSAB) and contains contributions from its member agencies. The Board is statutory and coordinates local partnership arrangements to safeguard adults with care/support needs who are at risk of harm. This report details the work carried out by the HSAB last year (2018/2019) and highlights the priorities for 2019/2020.

The Care Act 2014 sets out the main purpose of a safeguarding adults board as:

- to assure itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance;
- to assure itself that safeguarding practice is person-centred and outcome-focused;
- to work collaboratively to prevent abuse and neglect where possible;
- to ensure agencies and individuals give timely and proportionate responses when abuse or neglect have occurred;
- to assure itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in Harrow

1.1 The Harrow Safeguarding Adults Board (HSAB)

The Harrow Safeguarding Adults Board (HSAB) was chaired in 2018/2019 by Visva Sathasivam (Director – Adult Social Services, Harrow Council) and is the statutory body that oversees how organisations across Harrow work together to safeguard or protect adults with care/support needs. At the time of writing this report the HSAB members have agreed to the appointment of an independent Chair (Chris Miller) who took up the role at the end of May 2019.

The HSAB takes its leadership role very seriously with appropriate senior management attendance from member organisations and the active involvement of the elected Councillor who is the Council's Portfolio holder for adult social care, health and well-being. The list of members (as at March 31st 2019) is at Appendix 2, with their attendance record at Appendix 3.

1.2 HSAB Accountability

Under the Care Act 2014 the HSAB has core duties. It **must**:

i. publish a strategic plan for each financial year

- the HSAB has a 3 year strategic plan for 2017 - 2020 which is updated each year after production of the annual report

ii. publish an annual report

- the HSAB's 11th Annual Report (for 2017/2018) was presented to the Council's Scrutiny Committee on 16th October 2018 and this 12th report for 2018/2019 will go to a Scrutiny meeting on 5th November 2019
- the HSAB's 11th Annual Report (for 2017/2018) was presented to the Harrow Health and Wellbeing Board on 1st November 2018
- each partner organisation represented at the HSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent
- as in previous years, this report will be produced in "Executive Summary", "key messages for staff" and "easy to read" formats and will be available to a wider audience through the Council and partner agencies websites

iii. conduct any Safeguarding Adults Reviews (SARs)

- the HSAB has an agreed protocol for carrying out Safeguarding Adults Reviews, but no referrals were received requesting a SAR in 2018/2019

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- the membership of Harrow's HSAB (as at 31st March 2019) is shown in Appendix 2 and their attendance record is shown at Appendix 3

1.3 Strategic Links

The HSAB has links with the following partnerships also working with communities in Harrow, to help the Board ensure that local arrangements are effective in protecting people with care and support needs from the experiences or risk of abuse and neglect: *Health and Wellbeing Board; Harrow Safeguarding Children's Board (HSCB); Safer Harrow Partnership; Domestic Abuse Forum; Multi-Agency Risk Assessment Conference (MARAC); Multi-agency Public Protection Arrangements (MAPPA) and Prevent*.

1.4 "London Multi-Agency Adult Safeguarding Policy and Procedures"

The London Multi-Agency Adult Safeguarding Policy and Procedures have been used throughout the period covered by this report. The HSAB was consulted on the revisions to the London procedures and will adopt them once they have been finalised.

SECTION 2

HSAB Work Programme in 2018/2019

2.1 Harrow HSAB business meetings – work areas covered

The HSAB met on 4 occasions in 2018/2019 – three Business Meetings and an Annual Review/Business Planning Day. The following table lists the main topics discussed by the Board at those meetings – some being standing items; some were items for a decision; some were for information/discussion; others were aimed at Board development, and there were also specific items providing challenge to the Board. Some items were discussed at more than one meeting.

Prevention and Community Engagement (including user involvement)

- fatal fire presentation – and agreement to a "learning lessons" event (for information and decision)
- CNWL financial abuse report (for information)
- Provider concerns (item for information at every meeting)
- Nat West Bank - Community Banker scheme for awareness about fraud/scams (item for information/dissemination)
- experts by experience from Harrow Mencap input to annual review/business planning day 2018 - young people with a learning disability talking about feeling unsafe and the importance of social inclusion/integration (item for challenge)
- "feedback about keeping people with mental health problems safe" - experts by experience from Mind in Harrow input to annual review/business planning day 2018 (item for challenge)
- Harrow Council Serious Concerns (about Providers) Procedure (item for information)

Training and Workforce Development

- feedback from the third joint HSAB/HSCB conference ("trafficking and modern day slavery") on 25th January 2019 (item for information)
- coercive and controlling behaviour – outcome from recent court case in Harrow and any learning for the HSAB (item for discussion and information)
- HSAB training programme for 2019/2020 (item for information and decision)

Quality and Performance Review

- statistical “deep dive” reports: “how does Harrow compare to the latest national data?” and “sexual abuse by user group and location”
(items for information, discussion and decisions)
- quarterly statistics – findings used by the HSAB to inform changes to the training programme and local practice (standing item at every meeting)
- NHS England/ADASS Risk Audit completed in 2017/2018
(item for discussion and information)
- NHS England/ADASS Risk Audit for 2018 – 2019 (item for discussion/information)

Policies and Procedures/Governance

- HSAB Annual Report 2017/2018 - discussed and formally signed off
(item for decision)
- future HSAB chairing arrangements (item for decision)
- consultation on the revisions to the Multi-Agency Adult Safeguarding policy and procedures (item for discussion and decision)
- Appropriate Adult protocol (item for discussion)
- HSAB updated self neglect protocol (item for decision)
- Metropolitan Police information sharing agreement (item for discussion)
- revised HSAB Training Strategy 2019 – 2022 (item for decision)
- HSAB Strategic (Business) Plan 2017/2020 (exception reports)

Joint work with the Harrow Safeguarding Children’s Board (HSCB)

- HSCB Annual Report 2017/2018 (item for information and discussion)
- Harrow Safeguarding Children’s Board changes and new joint Strategic Partnership arrangements (item for discussion and decision)

Items for HSAB development

- GDPR – information sharing in safeguarding adults work (item for information)
- national and regional updates from Dr Adi Cooper (items for challenge, information and discussion)
- Learning Disability Mortality Review (item for information)
- Police custody changes (for information)

Safeguarding Adults Reviews (SARs)

No referrals were made to the HSAB requesting that a SAR be commissioned during 2018/2019, however the Board did receive a report on a fatal fire and discussed the outcomes from a "learning lessons" event.
In addition, every HSAB newsletter covered a different SAR carried out by other Board's so that the learning could be disseminated.
The World Elder Abuse Awareness Day 2018 Best Practice Forum covered the learning from SARs where the people harmed were hard to engage and delegates heard about legislation that can be used which is outside the usual (social care) framework e.g. Environmental Health powers.

2.2 Management information (statistics)

The Board collates multi agency information on a range of adult safeguarding statistics in order to produce a management report. The report which is available at each business meeting is overseen by and exceptions are discussed at the HSAB. The Board's strategic plan for 2017 – 2020 contains 5 year trend analysis which provides an excellent basis for planning future work. The 4 year trends post the implementation of the Care Act 2014 are shown at Appendix 1 and referred to in the narrative below. The more detailed background information for the statistical analysis of safeguarding adults services work in 2018/2019 is available on request from safeguarding.adults@harrow.gov.uk

Headline messages 2018/2019 – safeguarding adults

- 1,403 concerns compared to 1,467 in 2017/2018, represented a 4% reduction overall. The breakdown shows that Mental Health Services received a 24% increase in concerns whilst Adult Social Care had a 10% reduction. The Harrow SAB will continue to monitor referral numbers to be reassured that cases of abuse are being reported appropriately
- 42% of Harrow concerns were taken forward as enquiries, compared to 43% in 2017/2018. The most recent national comparator is 38%, so the HSAB can be reassured that locally a very similar number of concerns have met the threshold for enquiries. However, as previously reported, both internal and external file audits continue to check that appropriate concerns are being taken forward to the enquiries stage i.e. that threshold decisions are being correctly made in the safeguarding adults teams
- in 2017/2018 repeat enquiries were at 17% and in 2018/19 there was a very small further reduction to 16%. The most recent national comparator figure was also 16%
- completed enquiries in Harrow were at 101% last year (this will include work started in the previous year), suggesting that casework is progressing to a conclusion and not "drifting". The most recent national comparator figure was 100%

