Harrow Safeguarding Adults Board

Annual Report 2019-2020

Harrow COUNCIL
LONDON

& our Partners,

Committed to
Safeguarding Adults

Foreword

This is the 13th time that Harrow Safeguarding Adults Board (HSAB) have published an annual report[1]. Here you will find out how the partners in Harrow have combined their efforts, developed their practice and sought to meet their objectives in the previous 12 months. In June 2019, we published a set of shared priorities with our colleagues on the Harrow Safeguarding Children Board. You can view them at appendix 1 and see some commentary in this report on what we have done to achieve our priorities.

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 we are always better than the sum of our parts. Each organisation represented on the HSAB has its own priorities and objectives. Sometimes one organisation's needs can pull in the opposite direction to those of another; even when they are both seeking to do the best as they see it for someone with support needs. The HSAB seeks to ensure that together our efforts achieve the optimal solution to problems that are often very complex.

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.

In particular, we describe what we have done as a partnership to address our three priority areas of domestic abuse, mental health and contextual safeguarding[2].

This is my first year as the chair of the HSAB and I am pleased to report that in my dealings with the organisations that are working together in Harrow there is an active spirit of cooperation and a desire to work out solutions to the wide variety of safeguarding scenarios that confront the workforce on a daily basis.

Chris Miller Independent Chair

[1] Under Schedule 2 Care Act 2014 Safeguarding Adults Boards are required annually to publish a strategic plan to describe what they intend to do to keep adults safe and also annually to report on they have done in the previous 12 months in meeting their plan.

[2] **Contextual Safeguarding** 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.

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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] must publish a report, as part of their arrangements to safeguard adults , which describes what it has done to achieve its objectives and what it and each of its members have done to implement its strategy [4].

I have been appointed as an independent pair of eyes to chair and help with the leadership of the HSAB partnership and this is my assessment of how well the HSAB has performed in the past twelve months.

Engagement of Other Relevant Agencies

The SAB must not only make their own arrangements to coordinate their activities to safeguard vulnerable adults, but also include other agencies in these arrangement[5]. These other agencies, should then act in a mutually cooperative way to ensure the effectiveness of the local arrangements. The SAB 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. The engagement of a range of voluntary sector organisations work well. ✔

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

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. Before waiting for a review to be required it is also good to conduct regular case and system audits. This report includes later on the details of a range of such reviews and audits. The SAB in conjunction through the HSCB has a good system for identifying incidents, a well organised group of multi-agency professionals that move these cases forward and a strong learning ethos which ensures that lessons learned go on to improve practice. Furthermore, the audit regime established by Harrow Council in particular ensures that learning is revisited and embedded. There is not as yet as strong a multi-agency audit regime as I think there should be. Review Arrangements ✔; Multi Agency Audit Arrangements #

Enquiry and Challenge

This is one of the key activities that SAB need to have in place. This is a developing strength of the SAB but the Quality Assurance Function which is related to the audit issue above is strong in parts but as yet is not fully multi agency. #

Understanding performance information

This is a very much an improving picture. We have a rich data set provided by Harrow Council. The Metropolitan Police, following its restructure, continues to work on its data provision to the partnership. Health provider data has improved and developed over the past 12 months. Compounding all the data that is available will further improve the picture of what is happening. There is though real determination among the partners to get this right ✔

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 annual conference this year 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. ✔

[7] Section 44 care Act 2014

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. ✔

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. I observed a number of issues of concern, which have been dealt with speedily and safely✔

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[8] 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 many areas of strength and there is evidence of striving for improvement. The enquiry and challenge function needs to continue to drive change and improvement. Senior staff in the SAB set a good example in the way that they engage with problems, accept the need for change and put in place ways of making practice better. There is a strong air of mutual cooperation and leaders show candour in facing up to issues that need service improvement.

Chris Miller
Independent Chair HSAB

[8] Schedule 2 (2) Care Act 2014

Welcome to Harrow

Harrow[9] 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 it makes up a smaller proportion of the population than is the case in the rest of England.

Currently unemployment levels are low, although the impact of Covid 19 is sure to make a difference to the long-term employment prospects of all who live in the borough.

