& our Partners,

Committed to Safeguarding Adults

Harrow Safeguarding Adults Board (HSAB)

Annual Report 2018/2019

(headline messages for staff)

"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)

1. Introduction

Acknowledgments

The HSAB would like to thank the staff and volunteers from all agencies who have contributed to safeguarding and dignity/respect work in Harrow over the last year.

What is "safeguarding adults"? – a reminder

"Safeguarding adults" is about keeping people with care and support needs (unable to protect themselves because of those needs) safe from abuse or harm. It is only about people who are aged 18 years or older as there are other arrangements for protecting children.

What is abuse?

Abuse can be: physical; financial; neglect; emotional/psychological; institutional; sexual; discriminatory; modern slavery; domestic violence or self-neglect.

"London Multi-Agency Adult Safeguarding Policy and Procedures"

The final version of the London Multi-Agency Adult Safeguarding Policy and Procedures was implemented by the Harrow Safeguarding Adults Board from 1st April 2016 and has been used throughout the period covered by this report. The Board was also consulted about changes to the policy/procedures which are being introduced in 2019.

How can you find out more about safeguarding adults for yourself or your clients/patients?

- there are “easy to read” leaflets (e.g. “keeping safe in Harrow” and “what happens after you report abuse?”)

- there is information on the Council’s website
  http://www.harrow.gov.uk/info/200184/adults_at_risk/734/harrow_s_local_safeguarding_adult_s_board_HSAB

- the Safeguarding Adults Team run briefing sessions at various locations in Harrow – please ask if you would like one for your Team. They can also provide posters, leaflets and other publicity materials that you can use in your service to keep clients/patients well informed

- the HSAB’s newsletter which commenced in 2013 continued throughout last year to keep all relevant individuals and organisations up to date with its work and any key issues that needed to be highlighted. The four editions (published April, July and October 2018 and January 2019) included topics such as: statistical information; doorstep crimes; Dignity Action Day 2019; fire safety; coercion/control; learning from Safeguarding Adults Reviews (SARs) e.g. the abuse at Mendip House; and training information.

  Current and historical newsletters are available through the Council’s website**:**
  http://www.harrow.gov.uk/info/200184/adults_at_risk/734/harrow_s_local_safeguarding_adult_s_board_HSAB

2. Statistics

How many people were worried about being abused?

In 2018/2019 the Safeguarding Adults Teams (across the Council and in CNWL Mental Health Trust) were contacted about 1,403 people where there was a safeguarding concern, compared to 1,467 the year before. This was a small (4%) reduction, so the Harrow SAB will continue to monitor referral numbers to be reassured that all possible cases of abuse are being reported appropriately.

Out of the 1,403 people, 594 (42%) needed someone to look into their problems more carefully i.e. the "concern" progressed and "enquiries" were made.

How many men and women were worried about abuse and what background were they from?

As in all previous years where statistics are available, more women were worried about possible abuse than men. Out of the 594 enquiries: 378 were from women and 216 were from men.

Of the 594 people, 56% were from black or black Asian communities which reflects the Harrow adult population.

What was the type of abuse that people were worried about?

- 193 people were worried about neglect
- 156 people were worried about physical abuse
- 154 people were worried about emotional/psychological abuse
- 145 people were worried about financial abuse
- there were 74 cases related to domestic abuse
- 33 people were worried about sexual abuse
- 21 cases were related to self neglect
- 3 people were worried about discriminatory abuse
- there were 3 cases of modern day slavery

What disability did the person have who was worried about abuse?

- 309 people were over 65 years of age
- 224 people had a physical disability
  (NB. some people with a disability were also over 65 years, so have been counted twice)
- 163 people had a mental health problem
- 67 people had a learning disability

Where did the abuse happen?

- 353 people were living in their own home
- 98 people were living in a care or nursing home
- 44 people were living in “sheltered” or supported housing
- 31 people were in a mental health hospital ward
- 9 people were in a hospital
- 7 people were living in the home of the person that they said was abusing them
- 6 people were at a day centre

Who was the abuser?

- 254 were family, including husband, wife or partner
- 130 were social care staff (for example home care workers)
- 27 were health care workers
- 25 were neighbours or friends
- 9 were strangers
- 4 were volunteers or befrienders

How many "persons alleged to have caused harm (PACH)" were prosecuted?

86 cases resulted in Police action or prosecution which was a drop of 19. This is disappointing as nationally users have expressed a strong wish that more PACH are prosecuted if a crime appears to have been committed. A recent inspection of the Crown Prosecution Service (CPS) and the Police summarised in the report titled "the poor relation - the police and CPS response to crimes against older people" stated: "in our inspection, we found that the police and the CPS need to prepare for the growing challenges of helping and keeping safe an ageing population". "Crime against older people isn't well understood, despite the vulnerability of older people and the importance that society attaches to looking after people in their old age. There has been little police analysis of the problem, including the links to disability hate crime and domestic abuse. We found that police forces had only a superficial understanding of the problems, although all had recognised that fraud was an increasingly common concern for older victims".

The HSAB will therefore continue to focus on this issue in the next few years.

What was the outcome for the adult at risk?

The outcomes were varied and include: community care assessment and services at 23%; increased monitoring at 10%; management of access to PACH at 4%; 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 the previous year's figures.

Making Safeguarding Personal (MSP) means that a much more varied set of outcomes are being identified for adults at risk which is very positive. However the challenge is to get big data systems (like Mosaic in the Council) to capture all of them for this type of report.