- in Harrow the female:male ratio at the end of 2018/2019 was 62:36 for enquiries, which is very close to the figure in 2017/2018 of 60:39. Nationally the percentage of women subject to safeguarding adults enquires also remains higher than for men (59:41) and the ratio in Harrow has been fairly stable since the statistics were first collected
- the figure for older people has increased slightly at 52% (309 people in 2018/2019 compared to 301 in 2017/2018) and they continue to be the highest "at risk" group in Harrow as they have been since 2009/2010. Nationally older people represented 45% of the concerns, so locally there are more older people at risk than the national average
- for adults with a physical disability the figure in Harrow last year was 38% of concerns (224 people) compared to 34% (217 people) in 2017/2018. As indicated in previous annual reports it is important to note that in the statistics (as required by the Department of Health/NHS Information Centre), people (for example) who are older but also have a physical disability are counted in both categories. It therefore remains quite difficult for the HSAB to form a view about the extent and nature of the risks to younger adults whose primary disability is physical or sensory
- mental health numbers were 27% (163 people) last year. Numbers now seem to have stabilised at a figure well above the most recent national average of 9%
- in Harrow enquiries for people with a learning disability in 2018/2019 were slightly lower at 11% (67 people) than the previous year's figure of 80, but numbers remain relatively stable. The most recent national figure is 10%
- concerns from "BME" communities last year were at 56% compared to 51% in 2017/2018 – which remains in line with the makeup of the Harrow adult population. The enquiries figure was 53% which is also positive, as it suggests that a proportionate number of concerns progress and concerns from "minority" communities are not disproportionately closed before that stage of the process

- statistics showing where the abuse took place in Harrow have changed somewhat from the previous year particularly in respect of care homes. The highest percentage at 58% remains in the user's own home, compared to the average over the last 8 years of 55%. However concerns about care homes fell last year (from 19% to 15%). The national statistics are in similar proportions i.e. highest levels of abuse in the user's own home (43%), but show higher numbers in care homes (35%). It is believed that the role of the Council's Safeguarding Quality Assurance (SQA) Team in working to improve standards in local care/nursing homes is having a positive (prevention) impact on this statistic.

  Numbers in other settings were - 5% in mental health in-patient units (31 patients compared to 30 in 2017/2018); 7% in supported accommodation (44 people compared to 33 in 2017/2018); 3% (21 incidents) in a public place; and 1% in acute hospitals (7 patients compared to 10 the previous year).

These figures confirm the experience in the Safeguarding Team that the number of issues arising in supported housing settings (unregulated by CQC) are rising.

- allegations of physical abuse, neglect, emotional abuse and financial abuse have been the most common referral reasons in previous years and reported in successive annual reports.

  It is therefore possible to compare the 2018/2019 statistics with the average figures from the last 8 years.

  Physical abuse was 20% last year (156 people) compared to the 8 year average of 24%. Neglect was at 24% in 2018/2019 (193 people) compared to the average of 20%. Emotional abuse was at 19% (154 people) compared to the average of 20%. Financial abuse was at 18% last year (145 people) compared to the average of 17% and has been growing in numbers over the last few years.

  The following areas can be compared to 2017/2018:

  - sexual abuse at 4% (33 people) compared to 5% (43 people). This figure has now reduced over 2 successive years in both Mental Health Services and Adult Social Care

  - concerns about self-neglect which decreased from 28 situations to 21 being dealt with under the local arrangements. It is noteworthy that there was a 43% increase in these cases in Adult Social Care and a 93% decrease in mental Health Services

  - concerns about domestic abuse fell slightly from 86 people to 74 people. The largest drop was in Mental Health Services which had dealt with 60 cases in 2017/18, but only 37 last year. Adult Social Care made 37 enquiries last year compared to 26 in 2017/18

  - the newer area of modern slavery dropped from 4 cases in 2017/2018 to 3 last year. All 3 cases were managed by Adult Social Care

  There was one reported case of forced marriage, but none for sexual exploitation last year.

- in Harrow, social care staff (22% across all care sectors); family/partner (48%); stranger (2%); and health care worker (5%) were the most commonly alleged persons alleged to have caused harm (PACH). The family/partner numbers increased again last year (by 5%), having already been the highest category in recent years
- given the numbers of training and briefing sessions undertaken in recent years, it is always important to look at the source of concerns and this is the fifth time that year on year comparison has been possible for the HSAB to carry out:

Last year the highest numbers (18%) were from social workers/care managers; mental health staff (12%); primary health care staff (15%); secondary health care staff (10%); and Police (8%).
The other sources were: residential care staff (7%); family (9%); self referral (2%); and Care Quality Commission (1%). There are no significant statistical changes from the previous year

- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action dropped again which is disappointing given the continued focus on this area in the last 3 years. The figure in 2016/17 was 131 cases; this decreased to 105 in 2017/18 and fell to 86 last year. The safeguarding adults teams in both the Council and CNWL MH Trust will continue to give this issue high priority by reporting all relevant cases to the Police.

  Other outcomes for the PACH were: exoneration (11%); monitoring (7%); management of access to adult at risk (7%); and community care assessment (8%). There were 120 cases (a reduction from 154 the previous year) where the outcome was "not known" (primarily in the Council's service) which remains disappointing and will need to be a continued area of focus in 2019/2020

- outcomes for the adult at risk include: community care assessment and services at 23%; management of access to PACH at 4%; increased monitoring at 10%; and moved to different services at 5% (all exactly the same as 2017/18). Referral to counselling or training at 4%; referral to advocacy at 3%; referral to MARAC at 1%; management of access to finances at 2%; and application to Court of Protection (5 cases) were all close to last year's figures.

Summary/Actions Required

In the majority of the performance statistics above, there is now quite a lot of stability looking back over recent years. Areas for action in 2019/2020 include:

- a continued focus on the newer areas of work i.e. modern slavery; forced marriage/sexual exploitation; and domestic abuse so that the HSAB is reassured there is sufficient knowledge amongst professionals about recognition and referral mechanisms and good awareness across a wide range of settings outside the Council, NHS and CNWL MH Trust
- a continued focus on Police action/criminal prosecution where a crime may have been committed
- a relaunch of the self neglect protocol with a particular emphasis on attendance by CNWL staff
- ensuring that wherever possible the outcome for the PACH is recorded
- a focus on supported housing with a learning event looking at best practice for Providers; alongside the Council's SQA Team increasing the type and focus of the quality monitoring in these projects
- another review of the collection of statistics on sexual abuse
- a continued focus on any areas that tackle the vulnerability of older people living in their own home e.g. scams

- a statistical “deep dive” looking at type of abuse by person alleged to have caused harm (PACH)

The plan in section 4 of this report (year 3 of the HSAB Strategic Plan 2017 - 2020) includes the actions to address the key messages from the statistical analysis.

Headline messages - Deprivation of Liberty Safeguards (DOLS) 2017/2018

This is the fifth year that the HSAB Annual Report has included statistics for use of the Deprivation of Liberty Safeguards (DoLS). These are relevant for people in hospitals, hospices and care homes who lack the mental capacity to understand and consent to the care/support they need and in particular to any restrictions e.g. locked front doors and/or medication given covertly. The use of these safeguards is important in the Board’s oversight of the prevention of abuse as they are relevant for some of the most vulnerable people known to local services (including those that are placed out of borough) and the HSAB needs to be reassured that they are carefully applied and monitored.

At the time of writing this report the Mental Capacity (Amendment) Act 2019 has received Royal Assent and become law. The legislation provides for the repeal of the Deprivation of Liberty Safeguards and their replacement with a new scheme (the Liberty Protection Safeguards). Implementation is likely to be in mid to late 2020, giving time for organisations to prepare for the new process. The action plan at Section 4 refers to the possible preparatory work needed.

	Total Active Cases	**Granted**	**Granted (%)**	**Not Granted**	**Not Granted (%)**	**Withdrawn**	**Yet to be signed off**
2018/19	810	600	74%	55	7%	n/a	155
2017/18	1078	684	94%	35	5%	6 (1%)	353
2016/17	957	893	93%	51	6%	13 (1%)	0
2015/16	778	644	83%	88	11%	46 (6%)	0
2014/15	384	304	79%	66	17%	14 (4%)	0

‘Active application - an application is considered active from the date it is received until the date it is either formally withdrawn, not granted or the granted authorisation comes to an end.’

