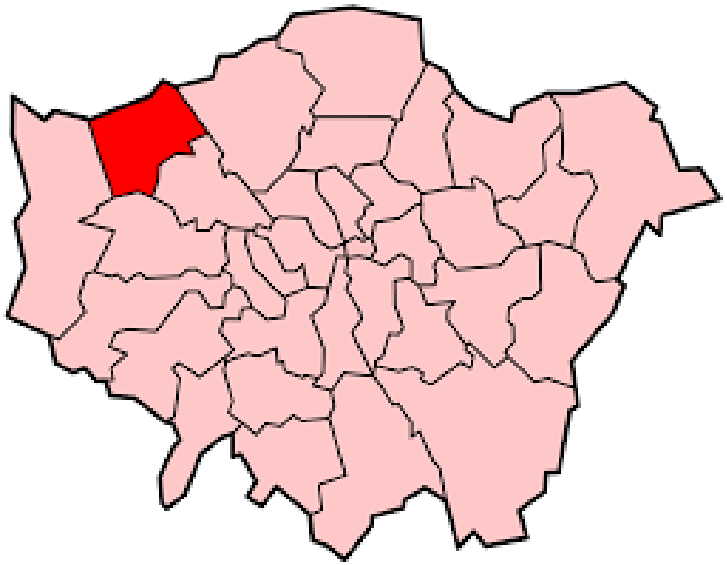
Harrow Safeguarding Adults Board

Annual Report 2020 - 2021



Harrow COUNCIL LONDON

& our Partners,

Committed to Safeguarding Adults

"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)

Harrow COUNCIL LONDON

in partnership with:

HAD – engaging potential – Harrow Association of Disabled People

Harrow age UK

mind – For better mental health

Harrow mencap – Providing opportunity : promoting change

Princess Royal Trust Carers Support Harrow

LFB – London Fire Brigade

Metropolitan Police – Working together for a safer London

NHS

Harrow Safeguarding HSCB Children Board

Foreword

This is Harrow Safeguarding Adults Board (HSAB) 14th annual report. It describes how the Harrow's safeguarding partners have combined their efforts, developed their practice and performed in relation to our most recent strategic plan. Of course, the year has been overshadowed by the Covid 19 pandemic and both statutory and voluntary agencies have had to introduce significant changes to the way they operate in order to carry on their work. This report looks at what the partners did in the face of the pandemic and also has some commentary on how it affected cases being referred to them.

Safeguarding comprises a wide range of issues and activities and to avoid getting stretched in too many directions at once we have focused on three priorities which we share with the safeguarding children board; domestic abuse, mental health and wellbeing and contextual safeguarding. These can be found described in their wider context in our strategic plan 2021-2024[1]. This report describes some of the things that the partnership did to tackle these issues.

HSAB is a coalition of all the statutory agencies and a number of voluntary sector partners, whose work impacts the lives of adults who have care and support needs in Harrow. Our aim is to ensure that when and as we act, we do so in ways that have the best interests of the service user at the centre. Each organisation represented on the HSAB has its own priorities and objectives and our partnership seeks to prevent any one organisation's needs from pulling in the opposite direction to those of another.

This report has a number of important statistics in it. They describe the demographic make-up of Harrow, the levels of reported incidents, where safeguarding issues have been identified and some of the things that the Harrow Safeguarding Partners have done to address the needs of those who are vulnerable.

Think Whole Family is an approach to safeguarding, which seeks to ensure that the work of safeguarding both children and adults with support needs is delivered in a coordinated way. Adults with care and support needs may be the parents or carers of children, whose welfare needs promoting. Children who experience adverse childhood experiences may grow into adults who then have care and support needs. Harrow's partners have identified these important crossover issues and their safeguarding structure, their objectives and their approach to learning and development reflect a determination to cooperate across disciplines. The **Think Whole Family** approach has grown in importance and relevance over the past twelve months and this report describes some of this development. Harrow is fortunate to have a team of committed and experienced professionals and volunteers, whose work to protect the vulnerable makes a genuine difference to the lives of so many. **Chris Miller Independent Chair**

[1] Accessed at https://www.harrow.gov.uk/downloads/file/29124/hsab-strategic-plan-2021-24

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Welcome to Harrow

Harrow [2] is a relatively prosperous borough. Table 1 provides a range of key data, which at a glance reveal some important things about the local population which has been growing steadily over the past decade. Harrow is a richly diverse place where the many resident communities generally get on well. The population of those over 65 is growing but makes up a smaller proportion of the population than is the case in the rest of England but makes up a larger proportion than in London itself.

Currently unemployment levels are low although this has got slightly worse in the past 12 months, probably due to Covid 19. The pandemic has not only made a difference to short term employment prospects, it may well have a long-term impact as well.

Life expectancy in the Borough outstrips the England average for both men and women and the levels of expressed satisfaction with their lives for all adults is high and has been rising over the past seven years. Notwithstanding the general expressions of satisfaction with life among the wider community, those over the 65 have high levels of life limiting illnesses.

The proportion of people with a learning disability in the population is similar to the rest of London but lower than England. Hospital admissions for intentional self-harm and hip fractures is lower than for London as a whole.

Ensuring access to justice (in the face of crime victimisation) for those who are vulnerable is an important theme for the Harrow Safeguarding Adults Board. Some of the crimes that particularly impact those who are vulnerable have stayed at similar levels to last year and the reported numbers are low, but domestic abuse crimes including those where the victim is injured have increased noticeably.

[2] Data in the table below taken from ONS mid-year estimates, the Metropolitan Police crime dashboard and Public Health England's Local Authority Health Profiles. In the case of numbers larger than 2000 they are rounded to the nearest 100.

Overall population	252,300
Deprivation (where 1 is most deprived Local Authority Area in England). This index is updated every few years. In 2015 Harrow was more or less in the same place.	207/ 317(England) 27/33 (London)
Percentage of Harrow residents who are black or minority ethnic.	63%
People aged Over 65	40,000(16%)(England18.5%) (London 12%)
People aged over 85	6000(2.4%) (England, 2.5%) (London 1.7%)
Number and percentage of working age people who are unemployed	7000 (5.6%), (London 5.9%, England, 4.6%)
Life expectancy at birth for women	86 (85, England)
Life expectancy at birth for men	83 (81, England)
Hip Fractures for +65s (per 100,000)	382 (473 London)
Emergency Admissions for intentional self-harm (per 100,000)	70 (London 82)
Percentage of people over 65 with a life limiting illness	85%. (London 86%, England 82%)
Proportion of adults with a learning disability	4/1000; (London 4, England,5)
Proportion of learning-disabled adults getting long term support from the Local Authority	3.18/1000; (London 2.98, England 3.42)
Disability Hate Crime	5 (9 in 2020)
Domestic Abuse Crimes (change over last year)	2150 (+18%)
Domestic Violence Crimes with an injury caused (change over last year)	507 (+8%)
Distraction burglary; where an offender tricks their way into the home of (usually) vulnerable adults to steal	11 (- 30%)

Table 1

1. What is Adult Safeguarding?

Introduction

It is now 20 years since ***No Secrets*** was published. This laid out how at a local level, partnerships should work together to protect vulnerable adults from harm. It was the first time that the need for cooperative working in this field between agencies was made explicit. Even then it was only guidance. The need for agencies to work together moved from a "nice to do" to a "must do" with the passing of the Care Act 2014 (The Act). In fact, as was the case in most areas, Harrow had already established strong local working arrangements and there was a broad welcome for placing the business of safeguarding adults on a statutory footing.