Life expectancy in the Borough outstrips the UK 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. Similarly, permanent admission to care homes for those over 65 is similar to London but lower than England 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. The sort of crimes that particularly impact those who are vulnerable have stayed at similar levels to last year and the reported numbers are low.

[9] 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 (an increase of 1000 in 12 months)	252,100
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%) (in England 18.5%)
People aged over 85	6000 (2.4%) (in England, 2.5%)
Number and percentage of working age people who are unemployed	4900 (4.0%), (London 4.7%, England, 3.9%)
Life expectancy at birth for women	86 (83 UK)
Life expectancy at birth for men	83 (79 UK)
Life Satisfaction in 2018-9; Change in Proportion of people in Harrow who are satisfied or very satisfied with their life since 2011-2012	+ 6%, (78% in 2011-2, 84% in 2018-9)
Percentage of people over 65 with a life limiting illness	85%. (London 86%, England 82%)
Proportion of people over the age of 65 being admitted permanently to a care home	4.19/1000, (London 4.06, England 5.86)
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)
Domestic Abuse Crimes (Change over last year)	1978 (- 1%)
Domestic Violence Crimes with an injury caused (Change over last year)	509 (-0.4%)
All other hate crimes (Change over last year)	486 (+2%)
Distraction burglary; where an offender tricks their way into the home of (usually) vulnerable adults to steal	17 (+ 13%)

Table 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 broad welcome for placing the business of safeguarding adults on a statutory footing.

The Act requires Safeguarding Adults Boards

- to publish an annual report and strategic plan,
- to commission Safeguarding Adult Reviews, and
- to 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 Act places a responsibility on local authorities such as Harrow Council and their safeguarding partners to conduct two types of enquiry. In a case where there is suspicion that an adult who has care needs is suffering a level of abuse or neglect that they cannot protect themselves from a local authority[10] has to make an enquiry to determine whether there should be some action taken to ensure the adult's safety. The first determination of such an enquiry is to decide whether the allegation of abuse or neglect has been substantiated or not-substantiated. Sometimes, of course, the outcome is Inconclusive. Following on from that determination Harrow Council then has to decide what provision should be put in place to ensure the continuing safety and welfare of the adult. This report describes later on the number, types of and outcomes of these enquiries in Harrow in the past year.

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 different type of enquiry – namely a Safeguarding Adult Review (SAR). The principle purpose of a SAR is one of 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. Further information regarding the current status of Harrow's SAR can be found on page 15.

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. In Harrow, we take pains to assess this and you can see how we do that in this report.

[10] Section 42 Care Act 2014

Deprivation of Liberty Safeguards (DOLS)

When someone who lacks mental capacity is receiving constant oversight and supervision in a residential care home, hospital setting, hospice or sometimes supported living and is not able to leave, a set of protective safeguards are put in place to ensure that an appropriate balance is struck between the adult's right to liberty and their need for supervised care. These are called Deprivation of Liberty Safeguards (DOLS). Harrow Council has to give authorisation for someone to be cared for in the sort of restrictive way that requires DOLS to be applied.

This is an area of law that has changed a lot in the past few years and will change again next year.

DOLS activity 2018-9 and 2019-20

The application for and grant of a DOLS authorisation takes some time. These data (below) are a snapshot of all applications for DOLS either begun or completed in the relevant year.

There has been a rise in the past year in the numbers of applications being made. 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. Most applications are made by care homes (89%) with hospitals making 10%. There is a strong correlation with age. 44% relate to people over the age of 85, 22% relate to people aged 75-84, 10% to people aged 64-74 and 24% to people aged 18 – 64.

	2018-9	**2019-20**
Total Number of applications begun or concluded	695	804
Total Number of applications not granted (number and %)	53 (8%)	98 (12%)

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. Each of these principles acts as

Empowerment

This requires staff to support and encourage those they are caring for to make their own decisions. It also requires us to ensure that consent to support is informed by real understanding of the options

Proportionality

It is all too easy to "over engineer" a safeguarding solution, whereby an individual is placed in a protective cocoon that is sure to prevent the likelihood of harm, but overly constricts the adult's capacity to go about their lives with as much freedom as they might like. This principle guards against that tendency and ensures the least intrusive response appropriate to the risk presented.