2.3 HSAB Resources

As at 31st March 2019, the staff and resources supporting the work of the HSAB are:

1 Service Manager (Safeguarding Adults and DoLS)

1 Safeguarding Adults Co-ordinator

In addition to staff, there are ongoing costs for the multi agency training programme; best practice forums; publicity (posters/fliers/wallet cards); awareness/briefing sessions; independent file audit; independent interviews with users; and administrative support to the HSAB etc.

The costs of these services are primarily borne by the People Services Department within Harrow Council, with contributions totalling circa £21,000 p.a. from three of the four local NHS partner agencies (Harrow Clinical Commissioning Group; London North West Hospitals NHS Trust; and the Royal National Orthopaedic Hospital Trust); the London Fire Service and Metropolitan Police. Costs related to the time spent by partner agencies on HSAB activities e.g. attending meetings, facilitating staff release for training etc, are borne by the individual member organisations.

Central and North West London Mental Health NHS Foundation Trust (CNWL) Under the formal Section 75 agreement there are also a number of trained Safeguarding Adults Managers with a dedicated lead located in Central and North West London Mental Health NHS Foundation Trust (CNWL). The statistics for the CNWL Safeguarding Service are included in section 2.2 of the annual report.

2.4 Metropolitan Police update

The Metropolitan Police Service is key member of the partnership, working in collaboration towards a shared vision and joint objectives, improving outcomes for vulnerable members of our community.

In November 2018, the police areas of Barnet, Brent and Harrow merged to form the North West Basic Command Unit (NW BCU) operating a single command structure across the three boroughs. There are 12 BCU's across London, bringing together other boroughs to improve service delivery and reduce inefficiencies. Within the BCU command structure, there are five portfolios – Emergency response, Neighbourhoods, Safeguarding, Local Investigations and Head Quarters.

In February 2019, the NW BCU Safeguarding model launched, embedding former Child Protection (CAIT) and serious sexual offence (Sapphire) teams firmly within NW Safeguarding operating model. The key principle behind this change is, bringing together, complex investigations with volume crime to improve outcomes and the victim experience. Frequently, domestic abuse investigations involving children, or sexual offences, were been investigated by two, sometimes three different investigators. This was inefficient and demoralising for both the victim and investigators.

Co-locating investigation teams means, one investigating officer will lead the investigation throughout its life cycle, without diminishing the availability of skilled staff to support other crimes and investigation, improving outcomes and satisfaction for vulnerable victims.

The NW Safeguarding portfolio has thematic areas, with a Lead Responsible Officer for each area. This ensures there is a subject matter expert for each theme, responsible for training and staff development, supporting partner meetings, quality assurance and audit for the NW BCU.

Child abuse referral teams are co-located within the Multi-Agency Safeguarding Hub (MASH), at three local authority sites, to ensure there is one front door for partner agency referrals, improving information sharing, case analysis and attendance at strategy meetings and child protection conferences. This is the same route adult referrals are made via our MERLIN system, whether they are victims of crime or have been identified as vulnerable.

The MPS will continue to train all frontline and custody staff to recognise people who are ill, vulnerable or in crisis; signposting them to help through the Adult Coming to Notice (ACN) referral process, or MERLIN for cases of missing, exploitation, vulnerability or involved in crime. Regular engagement with awareness campaigns and partner training helps to equip police officers and staff with the right skills to recognise illness and vulnerability, such as; dementia, modern slavery, criminal exploitation and mental illness.

During the BCU transition, three borough based Missing Persons Units (MPU) were consolidated into a single larger unit, bringing together a range of expertise, located at Colindale Police Station, to ensure they are close at hand to offer support and advice to control room staff and initial response officers. Since go-live in February the overall outstanding cases halved due to the new workflow processes and highly skilled officers working closely together.

The Metropolitan Police will work alongside partners to take advantage of the new safeguarding partnership arrangements in response to the Children & Social Work Act 2017 and Working Together to Safeguard Children (2018). Introducing long-term plans with the Local Authority and Clinical Commissioning Group, to reduce the prevalence and impact of adverse childhood experiences that can culminate or result in contact with policing. Police officers and staff have a distinct position in the community, in particular through their role as first responders at high harm incidents. This understanding will improve the multi-agency response to children and vulnerable people.

2.5 Learning Disability Mortality Review (LeDeR) programme

The Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 to support local areas across England to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice.

CCGs are expected to work with their local partners including people with a learning disability, families and carers, local authorities and NHS trusts. CCGs have a responsibility to improve the quality of the health and social care services provided to people with a learning disability, and to address the persistent health inequalities people often face.

It is of great concern that the latest LeDeR national report cites deaths reviewed where there were concerns about the quality of care, and an average age of death that is 23 years younger than the general population for men with a learning disability and 27 years younger for women. The report stated that, of the LeDeR cases reviewed to date, the most common causes of death were pneumonia, sepsis and aspiration pneumonia. Mortality reviews also indicated that issues such as constipation, the failure to recognise physical deterioration, and the application of the Mental Capacity Act applied to physical health issues were also significant factors in avoidable deaths.

The LeDeR programme provides a framework for making sure that local service improvements are being made in response to learning from deaths.

Harrow and Brent CCG

There is an established joint LeDeR steering group for Harrow and Brent. The Designated Nurse for Safeguarding Adults (Harrow CCG) is the Local Area Contact and Co-chairs the Steering group. The role of the LeDeR Steering Group is to:

- look into the reports of completed reviews presented by the reviewers or Local Area Contact . These reports are anonymised
- identify the gaps in practice and put action plans in place
- monitor actions and outcomes
- respond to recommendations with the aim of improving service provision and reduce likelihood of premature deaths
- demonstrate evidence of the changes
- recognise and share best practice and innovation

In the year 2018/2019 there were 10 cases allocated to Harrow. Five of these reviews have been completed and signed off. One of the reviews is on hold as it is going through a multiagency review.

Summary of the Harrow Review

Ethnicity: White British 6; Asian 3; White Other 1

Place of death: Hospital 6; Residential/Nursing Home 2; Hospice 2

Cause of death secondary to respiratory problems: 5

Cause of death secondary to circulatory problems: 3

Other e.g. epilepsy: 2

The process gives the following assurances to SABs:

- that all known deaths of people with learning disabilities receive a review of the full range of circumstances leading to death;
- that there is an effective route of escalation to the SAB if a wider safeguarding issue is detected that would require consideration by the SAB under its safeguarding adults review duties; and
- that there is an effective mechanism for SABs to share information and direction to services for people with learning disabilities within the local system

2.6 Learning Disability - institution based abuse

In the years since the abuse at Winterbourne View in 2012 there has been a large amount of focus across the UK by safeguarding boards, Council and NHS staff to ensure that the abuse faced by the patients in that setting would not happen again. Sadly, in May 2016 abuse was uncovered at Mendip House run by the National Autistic Society with a range of findings similar to those seen at Winterbourne View. In May 2019 the Durham Police started to investigate ‘physical and psychological abuse’ allegations at Whorlton Hall (Cygnet Healthcare), County Durham which led to 16 of the 85 staff being suspended.

Section 4 below contains an action for the Harrow SAB in relation to these issues of significant concern.

SECTION 3 – MAKING A DIFFERENCE
(Progress On Objectives 2018/2019)

The next section of the report looks at what difference the work of the HSAB made last year by reviewing progress on the priorities agreed for 2018/2019, as set out in the annual report for 2017/2018.

In addition to contributing to the HSAB priorities (highlighted in section 3.2 below), all member organisations have also progressed their own safeguarding priorities and reports on that work are available through the relevant representative on the Board.

3.1 Training and Workforce Development

Multi-agency training remains a high priority for the HSAB. As a supplement to the formal training programme, the Safeguarding Adults and DoLS Service also ran briefing sessions across a range of agencies, offering most at the organisation's premises.