The Act requires that local Safeguarding Adults Boards:

- publish an annual report and strategic plan,
- commission Safeguarding Adult Reviews, and
- hold partner agencies accountable for how they work together to protect adults from abuse and harm

How are adults abused?

There are a range of ways in which vulnerable adults can experience abuse: these are physical abuse, domestic violence, organisational abuse, modern slavery, discriminatory abuse, physical abuse, psychological abuse, sexual abuse, self-neglect, neglect and acts of omission, financial or material abuse.

The responsibility for carrying out enquiries and reviews

The core purpose of adult care and support is to help people achieve the outcomes that matter to them in their life. To achieve this the Care Act 2014 introduced the 'Wellbeing Principle.' Wellbeing is at the heart of safeguarding adults and is broadly defined as:

- maintaining personal dignity (including treating the individual with respect)

- physical, emotional and mental health and wellbeing

- protection from abuse and neglect

- control by the individual over day to day life (Including the care and support provided) and the way it is provided.

- participation in work, education, training and recreation/social and economic wellbeing/the individual contribution to society

- domestic, family and personal wellbeing and suitability of living accommodation

People with care and support needs require a safeguarding plan. To achieve this, care and support staff need to be creative. They can call on family support and community services. Accommodation and other spaces can be fitted with equipment and adapted to meet service user need. Assistive technology and technological solutions can be deployed. However, central to every plan is:

- the need to identify risks so that service users can be protected
- the assumption that the individual is best placed to judge their own wellbeing

- the need to ensure that any restriction on the individual's rights and freedom of action is minimised and is the least restrictive option

- the need for the plan to take into account the individual's expectations, views, wishes and feelings
- the importance of preventing or delaying the need for care and support and the importance of reducing needs that already exist

- the need to place the individual at the centre of decision making and to ensure that decisions are bespoke to each individual's circumstances
- the importance of balance between the individual's wellbeing and that of any friends or relatives who are involved in the caring of that individual

Those who need safeguarding help are often elderly and frail, living on their own in the community, or in care homes. They may be people who have physical or learning disabilities and people who have mental ill health or other care and support needs. They are people at risk of suffering harm both in institutions and in the community.

Safeguarding adults means ensuring that they can live in safety, free from abuse and neglect. This means that people and organisations need to work together to prevent abuse or neglect, while also ensuring adult's wellbeing is promoted. This requires professionals and families to pay proper regard to the views of those being safeguarded before deciding on any action. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved.

Safeguarding partners have to cooperate in this activity and they also need to share information. When abuse or neglect is reported the Local Authority has a duty to make enquiries to see what the appropriate protective or preventative response should be. Many people with care and support needs experience difficulty maintaining physical and mental wellbeing following abuse or neglect and the safeguarding process should support the person to maintain wellbeing and gain equitable access to criminal justice.

Section 42 of the Care Act (2014) describes a safeguarding enquiry and identifies that a Local Authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether action is required. The enquiries are to be conducted when the adult (aged 18 or over) meets the three-part eligibility test for safeguarding and there is reasonable cause to suspect that the adult is in the Local Authority area (irrespective of whether they are ordinarily resident there or not).

In the most serious cases of abuse and neglect, where an adult has died or come to serious harm and there is suspicion that there has been a lack of joined up working among responsible agencies the Act requires Safeguarding Adults Boards (SAB) to conduct a Safeguarding Adult Review (SAR). The principle purpose of a SAR is learning. The sort of case that requires a SAR is inevitably one of high impact and it is vital that the partners to the SAB learn lessons to improve future practice.

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2. Covid 19 and safeguarding adults work

Safeguarding adults work during the Covid 19 pandemic did not change. The provisions of the Coronavirus Act 2020 emergency legislation (25 March 2020) allowed for ‘easement’ or suspension of a number of duties in the Care Act 2014. However, Sections 42-45 of the Care Act 2014 that relate to safeguarding adults did not change nor were they ‘eased’, so remained a statutory duty. Consequently, safeguarding adults remained the responsibility of local authorities and partner agencies − to keep everybody safe from abuse or neglect, with a clear role in avoiding any breach of human rights.

The impact of the pandemic in safeguarding adults work is covered in the relevant sections of this report. In Harrow the Safeguarding Strategic Partnership (HSSP) met on a more frequent basis between March 2020 and March 2021 so that it could oversee the impact of the pandemic/lockdown in safeguarding work (for both adults and children) and support the work of front-line staff across all the partner agencies.

3. Making Safeguarding Personal (MSP)

The underlying principle of MSP is that we are the best experts in living our lives. The ability to make decisions about one's own care, safety and welfare is a key difference between children and adults. Adults with mental capacity have the right to make decisions about themselves even when some of those decisions may seem to others to be unwise or personally harmful. Any enquiry into an adult's welfare or safety should start with an understanding of what the adult at risk would like to happen. This leads to tricky judgements and it can be hard for safeguarding professionals to establish what an adult's wishes are and whether any care offered or received meets the wants as well as the needs of the person cared for. Harrow has embraced MSP and how this is done is shown in this report.

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4. Evaluation of the effectiveness of the Harrow Safeguarding Adult's Board

✔ = Good # = Some Work to Do ✗ = Much Work to Do

Introduction

The Harrow Safeguarding Adults Board (SAB) [3] as part of their arrangements to safeguard adults must publish a report, which describes what it has done to achieve its objectives and what it and each of its members has done to implement its strategy [4]. I have now been in post as Harrow's Independent Chair since the summer of 2019 and this is my assessment of how well the SAB has performed in the period April 2020 – 2021.

[3] These are Harrow Council, The Metropolitan Police and The Harrow Clinical Commissioning Group and other agencies and organisations listed in Appendix 3
[4] Schedule 2 Care Act 2014

Engagement of Other Relevant Agencies

The SAB is required to be a partnership which coordinates its arrangements so that vulnerable adults are safeguarded. It needs to include a wide range of other agencies in these arrangement[5]. These other agencies, should then act in a mutually cooperative way to ensure that the local arrangements are effective. The Harrow SAB partners have identified a significant range of relevant agencies[6] including organisations in the voluntary and third sector. Their joint and singular activities are described in this report. These agencies have been effectively engaged in the SAB since its formation. They have demonstrated this through their contribution across a range of meetings and activities and involvement both as attendees of the main board and of its various sub groups.