Protection

The core of safeguarding is the requirement to protect those at risk of harm. The umbrella of protection includes providing them with support and representation. It also requires Safeguarding Partners to ensure that there is proper access to justice for those who are vulnerable.

Protection; the Clinical Commissioning Group provided training to GPs on the importance of annual health checks as a protective factor for those with learning disabilities (LD) and other long-term conditions. Promoting the uptake of the pneumococcal vaccine as a protective factor for those with LD was also delivered as part of this training.

Partnership

Those at risk require a local coordinated response. These are best provided when statutory services work with their communities, because communities play a key role in preventing and reporting neglect and abuse.

Partnership; Members of the HSAB workforce provide information to the London Fire Brigade (LFB) of instances where they see or suspect fire risk in the home of an adult with care and support needs. LFB will conduct a fire safety check, providing both advice and fire prevention hardware like smoke detectors. Over the past two years, house fires have declined by 30% in Harrow, from 129 to 91

Accountability

The members of the Harrow Safeguarding Adults Board are responsible for safeguarding practice. Through review, learning and scrutiny we seek to ensure that at our core we are accountable and transparent in the way we go about our safeguarding work.

Prevention

Anticipating and preventing harm is better than to react to harm is clearly better for all. The work of safeguarding professionals on a day to day basis is rooted in this principle.

Prevention; As part of World Elder Abuse Day 2019 Harrow Council's safeguarding team ran a workshop for the public. The team sought to raise awareness of the sort of scams and fraud that criminals perpetrate on the vulnerable and provided advice on how to combat them.

How to report abuse in Harrow

If you or someone you know is suffering abuse, harm or exploitation, then please don't keep silent. Reporting your concerns may help to protect an adult at risk from further abuse and could ultimately save their life. You can report abuse by emailing the safeguarding Adults Team or calling them on 020 8420 9453.

Access to Justice – Case Study

Four fraudsters who scammed pensioners across London out of three quarters of a million pounds received prison sentences totalling 18 years after a major investigation conducted by Brent and Harrow Trading Standards.

The defendants, who all worked for Randhawa Roofing Ltd, cold-called and bullied their victims to pay huge sums of money for unnecessary work that was either not carried out or done to a poor standard.

The company, owned by Harpreet Singh Randhawa, came to the attention of Trading Standards in 2017, when two Harrow homeowners, aged 84 and 86, were tricked into making payments totalling £350,000. Officers discovered more victims in Enfield, Haringey and Bromley. Some were left with no roof when they refused demands to pay more money.

The investigation, supported by the National Trading Standards Team, also discovered an international money laundering operation in which the victims' money was transferred out of the UK to Dubai, China and Singapore.

At Harrow Crown Court on October 11 2019, Harpreet Singh Randhawa, Harinder Singh Arora, Mahmoddun Nobi Siddique, and Vytautas Glinskas were found guilty of conspiracy to defraud and money laundering. As well as their prison sentences Siddique, Glinskas and Randhawa were also banned from owning a business for eight years. Between September 2017 and March 2018, a total of £870,000 was taken from six victims with £150,000 eventually being recovered by the banks.