The details are as follows (see next page):

Training – multi agency formal courses	2018-19
Harrow Council Internal	111
Health	34
Statutory (other)	2
Private sector	90
Voluntary sector	104
HSAB Board Development	100
SGA Team Development	28
Partner Training: CNWL	10
Total:	**479**

SGA Team Briefing Sessions

Afghan Association - Scams & Fraud	22
Bereavement Care - Scams & Fraud	59
Domiciliary Care Agency Staff / Providers	20
Harrow Mosque - Scams & Fraud	35
MIND Staff & Volunteers	39
Neighbourhood Champions	90
Neighbourhood Champions - Scams & Fraud	26
Somali Voluntary Organisation - Scams & Fraud	28
Elected Councillors (LBH)	32

Good Practice Workshops / Events / Conferences

BIA Legal Update / Refresher Courses	24
Mental Capacity, DoLS and Safeguarding	15
HSAB/HSCB Joint Annual Conference - Modern Slavery & Human Trafficking	154
Self Neglect & Hoarding (Learning from Policy and Practice)	20
Social Work Conference	94
WEAAD 2018 - (Non-engaging Adults, thinking beyond Mental Capacity).	45

Community & Service User Briefings

Harrow Baptist Church - Scams & Fraud	23
Trinity Church Community Group	23

GP / Doctor / Medical Centres

GP Briefing	19

Total Briefings	**768**

Total (all sessions) 1247

Each year the training programme and Best Practice Forums are developed from the evaluation and experience of the previous year's sessions. Last year there was a focus on scams and fraud with particular reference to older people.

Analysis of the attendance across the range of events suggests that the uptake of best practice forums and on-site "bespoke" sessions is greater than for the commissioned multi-agency formal training programme. Consequently, for 2019/2020 the HSAB has agreed to trial a shift in emphasis away from the formal classroom events and on to the one-off sessions which can be tailored and set up more quickly to address themes emerging from casework audits or SARs etc. A decision can then be taken about the best approach in future years.

HSAB member organisations' training activity

Each of the organisations represented on the HSAB also carry out their own training programmes to ensure that their staff are up to date. An example from Central London Community Healthcare NHS Trust: "our training compliance in Harrow at the end of March 2019 was generally above 90%, including a "Workshop to Raise Awareness of Prevent (WRAP)" training; Level 2 adult safeguarding training was 88% at the end of March 2019, but is now 95%. We have reviewed our training to include level 3 MCA and adult safeguarding to comply with the RCN Intercollegiate Guidance 2018.

We are using the 7 minute briefings to embed learning across our teams and in training and have shared SAB cases with frontline staff. We have had a good response to the use of this resource in training and will continue to share learning using cases and patient's voices and experience. Hearing 'Miriam' speak at the HSAB safeguarding conference was so powerful regarding her being a victim of modern slavery and we are hoping she will speak at our safeguarding conference in October 2019".

Another example from London Northwest Healthcare NHS Hospital Trust: "LNWHT is located across the London boroughs of Harrow, Ealing and Brent, these three boroughs are identified as PREVENT priority localities. In 2018/19 the Trust continued to prioritise PREVENT training for the workforce. The number of staff trained with the 'Workshop to raise the Awareness of Prevent (WRAP)' training at 85.4% currently exceeds the target set by NHS England at 85%".

Safeguarding Adults Board Conference 2019

The HSAB and HSCB held their third joint conference in January 2019 (this time in collaboration with the Safer Harrow Partnership) with a focus on the trafficking of adults and children into slavery and exploitation. See below for details.

Progress on objectives in 2018/2019

Principle One: **Empowerment**	**Description:** *Presumption of person led decisions and informed consent*
Objectives and how they will be achieved and measured	**Actions**
The HSAB ensures effective communication with its target audiences Impact and effectiveness are evaluated and influence changes to future campaigns	A range of methods are used throughout the year to provide information to all sections of the community with a focus on people/groups highlighted in the statistics (e.g. older people living in their own home and about the risks of financial abuse)
The Harrow SAB's work is influenced by user feedback and priorities User feedback at annual review events reports progress on agreed projects	Further attempts are made with Head Teachers to engage with young people and adults at risk – in relation to disability awareness and social inclusion

Mind in Harrow

Mind in Harrow provided induction training to over 50 new volunteers in awareness of safeguarding adults and how to report a safeguarding concern. Mind in Harrow's education course programme provided the Met Police 'Little Book of Big Scams' section on online scams and an information sheet about safeguarding to over 200 people with mental health needs to increase awareness. 100% of service users self-reported feeling safe and supported while using Mind in Harrow's services and 99% felt staff and volunteers treat service users with respect and dignity.

The Council's Safeguarding Adults Coordinator widely promoted the "little book of big scams" produced by the Metropolitan Police/Home Office.

The Council's September 2018 edition of "Harrow People" magazine which is delivered to all households in the borough included an article titled "Safe From Scams" which (through the fictitious story of Naveen) explained how the safeguarding adults team can assist elderly or disabled people at risk from this type of crime.

The Council's Safeguarding Assurance and Quality (SAQ) Team newsletter in June 2018 covered a range of topics including: "Dignity Day 2018"; training information e.g. diabetes, dementia/challenging behaviour; falls and recognising the deteriorating resident. There was also an article from the safeguarding adults team about "dignity and safeguarding" in relation to prevention.

The Council's safeguarding adults web pages are well used with (for example) 13,622 visits about organisational abuse and 5,521 about discriminatory abuse. It is difficult to be sure which individuals are accessing the website but if even a small proportion are people with care/support needs or their families then it is very positive.

In the Council an independent/external social worker continued to interview users at the point of the enquiry being concluded. Her questions were focused around the Making Safeguarding Personal areas about involvement in the process and outcomes. All feedback is given to the Team so that practice continues to develop. The retiring social worker has provided a summary report at the end of her involvement which shows an average 65% response rate which is excellent in the context of most surveys which rarely obtain more than 30 – 40%. The overall majority of respondents felt "heard" and are pleased that their issues are taken seriously, however "safeguarding" remains a term that many people don't understand but when described as "helping them to keep safe" they are more pleased with the process. The main challenge (also highlighted in audit reports) is the need to express the outcomes desired by users in a more measurable way. A new independent external auditor for user interviews has been recruited and started in June 2019.

Harrow Mencap

Harrow Mencap is a campaigning organization, as well as being a service provider. In addition to our target audience being clients who use our own community support services, we also strive to communicate with a much wider group, helping to raise awareness about the rights of disabled people and their families. We support people with challenges and barriers they face and to get their voices and concerns heard on a number of issues at various levels.

One initiative/collaboration we have been involved with has been helping to develop a carers groups. These groups meet with Harrow Council officers, sharing their thoughts and concerns on some key issues such as housing, support with accessing supported living and residential services. They have also delivered training and events in some of the areas where carers have shared worries and concerns (in collaboration with the council) which have been delivered to a wider group of clients/carers/ staff.

Harrow Mencap have a number of mechanisms for communicating with our target audience around their rights, quality of services we provide and empowering individuals to stay safe. This includes: forums, surveys / complaints process and policy / advocacy / external audits / CQC inspections / regular monitoring calls to families and clients / Harrow safeguarding assurance team / carers groups swish / safeguarding leads and group / Internal audits.

Feedback has been obtained through these mediums and evaluated. This has helped to shape HM policy and fed back to HSAB to help gain local intelligence.

Principle Two: **Prevention**	**Description:** *There is a culture that doesn't tolerate abuse, dignity/respect are promoted and it is better to take action before harm occurs* *Communities have a part to play in preventing, detecting and reporting neglect and abuse*
Objectives and how they will be achieved and measured	**Actions**
The HSAB is reassured that partnership priorities are informed by local intelligence about risk and prevalence Performance reports at quarterly Board meetings and the annual review day provide more detailed analysis – informing decisions about future campaigns	Change the reporting to the HSAB such that routine performance information (e.g. repeat referrals, Police action, modern slavery) is highlighted on an exception basis only Focus to be on more "deep dive" statistical reports in areas of interest/concern to the HSAB e.g. sexual abuse by location
The Harrow SAB ensures that community safety for adults with care/support needs is a high priority for action Numbers of home fire safety checks increase from the 2017/18 out-turn position	Relevant campaigns take place each year (e.g. a focus on scams, door step crime, distraction burglary) and formal evaluation influences future activities Work continues with care providers and the general public about fire safety

The Harrow SAB ensures that dignity is a high priority for local care providers More Providers in Harrow improve their CQC rating each year	Provider concerns are monitored at Board meetings and commissioners oversee quality assurance Providers are supported with relevant information/training
The Board supports elected Councillors and others in similar roles to recognise abuse and report their concerns	Provide annual training/refresher events for elected Councillors and those in similar roles across partner agencies

Statistical reports to the HSAB continued on a quarterly basis but were exception reports. There were 3 "deep dive" reports in 2018/19 with a focus on sexual abuse by location and national comparisons (twice). CNWL had also carried out a further analysis of the financial abuse statistics following the deep dive report presented to the HSAB in March 2018.