Covid 19 tested the resourcefulness of the SAB partners to the full. The development of new ways of working, the emergence of effective contingency arrangements and the flexibility demonstrated by the partners in stepping up to this challenge is testament to the strength of the partnership. The SAB's arrangements with its range of voluntary sector organisations work well. There is also strong and appropriate support from elected Councillors. ✔

Learning from audits, reviews and incidents

It is a responsibility of the SAB[7] to identify those safeguarding cases which are so serious that they need to be formally reviewed. This is so that improvements can be made to systems, process and operations so that adults will be better protected in future. In the past twelve months the SAB has more or less concluded a Safeguarding Adult Review, the result of which will need to be fully explored in next year's annual report. However, before waiting for a review to be commissioned (by which time a case must have become serious) it is also good for an SAB to conduct regular case and system audits to identify areas where preventative action could be effective.

This report includes the details of a range of such reviews and audits. The SAB in conjunction with the HSCB has a good system for identifying serious incidents, a well organised group of multi-agency professionals that assess and move them forward and a strong learning ethos, which ensures that difficult cases improve practice. The audit regime which has been established by Harrow Council ensures that learning is revisited and embedded. The partnership contribution to this audit regime continues to develop but still has a way to go before it is visibly multi agency. Review Arrangements ✔; Multi Agency Audit Arrangements #

[5] Ibid

[6] Accessed at Appendix 1; http://www.harrowscb.co.uk/wp-content/uploads/2019/06/Harrow-Safeguarding-Children-Arrangements-May-2019.pdf

[7] Section 44 care Act 2014

Enquiry and Challenge

This is one of the key activities that an SAB need to have in place. This is a developing strength of the SAB. The Quality Assurance Function which is related to the audit issue above is strong in parts but as yet is not fully multi agency. Recently the SAB and the HSCB have recruited two independent lay members, to strengthen the challenge to the work of professionals. There is regular oversight of adult safeguarding performance by elected councillors and officers. This helps to demonstrate the strong commitment of the Council to the work of adult safeguarding.

The voice of the service user is an important factor in understanding real effectiveness and impact. Currently the role of presenting the user voice falls to representatives of various user groups. Developing a way of hearing more directly from service users is an area which the SAB intends to explore. #

Understanding performance information

This is a very much an encouraging and improving picture. We have a rich data set provided by Harrow Council. The Metropolitan Police, following its restructure, is still developing its data provision to the partnership. Health provider data is now regularly inspected at the SAB quality assurance sub group. There is still a willingness and an ambition to compound and analyse all the data that is available. This will further improve the SAB's understanding of what is happening. The partners need to build on what they have achieved in the past twelve months or so and take their insight and analysis work to the next level. ✔

Working strategically with other partnership boards

Partnership work is a strength of these arrangements and there is a real commitment to work together with other partners and boards wherever there is mutual advantage to be had. The 2021 annual conference was conducted jointly with HSCB and Safer Harrow. I chair the HSCB as well as chairing and scrutinising the work of the SAB. I am also a member of the Health and Wellbeing Board and take part in the joint strategic need analysis working groups. The way that Harrow Partners seek to join up their work across departments is very impressive. ✔

Making Safeguarding Personal

This report contains a section on how SAB has developed a culture of making safeguarding personal. Service user views are sought, acted on and performance improved. This work will be enhanced by the arrival of the two new lay members and the intended expansion of the work to hear the authentic voice of the service user. ✔

Assurance on Provider Concerns

The partners have a strong culture of examining provider issues. There is good constructive engagement with providers, speedy action to manage problems and strong channels of two-way communication. There has needed to be a constructive dialogue with providers during this difficult year. Engaging more directly with providers is an avenue that the SAB may want to explore. Currently engagement is principally through the Council; making this more of a shared task across the partnership would demonstrate the strength of the partnership. ✔

Performance Against Strategic Plan

The SAB is required in its annual report[8] to describe what it has done to achieve its objectives and how it has delivered its strategic plan. The SAB has a range of stretching priorities (described at Appendix 1 of this report) and further goals to be achieved described in its strategic plan. There have been some interesting developments in individual agency and partner activity to make progress against the priorities and the data set about these priorities is improving all the time. The work of the quality assurance sub group, which reviews in detail certain aspects of safeguarding performance is also becoming more integrated. The partners have identified the need to develop more coordinated action to safeguard vulnerable people living at home. This remains work still to be developed. The strategic plan is ambitious so there is a lot to do before some of what is aspired to is achieved. #

Resourcing Commitment of Partners

Safeguarding is a complex business and the joint HSAB and HSCB arrangements require administrative resources to function. The law and guidance that impacts the establishment of SABs invite partners to make financial contributions[9] but do not require them to do so. Funding should be agreed, proportionate, equitable and transparent and the burden should not fall disproportionately on one member more than another. The funding arrangements for this work which are described at Appendix 4 show clearly how they fall disproportionately on Harrow Council. They lack equity and transparency. This is not fair to Harrow Council and is unsatisfactory. ✗

Conclusion - The SAB has had a taxing year. The partnership found ways of adapting how it worked in the shadow of Covid and emerged from a difficult 12 months having learned that its contingency planning could withstand the toughest of challenges. My assessment is that the Harrow arrangements are sound and there is ambition for improvement.
Chris Miller (Independent Chair HSAB)

[8] Schedule 2 (4) Care Act 2014
[9] Schedule 2 (2) Care Act 2014

5. Principles of Safeguarding Adults

These six principles are contained in the statutory guidance to the Care Act 2014 and underpin the way that we seek to work across our partnership in Harrow. The principles are:

Principle	Objective	User outcome
Empowerment	Adults are encouraged to make their own decisions and are provided with support and information	I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens
Prevention	Strategies are developed to prevent abuse and neglect that promotes resilience and self determination	I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help
Proportionate	A proportionate and least intrusive response is made balanced with the level of risk	I am confident that the professionals will work in my interest and only get involved as much as needed
Protection	Adults are offered ways to protect themselves, and there is a co-ordinated response to adult safeguarding	I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able
Partnership	Local solutions through services working together within their communities	I am confident that information will be appropriately shared in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to find the most effective responses for my own situation
Accountable	Accountability and transparency in delivering a safeguarding response	I am clear about the roles and responsibilities of all those involved in the solution to the problem

Some examples of the work of HSAB partners under these principles are:

Prevention
The LFB (Fire Service) has continued to work with hoarders across the borough through the existing peer support activities being carried out. Even with the restrictions around Covid 19 they managed to carry out over 390 Home Fire Safety Visits in 2020 - 2021 and these have been targeted at the most vulnerable.

Prevention
Based on the learning from SAR "A", Adult Social Care (LBH) refreshed and re-launched the self-neglect/hoarding protocol which includes greater oversight by the Safeguarding Adults Team and a new self-neglect panel to discuss high risk cases.

Prevention
During COVID -19 there was a focus on raising awareness of domestic abuse with frontline staff via webinars/staff communication (CLCH NHS Trust).