Comparison with national data

There is a much more limited set of national data now available for comparison since the introduction of the Safeguarding Adults Collection (SAC) provided annually to NHS Digital. However the Harrow SAB continues to collect a wider set of information so that it can review trends and have relevant information to inform its work.

The table below is reproduced form the Board's 2017 – 2018 Annual Report and has been updated to include the 2018/2019 statistics and 2017/2018 national comparator data (the most up to date information available).

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	Physical Disability	Physical Disability	Physical Disability	Physical Disability

	(40%)	(38%)	(34%)	(38%)	(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

Analysis

Repeat referrals had been a cause for concern for the Harrow SAB when it reached 31% of cases a couple of years ago, however this percentage is now much reduced and almost identical at 17% to the figure of 16% nationally.

Given its very diverse population, it is to be expected in Harrow that the concerns received from people with non-white backgrounds would be significantly higher than the national average and this is an area that the HSAB continues to keep under review.

Harrow remains slightly different in respect of the profile as to where the abuse took place – with a greater number of concerns in the person's own home and less than the national average in care homes. The work of the Council's Safeguarding Assurance and Quality Team (SAQs) continues to pick up issues with Providers early on to improve care quality, thus avoiding the need in some cases for a safeguarding concern to be raised. This remains an important strand of the HSAB's prevention work.

The HSAB continues to prioritise awareness raising for people living in their own homes e.g. the community safety work.

The user group figures are very close to the national average with the exception of mental health where the local figures are 22% higher. Generally speaking there is greater pressure on mental health services in metropolitan areas and less in rural populations – which my make national comparison more difficult. It would possibly be helpful for the HSAB to compare with the data from London boroughs only. .

The only other figure of note is that the number of concerns about neglect in Harrow is slightly lower than the national average with emotional abuse being higher. Self neglect numbers are similar to the national picture, however domestic abuse numbers are higher which may reflect the large amount of work done (and ongoing) in this area e.g. the HSAB/HSCB joint conference.

So **"THANK YOU"** to all staff who either attended a training event, reported a situation that they were concerned about or participated in a safeguarding enquiry for their client/service user/patient. It all makes a big difference.

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3. 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.

4. 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.

<u>Summary of the Harrow Review</u>

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

5. 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.

6. Some examples of HSAB work in 2018/2019

- 1,247 staff across all organisations had some safeguarding adults training last year
- some care providers ran events with their users to mark Dignity Awareness Day 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. Topics included: "modern day slavery - eradication is our duty"; "a partnership approach to combating modern slavery"; "the voice of a victim"; "national and local challenges" and "supporting the human rights of trafficked individuals".

Evaluation was almost 100% positive from the 150 multi-agency staff that attended and there is a commitment from both Boards to continue collaborating on events in future years (see below)

- the 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 Mind in Harrow education course programme promoted the Metropolitan Police ‘Little Book of Big Scams’ section about online scams and has provided a new user-friendly information sheet about safeguarding & Prevent to over 200 people with mental health needs to increase awareness

- numbers of referrals for home fire safety checks to the local Fire Service via the Council’s safeguarding adults coordinator 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 2019 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

- 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. The organisation also facilitated 4 scams and fraud awareness sessions attended by over 50 of their service users, reporting positive feedback from participants

- two Independent Domestic Violence Advocates (IDVA's) are now 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

- CLCH NHS Trust held its second Annual Safeguarding Conference in October 18 which was well received by staff, with a broad range of speakers covering both Children's and Adults Safeguarding. The conference covered topics such as self-harm in schools, the Mental Capacity Act 2005, Prevent, and hoarding/self-neglect, homelessness, modern slavery, a legal update and the CLCH Safeguarding Champions programme

- CNWL's commitment to reduce restrictive practice continued with the Violence Reduction Work that is being undertaken to decrease the use of restraint on in-patient wards. Some very innovative interventions supporting this work are around sleep hygiene, use of sleep apps and travel masks. This is having a positive effect - good sleep patterns promote more positive interactions and less incidents on wards

- Harrow Mencap deliver quarterly forums for people with learning disabilities which have included sessions on mate crime and speaking up

- the Police with support from the Harrow Council Safeguarding Adults Team 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

- the Council's Children and Young People's Service (CYPS) have contributed to quality assurance 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

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7. What next? HSAB key objectives for 2019 - 2020

The areas for the Board to action in 2019/2020 include:

- 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)
- 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
- use "deep dive" statistical reports in areas of interest/concern to the HSAB e.g. crimes against older people in their own homes
- 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 recommendations from the fatal fire review are implemented
- 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
- training events for Providers are organised on: sepsis; constipation; aspiration pneumonia and mental capacity assessments (with a focus on learning disability services)
- focussed monitoring of supported housing units by the Harrow Safeguarding Assurance and Quality (SAQ) Team of supported housing services, alongside the above events for Providers about best practice
- 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
- a 4th joint HSCB HSAB conference will be held in 2020 with a focus on "suicide prevention and mental health"
- the existing transition protocol in place for the HSAB and HSCB will be updated and relaunched, incorporating Research in Practice findings/recommendations

Progress on the above actions will be monitored at quarterly HSAB meetings and an end of year review will be summarised in the HSAB Annual Report 2019/2020.

If you or your colleagues have ideas about how to do any of the above or would like to help, please contact the Safeguarding Adults Service on 020 8420 9453

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:

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