Numbers of referrals for **home fire safety checks** to the local Fire Service via the safeguarding adults team fell last year to 12 which is disappointing given the level of priority for fire related issues at the HSAB. Following a fatal fire, a "learning the lessons" event was held in March 2018 which generated 2 main recommendations: (1) that HSAB along with LFB review its procedures for alerting LFB about fire risks to ensure that threats to cause fire are treated in much the same way as a visible fire hazard as a trigger for a referral; and (2) the HSAB reviews its practice in relation to information sharing in those cases where a service user, who has previously had dealings with one or more service provider, subsequently refuses to engage with the LA in their attempts to conduct a needs assessment.

The Council's Safeguarding Assurance and Quality (SAQ) Team ran training sessions for local care Providers: pressure ulcer prevention x 3 sessions (120 people); diabetes awareness x 3 sessions (115 people); six month falls champion course (38 people); dementia challenging behaviour (100 people). Total 373 attendees in 2018/2019. In addition, 35 care homes in Harrow had an onsite talk from the OT falls specialist.

In June 2018 the **Council's Safeguarding Adults Team** provided a training session for 32 elected Councillors.

In the NHS Prevent Data is collated on a quarterly basis by the Provider Organisations for the NHSE and also the PREVENT Lead in the CCG for scrutiny. It assists Providers in identifying potential areas for development and provides Clinical Commissioning Groups with an assurance framework on which they monitor their commissioned providers' delivery of the Prevent Strategy.

The NWL CCGs quality assurance visits are intended to be supportive and the overall objective is to work with providers for continuous improvement. It is not a regulatory process and as such does not rate the performance or the quality of a service that is visited. The outcome of quality assurance visits can change and influence both the practice of individual provider services and the CCG's commissioning intentions/decisions. In Harrow some of the Providers visited included Harrow Health Community Interest Company, St. Luke's Hospice, Harrow Women's health centre and Mind in Harrow. As a result of these safeguarding and quality assurance visits, policies and processes have been modified and updated and appropriate staff have had their skill levels improved.

Harrow Mencap has 6 safeguarding leads, including managers, divisional heads and the Chief Executive. The safeguarding leads meet as a group on a quarterly basis. There is a direct link to HSAB as our chief executive sits on both groups, so always shares information where appropriate. We carry out a critical analysis of all safeguarding referrals/reports. The critical analysis influences policy, training and practice. Harrow Mencap staff all attend safeguarding training delivered through Harrow Council. The training is good quality and covers a range of safeguarding topics.

Harrow Safeguarding Quality Assurance Team also carry out an annual audit of our CQC registered service, carrying out a thorough inspection providing feedback and advice. There is a direct link to CQC as the report is also shared sent to them by the Safeguarding Assurance Team. This inspection also involves getting direct feedback from clients and carers and getting feedback from our own annual questionnaires/surveys.

Mind in Harrow promoted the free scams and fraud awareness sessions offered by the NatWest Harrow & Wembley Community Banker to 20 local voluntary sector and mental health providers. Mind in Harrow facilitated 4 scams and fraud awareness sessions attended by over 50 of their service users, reporting positive feedback from participants.

London Northwest Healthcare NHS Trust - Modern Slavery and Human Trafficking abuse was incorporated in Adult safeguarding Training. Staffs across Children's and Adult Safeguarding Service have completed the London ADASS & NHS England "Train the Trainer: Human Trafficking and Modern Slavery Multiagency Awareness Raising Training". Domestic abuse awareness has been firmly incorporated into the training provided to Trust staff with two Independent Domestic Violence Advocates (IDVA's) employed in the Emergency Rooms at both Ealing and Northwick Park Hospitals. The IDVAs provide support to patients attending the hospital and act as a crucial resource for front line staff delivering care.

The Hospitals' adult safeguarding team has been involved in the Trust's commitment to improve care provided to patients with dementia. In the past year the team contributed to the development of a new patient pathway for patients suffering with confusion. Additionally the Trust has signed up to John's Campaign which enables relatives and carers of patients, who are suffering with dementia, greater access to the hospital outside of normal visiting hours. The Trust currently employs a Learning Disability Specialist Nurse. The nurse oversees the delivery of training and education to Trust staff, recently setting up and training a team of learning disability (LD) champions within the nursing workforce. The service provided by the LD nurse includes the assessment and support of patients with Learning Disabilities attending the Trust for care.

Principle Three: **Proportionality**	**Description:** *Proportionate, person centred and least intrusive response appropriate to the risk presented (best practice)*
Objectives and how they will be achieved and measured	**Actions**
The HSAB has an effective Quality Assurance framework in place which includes relevant approaches to overseeing effective practice Demonstrable changes in practice are evident through file audit, user interviews and as presented by experts by experience at the HSAB Review Day and other relevant partner events	A minimum of 40 externally audited and 30 internally audited cases will be completed each year; and independent user interviews will take place – with a focus on ensuring that a person centred approach to practice (including use of advocates) identified the outcomes desired by users Audit reports will be taken to the HSAB with any required actions and proposed recommendations
Staff are confident in balancing risks with user empowerment	Audit findings, user feedback, SAR actions and Risk Panel learning to be fed into the Multi-agency Training Programme and Best Practice Forums Work continues to take place to increase staff confidence (in all agencies) in completing mental capacity assessments and using DoLS/Court of Protection

Learning is embedded in practice and leads to continuous service improvement The multi-agency safeguarding adults training programme is updated annually based on formal evaluation; and learning from audits, user feedback and SARs	The approach to multi-agency safeguarding adults training is changed in 2019/2020 – to run more best practice forums and bespoke events (on emerging topics) - with recommendations for future programmes reported to HSAB in March 2020
The Harrow SAB is reassured that Making Safeguarding Personal (MSP) is well embedded in practice There is a reduction in "not known" and "other" outcomes recorded at the end of safeguarding enquiries Return is made to NHS Digital	Work is completed to investigate if the Jade (or its replacement) and Mosaic systems can record the more diverse variety of outcomes likely to be achieved for adults at risk through MSP HSAB is provided with quantitative data (in addition to the existing qualitative information) about MSP outcomes (based on the return to NHS Digital)

The **Council Mosaic Team** has made a number of adjustments to the data recording system so that in future it should be possible to capture the MSP outcomes.

The training statistics demonstrate that greater numbers attend one-off best practice forums and conferences than the formal/scheduled training events. Examples include the conference held on 15th June 2018 to mark World Elder Abuse Awareness Day 2018 which covered the learning from Safeguarding Adults Reviews (SARs) where the people harmed were hard to engage and delegates heard about legislation that can be used which is outside the usual (social care) framework e.g. Environmental Health powers.

In the Council the practice of inviting an external independent auditor to review casework twice a year continued. In parallel internal routine monthly audits were carried out by the Team Manager. The independent audits took place in May and October 2018 and the areas for focus agreed with the auditor were: complex cases as they are the ones that worry social workers most and (arguably) have the most to learn from; a couple of "institutional concerns" enquiries as they are challenging and most staff/managers have less experience in running them given the low numbers; and at least one case from each worker in the Team so there is external oversight of practice. The other agreed focus to review MSP practice was: were outcomes identified at the outset by the adult at risk?; was the mental capacity assessment recorded where required?; and was the adult seen / spoken to as part of the enquiry?

The key findings were:

Strengths - excellent collaborative work with other relevant professionals including SAQS team, care management and children's social care; generally mental capacity issues are addressed, recorded and for one complex case a specialist assessment was commissioned; appropriate unannounced visits were made as a way of extending enquiries; recording is comprehensive and important case notes are usefully typed in bold to highlight; safeguarding meetings are fully and consistently minuted; enquiry reports are now routinely written using the standardised template, making a significant improvement to the quality of the recording of key information including better reference to previous safeguarding concerns and enquiries; managers and supervisors continue to fully support the work and supervision is recorded more fully; and there is evidence of reflection and analysis in both safeguarding meetings and supervision.

Areas for development **- s**ome complex enquiries would benefit from a more detailed and structured plan; better clarity is needed on some cases about the role of the enquiry officer and how much general social work tasks are taken on during the enquiry; and risk assessments need reviewing when new safeguarding concerns are raised.