Prevention
Training on Annual Health Checks for people with a learning disability and STOMP (stopping over medication of people with a learning disability) has been provided at the Practice Managers Forum, the Practice Nurses Forum and a selection of Primary Care Networks meetings (Harrow CCG).

Prevention
Cases of cuckooing, modern slavery, scams/financial abuse/exploitation are all being raised by staff (CLCH NHS Trust).

6. Safeguarding Activity

When an adult appears to a member of the public, a charity, or a statutory agency such as the Police or the Health Service to be in need of care and support and is experiencing some form of neglect or abuse they need to inform Harrow Council or CNWL Mental Health Trust - so that an assessment can be carried out. Last year:

- **2,621** such concerns were raised. This was considerably more than the previous year's number of **873** (an atypical year), but also more than 2018/2019 (**1403)** and 2017/2018 (**1,467)**. The highest percentage of concerns are now coming in from the Police for the first time since HSAB data has been collected and presented
- **596** (**23%**) of these cases progressed to full enquiry. The volume is considerably greater than in 2019/2020, but alongside the large increase in concerns the percentage taken forward as enquiries reduced **(42% in 2018 - 2019**). This will continue to be kept under review to ensure that enquiries are made in all relevant cases
- **22%** of concerns were "repeats" i.e. had been previously referred. This has risen since 2019 - 2020 (**14.1%**) with the Police being involved for at least one concern in 47% of repeat concerns
- Over the past year there has been a shift in source of concerns. In 2019-20 the majority of concerns came from Social Care (**39%, down to 23% in 2020-2021**) and Health (**30%, down to 21% in 2020-2021**), however in 2020-21, the Police now refer the most people (**38%, up from 11%**)
- **37%** of these records relate to people aged 75 or over
- **60%** of concerns relate to women. This is similar to last year
- In relation to ethnicity, **49%** of concerns involve white clients and **22%** Asian. Given the age profile of those about whom concerns are raised this is similar to their representation in the community
- Of those that led to a full enquiry the four principle issues were neglect (**31%**), financial abuse (**20%**), physical abuse (**17%**) and psychological abuse (**17%**)
- By far the largest number of enquiries involved incidents reported in peoples own homes (**61%**), with residential care homes (**11%**), community service setting (**7%**) and mental health hospital setting (**6%)** also featuring

- **72%** of cases involved a risk originating within the person's family or other close contact group. **18%** originated with a service provider and in **10%** of cases the origin of the risk was unknown or unascertainable

Domestic Abuse

Significant increase in recorded concerns (up 284%)
Significant increase in cases investigated (up 135%)
Significant increase in substantiated cases (up 225%)

• most referrals come from health and police, while only 4% were self referrals or from **family members**
• the top 2 alleged perpetrators were **family members** followed by partner
• almost a quarter of investigations ceased at the individuals request (down from the previous year)
• risk was removed or reduced in 69% of substantiated cases compared with 88% in 2019-20

Analysis

In many respects the data shows the same picture as it has in previous years. The person most likely to be abused is older, female and living in her own home. At its 2020 annual review event the HSAB agreed a priority related to this issue (see Priorities section below).

It is unsurprising that numbers reported for care homes fell in the COVID period, as registered managers were primarily focused on dealing with COVID related issues and less visitors were accessing the residents. At the time of writing this report, safeguarding concerns are routinely being reported again from both home care agencies and residential/nursing providers.

Impact of COVID 19 **-** the full year data now supports the anecdotal experience of the safeguarding teams that incidents of domestic abuse had increased (up by 284% from the previous year). Most referrals came from health and the police, while only 4% were self-referrals or from family members. Almost a quarter of enquiries ceased at the individual's request.

Ethnicity and referrals **-** historically the HSAB has received generalised data about which sections of the Harrow community were reporting abuse and over recent years saw improvements to the point where in percentage terms the number being received from BAME communities was in line with the adult population. However, the Council's Business Intelligence Unit data is more detailed and suggests that of the concerns received about black/black British people, only 18% are progressed to enquiries compared to 26% for white people. The new strategic plan for the HSAB covering the period 2021 – 2024 includes an action point to look further into this issue.

In relation to Making Safeguarding Personal, a high percentage (93%) of people by the time of case closure had been asked for their required outcome. Risks had also been reduced in 81% of cases.

8. Deprivation of Liberty Safeguards (DOLS) activity in 2020 - 2021

Article 5 of the Human Rights Act states: "Everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty (unless) in accordance with a procedure prescribed in law."

The Deprivation of Liberty Safeguards (DOLS) is a procedure prescribed in law when a person who lacks the mental capacity to consent to their care or treatment is being deprived of their liberty in a care home or hospital in order to keep them safe from harm. The procedure involves having the arrangements independently assessed to ensure they are in the best interests of the individual concerned and to give those subject to a deprivation of liberty the means to challenge this. The safeguards relate only to people aged 18 and over. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered – such as the existing powers of the court, particularly those under section 25 of the Children Act 1989, or use of the Mental Health Act 1983.

	2020-21	**2019-20**	**Change in %**
Number of active DoLS in-year	656	629	4%
Number of Applications in the full year	564	469	20%
Granted	368	338	9%
Not Granted	360	98	267%
- of which request withdrawn*	*338*	*72*	369%
Not yet signed off by supervisory body	237	369	-36%
Total applications (Granted, Not Granted and Not yet signed off)	**965**	**805**	20%
Of which Total Completed (granted and not granted)	728	436	67%
Note: *Request Withdrawn includes 130 deceased and 208 change in circumstances e.g. moving to a different care setting			

Analysis

There has been a rise in the past year in the numbers of applications being made (up 4%). This compares to the national data where there has been a 3% reduction in applications received. There has been a proportionately higher number of cases where the authorisation was not granted. The non-grant of an application can happen for a number of reasons, including withdrawal – which happens if the subject dies or moves to a different setting before the application is complete. Nationally 60% of not completed cases were for "change of circumstances". Most applications are made by care homes (89%) with hospitals making 10%. In relation to age group: 51% relate to people over the age of 65, with 49% to people aged 18 – 64.