Harrow Clinical Commissioning Group (CCG) - for 2019-20 NW London CCGs have developed the Safeguarding Health Outcomes Framework as a consistent reporting framework for providers to enable a clear picture of Safeguarding Adults and Children across North West London and one that provides assurance for the CCGs, Trust Boards, Local Safeguarding Children Boards (LSCB) and Local Safeguarding Adult Boards (LSAB). This document sets out the strategic approach required to ensure safe and effective Safeguarding processes are in place, hence strengthening the arrangements for Safeguarding Children and Adults across the commissioned health services of eight North West London CCGs; Brent, Harrow, Hillingdon, Central London, West London, Hammersmith and Fulham, Hounslow and Ealing.

The CCGs aim to commission services that protect individual human rights, promote dignity, independence and wellbeing, hear and respond to the needs of children, young people, adults and carers and demonstrate assurance that any child, young person or adult with care and support needs, is safeguarded and protected from harm, neglect and/or abuse.

Central London Community Healthcare NHS Trust (CLCH) - it has been a positive but challenging year for the CLCH adult safeguarding team due to the increasing volume and complexity of cases of concern our staff are identifying and ensuring they are supported to work in partnership with service users and their families to promote independence, and positive outcomes. There has been continued investment in adult safeguarding within the Trust and we have successfully recruited a dedicated MCA Lead to support the Trust in implementing the MCA/ Liberty Protection Safeguards. We have undertaken audits into the application of the MCA and use of the Pressure Ulcer Protocol (PUP) by our Harrow staff.

We can evidence staff have improved knowledge of applying the MCA and using the PUP to support safe and effective care. There has been an increase in frontline teams contacting for safeguarding advice and support and evidence they complete the safeguarding pressure ulcer protocol (PUP) so they respond to and manage risk appropriately.

Our second Annual Safeguarding Conference in October 18 was really well received. We had a broad range of speakers covering both Children's and Adults Safeguarding and the feedback was positive from staff. The conference covered topics such as self-harm in schools, the Mental Capacity Act 2005, Prevent, and Hoarding and Self-neglect, Homelessness, Modern Slavery, a legal update and the CLCH Safeguarding Champions programme.
Our training compliance in Harrow at the end of March 2019 was generally above 90%, including Workshop to Raise Awareness of Prevent (WRAP) training); Level 2 adult safeguarding training was 88% at the end of March 2019, but is now 95%. We have reviewed our training to include level 3 MCA and adult safeguarding to comply with the RCN Intercollegiate Guidance 2018.

We are using the 7 minute briefings to embed learning across our teams and in training and have shared SAB cases with frontline staff. We have had a good response to the use of this resource in training and will continue to share learning using cases and patient's voices and experience. Hearing 'Miriam' speak at the HSAB safeguarding conference was so powerful regarding her being a victim of modern slavery and we are hoping she will speak at our safeguarding conference in October 2019.

We continue to support the Harrow SAB in developing and achieving the Board priorities of empowerment, prevention, proportionality and protection.

Central and North West London Mental Health NHS Trust - staff are confident in balancing risks with user empowerment – this is addressed at the monthly Safeguarding Forums held at Bentley House (Bi-monthly with Cygnet Hospital and Cygnet Lodge). Plan in place to organise monthly surgeries at NPH with staff in acute services.

Best Practice Forums – Monthly Social Work Forums and Band 5/newly qualified staff (Health & Social Care) continues to take place to increase staff confidence and learning is embedded in practice. Mental capacity assessments forms an integral element of the safeguarding process and using DoLS/Court of Protection considered as part of the protection plan.

In terms of in-patient services and CNWL commitment to reduce restrictive practice the Violence Reduction Work that is being undertaken to decrease use of restraint on in-patient wards is having good effect. Some very innovative interventions supporting this around sleep hygiene use of sleep apps and travel masks. Good sleep patterns promotes more positive interactions and less incidents on wards.

CQC spotlight has been on sexual safety in MH wards and CNWL have been acknowledged nationally for being ahead of things with our sexual safety leaflet that is now on version 2. Well received by service users and carers alike.

Harrow Mencap carries out folder audits ensuring care planning documents/risk assessments/annual reviews are up to date/identifying any gaps and taking corrective action. We have also commissioned an external audit from an independent company called Competitive Insights who have sought feedback from key stakeholders including clients/families/Harrow Council/Staff/ Managers.

Changes in practice have included new internal and external bulletins for improved communication / /Carer's forums/ Clients signing off on important documents/clients involvement in recruitment.

Mind in Harrow's User Involvement Project Coordinator facilitated 4 Mental Health Service User Representatives of the Harrow User Group (HUG) to present a user challenge at the Safeguarding Adults Board awayday June 2018. Improvements requested by User Representatives included MSP and responses to allegations of sexual abuse raised by mental health inpatients. As a result, a deep dive of sexual abuse allegations data and MSP outcomes were reported to the HSAB and Mind in Harrow is contributing to the learning from a mental health inpatient case study example. Mind in Harrow staff attended the joint safeguarding adults and children's conference in February 2019, increasing their awareness and understanding about trafficking and modern slavery in UK. Mind in Harrow staff who attended the conference shared their learning with the wider team of 15 staff.

Mind in Harrow completed the voluntary sector version of the NHS England/ADASS Risk Audit Tool in 2019 and identified potential areas of improvement for future action including how safeguarding can be better embedded in supervision practice.

London Northwest Hospitals NHS Trust - provides its staff with a number of safeguarding related training courses, a variety of training methods are used to deliver the sessions, these include e-learning and face to face teaching sessions. In 2018/19 the Trust delivered training across all three required levels of safeguarding training. The Trust acknowledges that there is further work to do in respect to the workforce development and will continue to focus on adult safeguarding training in the year ahead.

Principle Four: **Protection**	**Description:** *Support and representation for those in greatest need*
Objectives and how they will be achieved and measured	**Actions**
The HSAB is reassured that adults at risk are empowered to raise concerns from any setting (including in-patient units and care homes) and that advocacy is being sought and provided to those that seek it as part of the safeguarding adults enquiry process	Projects are implemented as highlighted by users e.g. task and finish group or learning review for CNWL in-patient services; and presentation by Public Health about their role with reducing social isolation

Harrow Mencap – the Harrow Safeguarding Assurance Team have been in and met with our clients to raise awareness safeguarding how to share a safeguarding concern. This was well received by our clients and informative. Harrow Mencap deliver quarterly forums for people with learning disabilities which have included sessions on mate crime, speaking up. Harrow Mencap provides Care Act Advocacy support, referrals from Harrow Council, other professions, Swish. We have been in and met with various social work teams in order to ensure people understand about the service and how to access it.

Several Harrow Mencap team members attended the annual safeguarding conference focusing on modern slavery. We found it informative relevant and at times gripping. We all thoroughly enjoyed the event.

Harrow Council Safeguarding Team and the Police coordinated a successful prosecution (resulting in a custodial sentence) last year of a son who had systematically coerced and controlled his parents to give up both money and their home to him.

Principle Five: **Partnership**	**Description:** *Effective partnership working ensures a "whole family" approach leading to the best possible outcomes for users* *Effective partnership working ensures an effectively coordinated approach leading to the best possible outcomes for users*
Objectives and how they will be achieved and measured	**Actions**
The HSAB is effective as a partnership	HSAB monitors the actions resulting for each agency represented on the Board from the NHS England/ADASS Risk Audit completed in 2017/2018
The HSAB and HSCB work collaboratively ensuring a "whole family" approach to safeguarding work Joint projects (e.g. annual conferences, training events, community outreach, work with schools) will be explored wherever possible - to optimise both resources and outcomes	A third joint HSCB HSAB conference will be held in 2018/2019 with a focus on "trafficking and modern day slavery"

The HSAB and HSCB held their third joint conference in January 2019 (this time in collaboration with the Safer Harrow Partnership) with a focus on the trafficking of adults and children into slavery and exploitation. There were 150 attendees from across a range of agencies and topics included:

- modern day slavery "eradication is our duty" (Kevin Hyland)
- a partnership approach to combating modern slavery (Ruth Van Dyke)
- the voice of a victim (Miriam)
- national and local challenges (Tamara Barnett)
- supporting the human rights of trafficked individuals (Philip Ashola)

A follow up survey was completed 3 months after the event to track what actions delegates have taken prompted by the learning on the day.

Council's Children and Young People's Service (CYPS) - in the Council's Children and Young People's Service (CYPS) the HSAB's information is cascaded through the workforce for consideration for practice / training e.g. home fire safety assessments/information from the fire brigade / sharing information when missing adult notifications are received into CYPS. User feedback, which includes adults, is considered in the Annual Reports of the Independent Reviewing Officer Service, Child Protection Conference Service, LADO Service, and CYPS QA Annual reports. The agreed data set in the HSCB includes relevant adult facing issues e.g. Domestic Violence. CYPS has developed a National Referral Mechanism flag in MOSAIC that records referrals which will include risks associated with modern slavery.

HSCB/CYPS have contributed to QA activity where multi-agency audits have included Adult Services - so that practice learning is drawn out both from adult and children's services perspectives. One recent example is CYPS contributing to the multi-agency review of an adult death caused through fire setting. The Adult Services training programmes are cascaded across CYPS on a regular basis so that there is alignment of associated training priorities.

Principle Six: **Accountability**	**Description:** *There is accountability and transparency in delivering safeguarding. The Board meets its statutory requirements as set out in the Care Act 2014.* *Learning from local experiences and national policy/research improves the safeguarding arrangements and user outcomes*
Objectives and how they will be achieved and measured	**Actions**
The statutory HSAB Annual Report is produced	HSAB receives the Annual Report within 3 months of the end of each financial year
The HSAB Annual Report is presented to all relevant accountable bodies	Presentation is made to Scrutiny Committee to include progress against the previous year's action plan and objectives for the coming year All partner agencies present the Annual Report to their Board (or equivalent) within 3 months of the agreement by the HSAB

	Presentation is made to the Harrow Health and Wellbeing Board with particular reference to progress on agreed joint priorities and recommendations for the coming year
Elected Councillors, Executives and Committee members in HSAB agencies are aware of their personal and organisational responsibilities	Briefings are provided on a quarterly basis by HSAB members to their organisations at a senior level sufficient to ensure ownership of the issues and leadership to agree any changes required
The general public is aware of safeguarding issues and the work of the HSAB Relevant staff are aware of safeguarding issues and the work of the HSAB	The HSAB Annual Report for 2018/19 is published in an "easy to read" format and posted on all partner websites The HSAB Annual Report for 2018/19 is published in "Executive summary" and "staff headlines" formats and posted on all partner websites

The HSAB's 11th Annual Report (for 2017/2018) was presented to the Council's Scrutiny Committee on 16th October 2018 and this 12th report for 2018/2019 will go to a Scrutiny meeting on 5th November 2019. It was also presented at the health and Wellbeing Board on 1st November 2018. Each partner organisation represented at the HSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent.

As in previous years, the 2017/2018 report was produced in "Executive Summary", "key messages for staff" and "easy to read" formats and was made available to a wider audience through the Council and partner agencies websites.

In the Council a quarterly safeguarding update was provided to the Leader, the Chief Executive and portfolio holder by the Corporate Director (People Services) and the Director of Adult Social Services (DASS) in April, July and October 2018, and February 2019.

Section 4: Action plan priorities – 2019/2020 (year 3 from the Strategic Plan 2017 - 2020)

The Board's priorities are developed from analysis of the statistics presented at quarterly meetings; feedback from users; learning from research, audits; and case reviews. They are organised around the four Care Act statutory requirements and six principles.

Principle One: Empowerment *Presumption of person led decisions and informed consent*			
Priorities	**Actions**	**Lead agency/s**	**Timescale**
The HSAB ensures effective communication with its target audiences Impact and effectiveness are evaluated and influence changes to future campaigns	A range of methods are used throughout the year to provide information to all sections of the community with a focus on people/groups highlighted in the statistics (e.g. older people living in their own home)	Safeguarding Adults Service (LBH)	End March 2020
The Harrow SAB's work is influenced by user feedback and priorities Demonstrable changes in practice are evident through file audit, user interviews and as presented by experts by experience at the HSAB Review	Further attempts are made with Head Teachers to engage with young people and adults at risk – in relation to disability awareness and social inclusion Develop accessible information for hospital patients in both mainstream and mental health units about Making Safeguarding Personal (MSP) Develop more "safety hubs" in Harrow	People Services (LBH) and HSCB CNWL and LNWHT Harrow Mencap	End March 2020 End March 2020 End March 2020

Principle Two: Prevention *There is a culture that doesn't tolerate abuse, dignity/respect are promoted and it is better to take action before harm occurs* *Communities have a part to play in preventing, detecting and reporting neglect and abuse*			
Priorities	**Actions**	**Lead agency/s**	**Timescale**
The HSAB is reassured that partnership priorities are informed by local intelligence about risk and prevalence	Use "deep dive" statistical reports in areas of interest/concern to the HSAB e.g. crimes against older people in their own homes	LBH Safeguarding Team	End March 2020
The Harrow SAB ensures that community safety for adults with care/support needs is a high priority for action	Relevant campaigns take place each year (e.g. a focus on scams, door step crime, distraction burglary) and formal evaluation influences future activities	Trading Standards and LBH Safeguarding Team	End March 2020
Numbers of home fire safety checks increase from the 2018/2019 out-turn position	Work continues with care providers and the general public about fire safety	LBH Safeguarding Team	End March 2020
	The recommendations from the fatal fire review are implemented (see section 3 for details)	LFB	End March 2020

Principle Three: Proportionality *Proportionate, person centred and least intrusive response appropriate to the risk presented (best practice)*			
Priorities	**Actions**	**Lead agency/s**	**Timescale**
The HSAB has an effective Quality Assurance framework in place which includes relevant approaches to overseeing effective practice	A minimum of 40 externally audited and 30 internally audited cases will be completed each year; and independent user interviews will take place – with a focus on ensuring that a person centred approach to practice (including use of advocates) identified the outcomes desired by users HSAB members ensure use of the NHSE and ADASS audit tool within their organisations – with actions fed back to the HSAB	LBH Safeguarding Team All HSAB members	End March 2020 Annually
The Harrow SAB is reassured that Making Safeguarding Personal (MSP) is well embedded in practice – demonstrated through file audit, data returns and user feedback at the annual review	Develop accessible information for hospital patients in both mainstream and mental health units about Making Safeguarding Personal (MSP)	CNWL and LNWHT, with the MIND in Harrow HUG Group	End March 2020

Principle Four: Protection *Support and representation for those in greatest need*			
Priorities	**Actions**	**Lead agency/s**	**Timescale**
The Board oversees actions to address the issues highlighted in the national LeDeR report	Training events for Providers are organised on: sepsis; constipation; aspiration pneumonia and mental capacity assessments (with a focus on learning disability services)	LBH Safeguarding Team with Harrow CCG	End March 2020
HSAB has a focus on supported housing so that there are the same safeguards and protection for vulnerable people in these settings as for those in regulated services	Focussed monitoring by the Harrow Safeguarding Assurance and Quality (SAQ) Team, alongside events for Providers about best practice	LBH Safeguarding and DOLS Service	End March 2020
The HSAB is reassured that adults at risk are empowered to raise concerns from any setting (including in-patient units and care homes)	HSAB considers any actions required locally to address the recommendations arising from the investigations into the recent institutional abuse at Mendip House and Cygnet Healthcare The HSAB relaunches the revised self neglect protocol	LBH Safeguarding Team LBH Safeguarding Team	End March 2020 End December 2019

The HSAB is reassured that Liberty Protection Safeguards (to replace the DOLS arrangements) are implemented effectively	Reports provided to the HSAB during the implementation period	LBH DOLS Team with Harrow CCG; CNWL and LNWHT	Autumn 2020
Principle Five: Partnership *Effective partnership working ensures a "whole family" approach leading to the best possible outcomes for users* *Effective partnership working ensures an effectively coordinated approach leading to the best possible outcomes for users*			
Priorities	**Actions**	**Lead agency/s**	**Timescale**
The HSAB and HSCB work collaboratively ensuring a "whole family" approach to safeguarding work	A 4th joint HSCB HSAB conference will be held in 2020 with a focus on "suicide prevention and mental health"	HSCB and HSAB learning and development sub-group	January 2020
The HSAB and HSCB are reassured that there is a robust transition process in place for young people with care/support needs leaving care who have identified safeguarding issues	The existing transition protocol in place for the HSAB and HSCB will be updated and relaunched, incorporating Research in Practice findings/recommendations	HSCB and HSAB sub-group	End March 2020

"Think whole family"	The new joint HSAB HSCB sub-groups to focus on cross over issues: domestic abuse; safeguarding in transition; cross generational work e.g. with schools/colleges	HSCB and HSAB sub-group	End March 2020
Principle Six: Accountability *The Board meets its statutory requirements as set out in the Care Act 2014.*			
Priorities	**Actions**	**Lead agency/s**	**Timescale**
The general public is aware of safeguarding issues and the work of the HSAB	The HSAB Annual Report for 2018/19 is published in an "easy to read" format and posted on all partner websites	LBH Safeguarding Team	End August 2019
Relevant staff are aware of safeguarding issues and the work of the HSAB	The HSAB Annual Report for 2018/19 is published in "Executive summary" and "staff headlines" formats and posted on all partner websites	LBH Safeguarding Team	End August 2019

.....