Review and replacement of DoLS

The Government introduced a bill in July 2018 to reform DoLS and the legislation received Royal Assent on 16 May 2019. The legislation provides for the repeal of DoLS to replace it with Liberty Protection Safeguards (LPS). The key changes include:

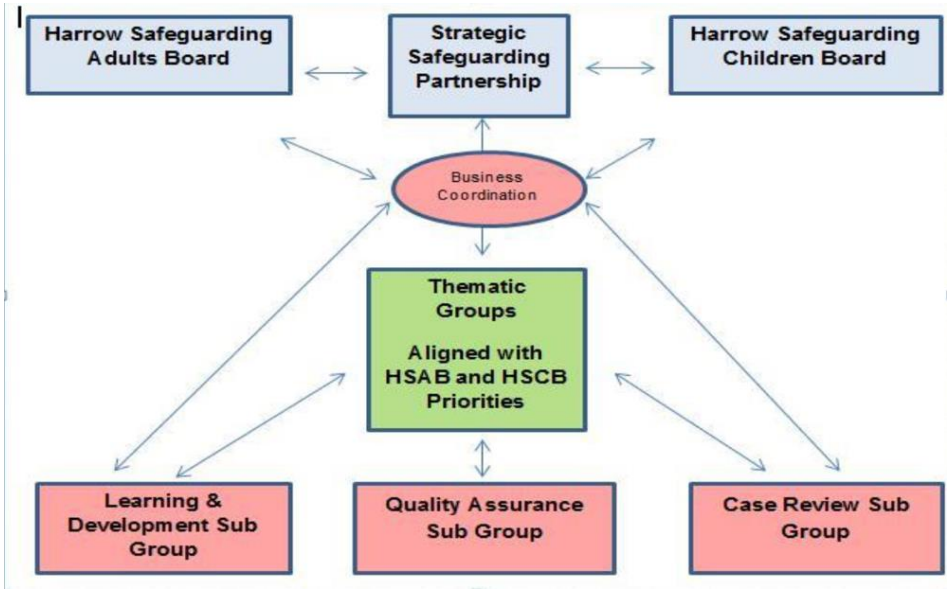
- applications can be made for people aged 16 and over
- LPS will also apply to people in private and domestic settings
- responsible bodies will replace supervisory bodies to authorise arrangements that give rise to a deprivation of liberty
- introduction of a pre-authorisation review
- authorisations to be renewed for a period of up to 12 months on the first renewal, or up to 3 years on any subsequent renewal

The LPS scheme was due to come into force in October 2020; this has now been postponed until April 2022.

To mark National Safeguarding Adults Week (16-22 November 2020), the LNWH NHS Trust Safeguarding Team used the theme **Awareness and Embedding** #**MentalCapacity #DoLS #NewDoLS** to raise staff awareness in embedding Mental Capacity Act in practice and re-introduce the new DoLS called Liberty Protection Safeguards.

9. Harrow Safeguarding Adults (HSAB) Subgroups

In June 2019 HSAB joined with the Harrow Safeguarding Children's Board (HSCB) and published a joint set of working arrangements[10]. There are a number of subgroups which carry out important functions for the HSAB. These are shared with the HSCB and are depicted in the figure and descriptions below.



<u>Learning and Development</u>

This subgroup aims to ensure that learning and development activity enables organisations and their staff to embed and promote learning that comes from reviews, audits and scrutiny. The group tries to ensure an appropriate response to safeguarding concerns and improvements in professional practice.

<u>The Case Review Sub-group</u>

This group considers referrals for Safeguarding Adult Reviews (SARs). It considers whether a set of national criteria (for the conduct of a formal review) are met and if so, decides how to go about the review.

In some cases when the formal criteria are not met it can undertake a local review to ensure that appropriate lessons are learned, shared and acted upon. In the past 12 months the HSAB concluded a SAR – the synopsis and learning points are covered on the next two pages.

[10] Accessed at https://www.harrowscb.co.uk/wp-content/uploads/2019/06/Harrow-Safeguarding-Children-Arrangements-May-2019.pdf

Quality Assurance Sub Group

This group conducts regular multi-agency audits to ensure the effectiveness of safeguarding arrangements across local partner agencies. The aim amongst other things is to test whether the HSAB work plan is achieving consistent and robust outcomes for adults at risk. It will also seek assurance regarding the application of learning derived from single agency audits in Harrow and will lead on the project looking further at what happens to concerns raised by different sections of the Harrow population.

Harrow Council commissions independent audits of its case work.

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10. Safeguarding Adults Review (SAR)

In October 2019 the London Ambulance Service (LAS) were called to attend a 46-year-old woman (A) at her home. They found her dead. With her was her 21 year old daughter (B). A was mal-nourished and her living accommodation was in a very poor state with significant evidence of hoarding and poor hygiene. The LAS (along with the Metropolitan Police) had previously been called to the same address on three other occasions (once in 2017 and twice in 2019) by different officials, who in the course of their work had raised concerns about the health and welfare of A and B. Throughout her adult life A had a long history of interactions with health professionals, although there were also some substantial gaps, when she might go some years without presenting herself to a health setting. She had a complicated medical history and some of her reported medical conditions were undiagnosed.

As well as B, A had another child C, who was seven years older than B. B and C both missed a lot of schooling and both received medical treatment for a variety of conditions, a significant proportion of which were never diagnosed. The large number of different and often undiagnosed medical conditions that they presented with (and this is particularly true of B) mirrored the situation of their mother.

The records of the agencies that dealt with A and her two daughters raise a number of concerns about the way that information was shared between those agencies. They also highlight opportunities for joint working and planning that were not taken or followed through.

The Harrow Safeguarding Adult's Board along with the Safeguarding Children Partnership decided that they should conduct a safeguarding adults review into this case. Because B and C were children living with A when she had care and support needs the report also looks at what impact the work of the relevant agencies may have had on B and C (when they were younger).

QUICK REFERENCE LEARNING POINTS FROM HARROW SAFEGUARDING PARTNERSHIP'S SAFEGUARDING ADULT REVIEW "A"

Learning about hoarding and resistant service users, elective home education and young carers and potential perplexing presentations

Background

The Safeguarding Partnership's Case Review Group carried out a safeguarding adult review into a case following the death of a 46 year old woman (A) who:

- was the victim of a hoarding disorder
- was resistant to offers of help and support
- adopted a particularly strict diet of raw veganism
- electively home educated her children (they were 21 and 30 at the time of her death)
- had been cared for by her children who acted as young carers
- along with her children had many perplexing medical conditions

Hoarding Hygiene and Gas Safety

"A" developed a progressive hoarding disorder. Her accommodation was also reported by neighbours as verminous. Environmental services, her landlord (to carry out a gas safety check) and the fire brigade wanted to access "A"'s property at much the same time as Harrow Council wanted access to "A" to assess her mental capacity.

There resulted a lack of clarity in how to act as a partnership. These are all difficult issues and more join up would have improved the response.

We need to better understand how to manage hoarding and we need to ensure that staff know how to fast track complex and escalating cases.

Elective Home Education

There was a recorded safeguarding risk in relation to "**A"'s** children when they were removed from school.

We need to be better at assessing safeguarding risks to children electively home educated and particularly those who are removed from school when a risk is already known.

Staff need to be confident in escalating concerns.

Young Carers

"A"'s children were identified as having young carer responsibilities. But they were not assessed because they refused to see a social worker (even though one of them was just 7 years old at the time)

We need to work with Harrow Carers to better understand the real numbers of young carers in Harrow.

It is important that young carers' assessments are conducted by both children and adult services.

We will audit these assessments to establish how effective they are now.

Perplexing Presentations

"A" and her children had a number of perplexing medical presentations. "A" claimed to have 68 medical conditions and her daughter B claimed to have 60. Her other daughter C also had many medical issues. Dealing with potential Fictitious and Induced illness is very complicated and while this issue was considered by professionals dealing with A, B and C it was not fully investigated.

We need to ensure that professionals know and understand the Royal Colleges Pathway for perplexing presentations - and

We need to review our procedures to ensure that they are clear and work for staff dealing with this issue

Resistant Service Users

"A" as a resistant service user posed problems for frontline workers wanting to respect her right to self-determination while wanting to safeguard her from the harm she was exposing herself to.

In such cases we must ensure decisions are multi agency and that staff receive good senior staff support.

The Safeguarding Response

"A"'s case generated significant activity. Quite a lot of it failed to reach a proper conclusion. A request for a mental health assessment received no result. Requests to other agencies for social workers to accompany them when they enforced court orders, although potentially a helpful idea, did not result in an effective joint visit. The safeguarding case appeared to have been closed too early and against the wishes of operational staff.

Since these events the Mental Health Trust has changed the way it logs requests for assistance. The Council has updated its hoarding and self- neglect policy.
We now need to check on the effectiveness of these changes, **ensure that staff who wish to escalate concerns know how to do so and we need to ensure that we have a shared and effective understanding of how social workers and other agencies can work together to gain entry to premises for assessment purposes**.

11. Communication

HSAB communicates its work to its partners and the wider community in a number of ways. The regular quarterly newsletter is a well-received and widely read. In the past year it has covered items as diverse as:

- Lessons from safeguarding adult reviews
- Safeguarding annual data and the Annual Report 2019 - 2020
- User voices
- Drink wise, age well
- Covid 19 vaccination guides
- Disability Hate Crime
- Transition in safeguarding work
- Scams
- Modern slavery and human trafficking
- The Herbert protocol for missing (vulnerable) people
- LPS updates
- Training opportunities
- Making Safeguarding Personal/self-neglect
- DNARs and purple self-respect forms

Harrow Safeguarding Adults Board (HSAB)
Newsletter – issue number 29
(Summer 2020)

Welcome from the chair of the HSAB (Chris Miller)

Hello and welcome to the Summer edition of our Harrow Safeguarding Adults Board Newsletter. The last few months have been unprecedented and I would like to start by thanking you and your teams again for the vital work you are doing to keep our communities safe. There has been a great deal of fantastic collaborative work that is being done to support the most vulnerable people of Harrow. We are now at a time where the lockdown is easing, many of us are returning to visiting our clients/patients and so I would like to encourage you to be very alert to any neglect or abuse that may have happened in the last 4 months. In that context, in this edition of the newsletter we are covering some key topics including modern slavery; human trafficking and some useful research about scams and the power of persuasive language. As in previous newsletters we have highlighted 2 recent Safeguarding Adults Reviews (SARs) that provide learning for us all.

I hope you will all be able to take a much needed break over the summer holidays. Chris Miller

As ever, suggestions for the newsletter can be sent to either Sue Spurlock (sue.spurlock@harrow.gov.uk) or Seamus Doherty seamus.doherty@harrow.gov.uk).

Liberty Protection Safeguards: update on implementation

On 16 July 2020 the Government announced that the implementation of the Liberty Protection Safeguards (LPS) will be delayed and that we are now aiming for implementation in April 2022.

LPS will replace the Deprivation of Liberty Safeguards (DoLS) and become the main authorisation process for a deprivation of liberty of a person who lacks the mental capacity to consent to their care and treatment arrangements.

The Government has decided that delaying the implementation of the LPS scheme is the most appropriate course of action to ensure that implementation is effective - in particular for those whose lives will be most affected. The Government will undertake a 12 week public consultation on the draft regulations and Code of Practice for LPS, allowing sufficient time for everyone that is affected to engage properly. After the Government has considered responses to the consultation, the updated Code and regulations will need to be laid in Parliament to allow for proper scrutiny.

More information is available here:
https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2020-07-16/HCWS377/

Scams: The Power of Persuasive Language

Professor Keith Brown from the National Centre for Post-Qualifying Social Work and Professional Practice (NCPQSW) and Dr Elisabeth Carter, Senior Lecturer in Criminology and Forensic Linguist at the University of Roehampton, have written this new guidance.

The publication shows how criminals use language in subtle and powerful ways to scam people out of money. It highlights how, far from the popular idea of the gullible or vulnerable person 'falling for' a scam, the reality is that scammers are highly skilled manipulators of language that use techniques designed to make people feel at ease and disguise any cause for concern.

This booklet will show some of the ways in which scammers use the reassurance of familiarity, our normal instincts to protect, and isolation from support to draw people in and justify their behaviour. They exploit all types of situations, including panic, uncertainty and isolation relating to COVID-19.

Copies of all the HSAB newsletters can be found at:
https://www.harrow.gov.uk/adult-social-care/staying-safe?documentId=13072&categoryId=210263

12. Learning Disability Mortality Reviews 2020 - 2021 (LeDeR)

The NHS has a crucial role to play in helping people with a learning disability, autism (LD&A) or both to lead longer, happier and healthier lives. One of the commitments within the NHS Long Term Plan is for the NHS to reduce health inequalities for people with learning disabilities, by taking action to prevent avoidable deaths through learning from deaths reviews. The following information is taken from the North West London 2nd annual report for 2020 – 2021 as it specifically relates to Harrow:

- a newsletter was developed for people with learning disabilities and / or autism and their carers

- GPs in Harrow were provided with Annual Health Check for Learning Disabilities training at a local level and more widely to PCNs. Training for the key workers who support patients to attend GP appointments was provided to ensure the health action plan is incorporated into individual reviews and care plans

- additional LD&A Hospital Liaison Nurse resource through London North West NHS Trust was, approved and implemented

- host commissioning arrangements at Harrow Cygnet ensured that all service users and staff had adequate access to PPE, COVID-19 Testing and COVID-19 vaccinations

- Harrow Parents Forum did a Parent Carer Survey looking at children/young person's Special Education Needs during the pandemic.

- the Harrow Association of Somali Voluntary Organisations increased its work focussing on COVID-19 awareness as BAME groups saw a disproportionate level of COVID-19 infections and death

- Harrow CCG commissioned Community Connex to support and encourage people with LD to have their Annual Health Checks

- Harrow CCG commissioned the Centre for ADHD & Autism (CAAS) to support with pre-screening for autism and post diagnostic group work. CAAS were also commissioned to offer ADHD follow-up support for adults diagnosed with ADHD and further to titration

- all Care Homes in Harrow now have an identified 'link GP', this has enhanced the vaccination response to the COVID-19 pandemic

- Harrow Health GP Federation has been commissioned to provide patient level support with Quality Outcome Framework (QOF) data on Annual Health checks to Harrow GPs. This has helped to ensure that 77% of people with LD access annual health checks

• training on Annual Health Checks for LD and STOMP has been provided at the Practice Managers Forum, the Practice Nurses Forum and a selection of Primary Care Networks meetings

• the Care Provider Support Group (CPSG) was set up in Harrow nearing the end of the first wave of the pandemic to bring together the CCG, Local Authority, Community Health Care Trust, and Public Health. The main aim of this group was to offer support to 33 providers in all care settings by offering training, and the support of an Infection Prevention & Control (IPC) nurse and the Care Homes Response Team. In collaboration with Harrow CCG and Harrow Local Authority a senior (IPC) nurse was deployed from December 2020 to support the various homes via supportive home visits to audit and review IPC practice and environment

• delivery of IPC training to all staff in the Care Homes and development of a checklist to monitor compliance. The support contributed greatly to the reduction of LD deaths within the second wave of the COVID -19 Pandemic as evidenced in the number of deaths allocated to the LeDeR team

• urgent Provider Concerns meetings were organised to address gaps in practice within the LD Nursing Homes and to support them as necessary

The following case study from Community Connex (previously Harrow Mencap) highlights the positive results for individuals when annual health checks are undertaken.