Appendix 1

Statistic	2015/2016	2016/2017	2017/2018	2018/2019	*National figure (2017/2018)
Concerns	1690	1662 (2% decrease)	1467 (11% decrease)	1403 (4% decrease)	Not available
Concerns taken forward as enquiries	40%	39%	43%	42%	38%
Repeat referrals (enquiries)	19%	31%	17%	16%	16%
Completed referrals (enquiries)	100%	95%	99%	101%	100%
Concerns from non white backgrounds	51%	48%	51%	56%	8%
Where abuse took place	Client's own home (61%)	Client's own home (63%)	Client's own home (57%)	Client's own home (58%)	Client's own home (43%)
	Care Homes (20%)	Care Homes (14%)	Care Homes (19%)	Care Homes (15%)	Care Homes (35%)
User group	Older people (46%)	Older people (48%)	Older people (48%)	Older people (52%)	Older people (45%)
	Physical Disability (40%)	Physical Disability (38%)	Physical Disability (34%)	Physical Disability (38%)	Physical Disability (31%)
	Mental Health (31%)	Mental Health (33%)	Mental Health (31%)	Mental Health (27%)	Mental Health (9%)
	Learning Disability (13%)	Learning Disability (12%)	Learning Disability (13%)	Learning Disability (11%)	Learning Disability (10%)

Type of abuse	Physical (23%)	Physical (19%)	Physical (19%)	Physical (20%)	Physical (22%)
	Neglect (21%)	Neglect (21%)	Neglect (22%)	Neglect (24%)	Neglect (32%)
	Emotional (20%)	Emotional (20%)	Emotional (20%)	Emotional (19%)	Emotional (13%)
	Financial (17%)	Financial (22%)	Financial (19%)	Financial (18%)	Financial (15%)
	Not recorded this year	Domestic abuse (75 cases)	Domestic abuse (86 cases)	Domestic abuse (74 cases)	Domestic abuse - (not available)
	Not recorded this year	Self neglect (14 cases)	Self neglect (28 cases)	Self neglect (21 cases)	Self neglect - (not available)
Person alleged to have caused harm (highest incidence first)	Family including Partner (35%)	Family including Partner (35%)	Family including Partner (41%)	Family including Partner (42%)	Not available
	Social care staff (22%)	Social care staff (19%)	Social care staff (21%)	Social care staff (22%)	Not available
	Not recorded this year	Stranger (4%)	Stranger (5%)	Stranger (2%)	Not available
Outcomes for adult at risk	Increased monitoring (13%)	Increased monitoring (13%)	Increased monitoring (12%)	Increased monitoring (10%)	Not available
	Community Care Services (13%)	Community Care Services (17%)	Community Care Services (20%)	Community Care Services (23%)	Not available
	Court of Protection application (1%)	Court of Protection application (1%)	Court of Protection application (1%)	Court of Protection application (1%)	Not available
	Advocacy (2%)	Advocacy (3%)	Advocacy (2%)	Advocacy (3%)	Not available
	MARAC referral (5%)	MARAC referral (1%)	MARAC referral (1%)	MARAC referral (1%)	Not available

Prosecutions or Police action as an outcome for PACH	12%	16%	14%	12%	Not available

*The 2017/2018 data is the most recent national information available for comparison

Appendix 2

HSAB Membership (as at 31st March 2019)

HSAB Member	Organisation
Florence Acquah	London North West Healthcare NHS Trust (hospital services)
Kate Aston	Central London Community Health Care NHS Trust
Christine-Asare-Bosompem	Harrow NHS Clinical Commissioning Group
Cllr Simon Brown	Elected Councillor (Portfolio Holder), Harrow Council
Barry Loader	Metropolitan Police – Harrow (Vice Chair)
Karen Connell	Harrow Council Housing Department
Julie-Anne Dowie	Royal National Orthopaedic Hospital NHS Trust
Jaya Karira	Westminster Drug Project
Andrew Faulkner	Brent and Harrow Trading Standards
Mark Gillham	Mind in Harrow
Lawrence Gould	Harrow (NHS) CCG – GP/clinical representative
Paul Hewitt	People Services, Harrow Council
Sherin Hart	Private sector care home provider representative
Chris Miles	London Ambulance Service
Marie Pate	Healthwatch Harrow
Alan Taylor	London Fire Service
Nigel Long	Harrow Association of Disability
Coral McGookin	Harrow Safeguarding Children's Board (HSCB)
Tina Smith	Age UK Harrow
Cllr Chris Mote	Elected Councillor (shadow portfolio holder), Harrow Council
Tanya Paxton	CNWL Mental Health NHS Foundation Trust

Deven Pillay	Harrow Mencap
Visva Sathasivam	Adult Social Care, Harrow Council (Chair from December 2017)
Officers supporting the work of the HSAB	
Sue Spurlock	Safeguarding Adults and DoLS Services – Harrow Council
Seamus Doherty	Safeguarding Adults Co-ordinator - Harrow Council

Appendix 3 **Harrow Safeguarding Adults Board** **Attendance Record 2018/2019**

Organisation	June 2018	September 2018	December 2018	March 2019	Total attended
HSAB Chair	√	√	√	√	4
Brent and Harrow Trading Standards	√	√	X	√	3
Harrow Council - Housing Department	√	√	X	√	3
London Ambulance Service	X	X	X	X	0
London Fire Service	X	X	√	X	1
Westminster Drug Project	√	√	√	√	4
Harrow Council - Adult Social Services	X	X	X	X	0
Harrow Council - elected portfolio holder	√	X	√	√	3
Harrow Council - shadow portfolio holder	X	X	√	X	1
Harrow Council – People Services/Children's Services	X	X	√	X	1
Mind in Harrow	√	√	√	√	4
NHS Harrow (Harrow CCG)	√	√	√	√	4
CLCH NHS Trust (Harrow Provider Organisation)	√	√	√	√	4
London North West Healthcare University Hospitals Trust	√	√	X	√	3

Harrow CCG – clinician	√	√	X	√	3
Local Safeguarding Children Board (HSCB)	√	√	√	√	4
Royal National Orthopaedic Hospital	√	√	√	√	4
Metropolitan Police – Harrow (Vice Chair)	√	√	X√	√	3
Age UK Harrow	X	X	X	X	0
Harrow Mencap	√	√	√	√	4
CNWL MH Trust	X	√	√	√	3
Harrow Association of Disabled People	X	√	X	X	1
Private sector provider representative (elected June 2013)	√	X	X	X	1
Public Health	X	X	X	X	0
Department of Work and Pensions	X	X	X	X	0
In attendance					
Care Quality Commission (CQC)	X	X	X	X	0
Healthwatch Harrow (other Board members e.g. from Harrow Mencap and Mind in Harrow are also Healthwatch Harrow members)	X	√	√	X	2

Further information/contact details

For further information about this report or any aspect of safeguarding vulnerable adults at risk of harm in Harrow, the website is:

www.harrow.gov.uk/safeguardingadults

If you would like information or advice (including how to access the multi-agency training programme) the Safeguarding Adults Service can be contacted on the telephone number below or via e-mail at:

safeguarding.adults@harrow.gov.uk

If you are concerned about an adult with care/support needs that might be at risk of harm and want to make a referral for an older person or an adult with a disability, this can be done through Access Harrow on: 020 8901 2680
(ahadultsservices@harrow.gov.uk)

If you are concerned about an adult with care/support needs that might be at risk of harm and want to make a referral for a younger person with mental health difficulties, this can be done through 0800 023 4650 (CNWL single point of access).

(cnw-tr.mentalhealthsafeguardingharrow@nhs.net)

Any enquiries about the Deprivation of Liberty Safeguards (DoLS) including requests for authorisations can be e-mailed to: DOLS@harrow.gov.uk

DoLS requests can also be sent to the safe haven fax: 020 8416 8269.

The address for written correspondence (to either Access Harrow or the Safeguarding Adults and DoLS Service) is:

Civic Centre
PO Box 7,
Station Road,
Harrow, Middx. HA1 2UH