Case Study

One of our clients with a learning disability, N, had a very positive experience while going for an AHC.

He discovered that he was at risk of diabetes. After learning this, he was supported to change his lifestyle, and has reduced his diabetes risk significantly.

He now feels more empowered to eat well, exercise more, and take care of his health; this has improved his quality of life.

13. Training

Alongside the training undertaken by individual partner organisations, the HSAB organised some other sessions which are shown below. Due to the COVID 19 restrictions with everyone working remotely and time taken for "virtual" events to be developed and delivered, the numbers of staff trained in 2020 – 2021 were significantly lower than in previous years.

Mental Capacity Act basic	8
Mental Capacity (Edge Training Consultancy)	31
Joint HSAB HSCB Conference (Contextual Safeguarding/County Lines)	182
Total	**221**

HSAB partner training activity examples:

- Three-monthly training days for new PCs/TDCs implemented and new CSU training introductory course started 26/07/21 (Met Police)
- Mental health first toolkit for adults and young people training delivered to staff 2021 (CLCH NHS Trust)
- Community Connex (previously Harrow Mencap) now have 4 trained safeguarding leads across the organisation which covers all areas of Community Connex. They currently meet weekly and have just had the first internal Safeguarding Forum for the organisation.

Joint HSAB HSCB annual conference 2021

Contextual Safeguarding was chosen for the 2021 Joint Safeguarding Conference as it remains one of the two Boards' shared top three priorities in Harrow. A synopsis of the event is shown on the following page.

JOINT ANNUAL SAFEGUARDING CONFERENCE 2021 – CONTEXTUAL SAFEGUARDING

Our First Virtual Conference!

This was the joint Safeguarding Boards' first conference delivered through MSTeams because of the restrictions in place for the pandemic. The format followed previous arrangements as closely as possible to ensure delegates had access to the key-note presentations as well as a good range of workshops. The usual partnership networking that takes place at our annual conferences was limited by its virtual delivery, but by running the event we learned much about how we can succeed in delivering such learning events through new ways of working.
Attendance was good throughout the event, with 185 delegates joining. Feedback has been very positive with many saying it was the best conference we had run so far – **Well done to the Conference Planning Team!**

Nazir Afzal OBE

We were delighted to have Nazir as one of our key-note speakers Amongst a number of relevant positions Nazir previously held the position of Chief Crown Prosecutor and came to share his legal perspective on exploitation.
During his 24-year career, Nazir prosecuted some of the most high-profile cases in the country, including the Rochdale grooming gangs. His work has been ground-breaking, and he has campaigned tirelessly on a range of issues including Violence against women and girls, and honour-based violence – helping to change the landscape of safeguarding.

Nazir's passion and commitment inspired the audience, with many delegates reporting a new energy and vision for addressing contextual safeguarding. Nazir makes protecting the vulnerable his business and everyone's business – both on a professional and personal basis: Listening to what children and vulnerable adults tell us whether by verbal means or their behaviour is key and we must all be receptive to the signs – and acting on these.

Dez Holmes

Another much respected and high-profile lead in contextual safeguarding, Dez Holmes joined us to share her vision for supporting young people into adulthood. Dez is the Director of Research in Practice, a not-for-profit organisation that since 1996 has been supporting those who work with children, families and adults to use evidence in their practice and leadership. She has a vast knowledge and expertise in early intervention, adolescent risk and transitional safeguarding. Dez challenged existing arrangements and presented thought provoking approaches which focussed on systems and not a service approach to the needs of young people. Much of her thinking has been influential with national bodies, policy makes and with our local arrangements for responding to victims of exploitation and youth offending.

'Rhiannon' - Marie Collins Foundation - voice of a survivor

'Rhiannon' courageously shared her experience of being groomed as a young teenager and talked about the impact on her into adulthood and on family relationships. This much needed perspective strengthened our understanding of the complexity and confusion faced by young people in managing normal transitions into adulthood - alongside risks, threats and actual harm presented by skilled perpetrators.

'Rhiannon's' mature reflection on her past is used to give valuable insight into the dilemmas face by young people who often feel isolated in such circumstances and manipulated to feel guilt and responsibility – acting as a powerful obstacle to them seeking help. The HSP is collaborating with the Marie Collins Foundation to enhance the contextual safeguarding training offer across Harrow.

Conference Workshops

The event was supported by an excellent range of specialist workshops – drawing upon both national and local knowledge and skills:
Rescue & Response – an intelligence led service for exploited young people run by St Giles in collaboration with statutory and voluntary services
Red Thread – Trauma informed support for young people affected by violence
National Referral Mechanism – intelligence network to respond to exploitation by trafficking
Community Safety – a local response to 'Cukooing' and 'County Lines'
Ignite – Substance misuse and 'County Lines'
NWG – Exploitation in Sport – prevention and response
VVE Team – The role of film, music and social media in exploitation

14. Strategic Plan 2021 – 2024

A strategic plan for 2021 – 2024 was agreed by the HSAB at its meeting in March 2021. It is published as part of the Board's legal responsibilities under the Care Act 2014.
In the plan the HSAB publicises how it intends to work together as a partnership to make Harrow a safe place for adults who have care and support needs or who are vulnerable in other ways. A copy of the HSAB Strategic Plan can be found at:

https://www.harrow.gov.uk/downloads/file/29124/hsab-strategic-plan-2021-24

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15. Partner approaches to HSAB priorities 2020 - 2021

HSAB partners have not only been working together in partnership to deliver HSAB's priorities, but also within their own organisations they have been developing initiatives and new practice to ensure continuing improvement. Here are some examples of new and improving practice provided by HSAB members

Making Safeguarding Personal

Making Safeguarding Personal
Despite the difficulties of face to face contact with clients in 2020 – 2021, 93% of people were asked what outcome they were seeking and outcomes were achieved in 87% of cases.
(LBH Adult Social Care and CNWL Mental Health Trust)

Domestic Abuse

Domestic Abuse
Domestic violence and abuse training was provided to GP receptionists by the CCG in view of the increase of DA cases during the Covid 19 national lockdown. This was achieved by collaborative work with the VAGW (violence against women) Team who commissioned Hestia to deliver the training.

Domestic Abuse
Introduction of a safeguarding newsletter which featured Domestic Abuse in its second edition (Royal National Orthopaedic Hospital - RNOH)

Domestic Abuse
During the Covid 19 pandemic the Acute Hospital Trust saw a sharp rise in domestic abuse cases. This provided an opportunity for the safeguarding team to develop Domestic and Sexual Abuse (DSA) Safety Planning information in the PULSE Newsletter and Trust Intranet. The Trust received a lot of positive feedback after sharing the DVA Safety Plan with members of the Safeguarding Adults Boards and Children Partnerships.

Contextual Safeguarding
Westminster Drug Project (WDP) published safe places i.e. victims of Domestic Abuse were able to access safe places at Boots pharmacy where they could contact services for support).

Domestic Abuse
CNWL has a new Domestic Abuse Coordinator. Her role is split between CNWL and West London NHS Trust. The role has been created following the Trusts' participation in the pilot Pathfinder project, which aimed to achieve best practice for health services in their response to domestic abuse.

Mental Health and Wellbeing

Mental Health
CNWL MH NHS Trust has established a safeguarding interface meeting to work with partner agencies to resolve local pathway issues.

Mental Health
At RNOH, mental health cases are discussed in the complex case meetings before admission. This has been productive and has brought about positive outcomes as well as timely management of patients who are admitted with mental health issues. Having the in-house Psychiatry team as part of the complex case meetings ensures proactive pre and post management of mental health patients.

Contextual Safeguarding - this seeks to understand and respond to people's experiences of significant harm beyond their families. It recognises that the different relationships that people form among their peers, in their neighbourhoods, in their schools (in the case of children and young people) and online can involve or lead to violence and abuse.

Contextual Safeguarding
The Acute Hospital Trust set up a contextual safeguarding network with multi-professional membership such as Doctors, Nurses and Allied Health Professionals who meet regularly.
The Trust also has Contextual Safeguarding Posters on display.

The Metropolitan Police have created a dedicated hate crime team to provide an enhanced response to victims across all communities. The team will ensure minimum standards of investigation are met, offenders are brought to justice swiftly, repeat and linked series offences receive a proportionate level of response.

COVID 19 specific

WDP created a vulnerable service user spreadsheet which highlighted all the service users who met the vulnerability criteria for COVID-19. Those service users who were prescribed Opiate Substitute Therapy (OST) had their prescriptions delivered to the pharmacy.

Single point of contact /duty system in place 7 days a week during COVID-19 (CLCH NHS Trust)

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16. HSAB priorities 2021 – 2022

The following priorities were agreed by the HSAB at its business development events in 2020 and 2021

Multi agency partnership work and particularly our relationship with HSCB: what we need to focus on:

- create and support a training programme for the Police to facilitate more successful investigations where crimes appear to have been committed against vulnerable people
- for Harrow Council to sign up to an Appropriate Adult Scheme (which ensures that vulnerable adults in police custody receive appropriate help and support)
- redesign the future multi-agency training programme particularly in the light of COVID19
- involve care homes in the wider safeguarding agenda (including prevention) in different ways - wherever possible using existing provider forums
- analyse data for adults at risk living at home and develop a strategy to improve preventative work targeting that group
- revisit and refresh the membership of the HSAB ensuring good adults' representation at the main meeting and all subgroups
- participate in the London SAB "user voices" work including recruitment of users for the HSAB

Relationships with and between health commissioners and providers: what we need to focus on:

- monitor the numbers of actual annual health checks carried out by GPs for people with a learning disability
- ensure that adult safeguarding is built into the functions and processes of the ICP, as it develops over the next 12 – 18 months

Data set: what we need to focus on:

- develop an HSAB data set with analytical capability that can cover all the HSAB partners focusing on people living in their own homes
- explore why there are proportionately less enquiries progressed for Black people adjusting for relative population sizes

Quality Assurance: what we need to focus on:

- recruit at least one lay member for the HSAB
- ask the QA sub-group to identify one key area from the data set for a multi-agency audit
- ensure that the QA subgroup is provided with audit reports compiled by the Statutory Agencies (NHS Trusts; Police and Adult Social Care)

Access to Justice: what we need to focus on:

- create and support a training programme for the Police to facilitate more successful investigations where crimes appear to have been committed against vulnerable people (repeated from above)
- for Harrow Council to sign up to an Appropriate Adult Scheme (which ensures that vulnerable adults in police custody receive appropriate help and support)
- ask business intelligence to run a report on cases where criminal prosecution is an outcome, compared to the number of requests for legal redress asked for at the outset of the enquiry
- seek reassurance from the CPS about their performance in conjunction with the police and other service providers

User voice: what we need to focus on:

- monitor and support the local implementation of Liberty Protection Safeguards (LPS) for April 2022
- develop a way of accessing the user voice through remote working
- explore training packages for those chairing or leading remote sessions
- develop a strand of work around homelessness
- explore why there are proportionately less concerns raised for Asian people adjusting for relative population sizes

Development on or changes to existing priorities: what we should focus on:

- ask Age UK to consider a campaign for older people living at home related to fraud, scams and financial abuse possibly in cooperation with the Trading Standards Team
- oversee implementation of the recommendations from the current SAR including more focused work on self-neglect
- collaborate with the HSCB in running the 2022 joint conference

Appendix 1

JOINT PRIORITIES 2019 To 2021

'THINK WHOLE FAMILY'

 **Preventing harmful behaviours**	**1. MENTAL HEALTH** • Promote an early intervention and prevention approach to mental ill health with a focus on harmful behaviours, including self-harm and suicide • Promote collaboration between services and agencies at all stages of assessment and intervention • Consider how multiple vulnerabilities impact mental ill health such as substance misuse and domestic abuse
 **Through a welfare lens**	**2. CONTEXTUAL SAFEGUARDING** • Target the contexts in which that abuse occurs, from assessment through to intervention • Develop partnerships with agencies who have a reach into extra-familial contexts e.g. transport providers, retailers, residents' associations, parks and recreation services • Monitor outcomes of success in relation to contextual, as well as individual, change
 **Early identification of risk**	**3. DOMESTIC ABUSE** • Ensure all relevant sectors have access to training and awareness training • Promote vigilance to the fact that age, gender, ethnicity and ability do not discriminate in term of who can become a victim or perpetrator of domestic abuse • Ensure early intervention and appropriate support for victims • Promote access to specialist intervention programmes for perpetrators
Safeguarding Guidance:	**Adults: http://www.harrow.gov.uk/safeguardingadults** **Children: www.harrowlscb.co.uk**

Appendix 2 **Finance**

The following financial contributions were made to the HSAB by its partners:

Organisation	**Contribution**
Harrow Council	£100,000
Harrow Clinical Commissioning Group	£10,000
London North West University Hospitals Trust	£5,000
Royal National Orthopaedic Hospital	£5,000
London Fire and Rescue Service	£500
Metropolitan Police	£5,000

How to report abuse

Further information and 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 (aged 18 – 65) with mental health difficulties, this can be done through 0800 023 4650 (CNWL single point of access: SPA).
(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