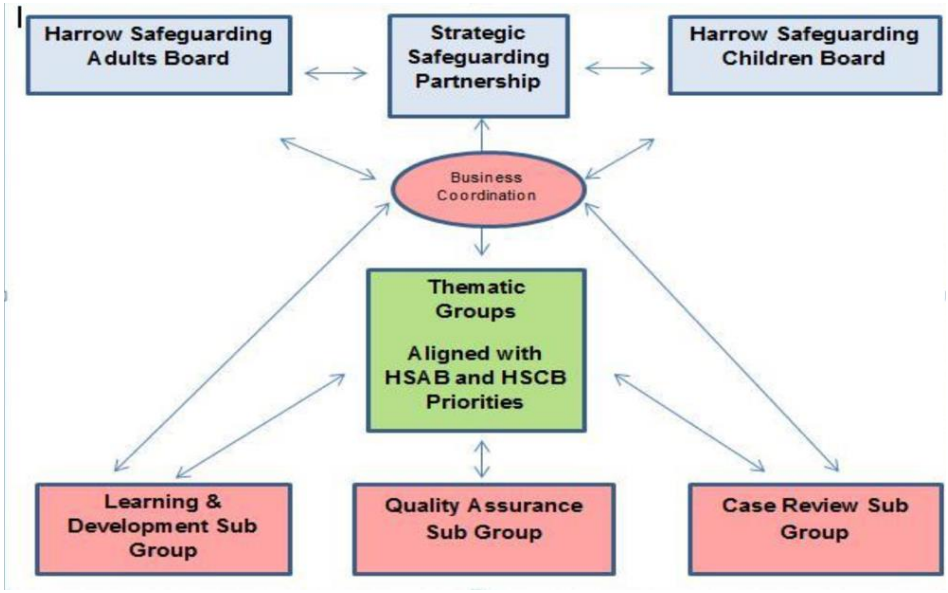
Safeguarding Activity

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 suffering some form of neglect or abuse they need to inform Harrow Council or CNWL MHH Trust so that an assessment can be carried out as to that adult's needs. Last year:

- **873** such concerns were raised. This was considerably fewer than the previous year's number of **1403** and Harrow is currently reviewing recording procedures to establish the reasons for this considerable drop.
- **387** (44%) of these cases progressed to full enquiry. The proportion is slightly higher than last year (42%) but the volume is considerably lower than 2018-9 **(595**). This, too, is also a matter that is under review.
- **37%** of these records relate to people aged 75 or over
- **60%** of these concerns relate to women. This is similar to last year.
- In relation to ethnicity **49%** of these 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.

Harrow Safeguarding Adults (HSAB) Strategic Plan and HSAB's Sub Groups

HSAB has a responsibility to publish annually a plan which lays out what it intends to do to achieve its overall objective of safeguarding adults. In June 2019 HSAB joined with the Harrow safeguarding Children's Board (HSCB) and published a joint set of working arrangements[11]. We have a number of sub groups who carry out important functions for the HSAB. These are shared with HSCB and these are depicted in Figure 1 and described below.



<u>Learning and Development</u>

This sub- group 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. We are always looking to ensure an appropriate response to safeguarding concerns and improve consistently in our professional practice. A record of the training provided and the organisations attending is at Appendix 2

Safeguarding Matters, Mental Health, Suicide and Self Harm Prevention

This was the title of our joint HSAB / HSCB Safeguarding Conference in January 2020.
177 Delegates gathered from a range of statutory and voluntary agencies to hear professionals, individuals and families whose lives and work made them engaging experts in this difficult subject matter.
The conference provided delegates with knowledge, skills and case studies aimed at improving the services available to a very vulnerable section of the community

This group considers referrals for Safeguarding Adult Reviews. 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 HSAB concluded a local review into a fatal fire and has assessed another case as requiring a formal review. This latter case has not yet been concluded.

Quality Assurance Sub Group

This group conducts regular multi- agency audits to ensure the effectiveness of safeguarding arrangements across local partner agencies. This is a relatively new group for the HSAB and its aim among other things is 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.

Quality Assurance Activity

Making Safeguarding Personal

For some time now Harrow Council has been asking those who receive services (or people who can speak for them) whether or not the services helped the recipient achieve the desired outcome. For the first time this year this was an activity that Central Government required of councils and Harrow's performance in this regard will be published in due course by NHS Digital

Of 420 eligible service recipients 344 (81%) were asked this question and of the 332 who expressed a view (some did not) , 257 people said that the outcomes they wanted were fully achieved, 60 said that they were partly achieved and 15 said that they weren't achieved.

Harrow Council Audits

Harrow Council commissions independent audits of its case work. In the past year the auditor commented on the strengths of Harrow's work

- Practitioners and managers excel at taking a collaborative and partnership approach with other professionals
- The adult at risk is routinely seen, their consent gained, their wishes and feelings gathered, and they are routinely involved through the process of the enquiry
- A 'Think Family' approach is evident in many cases
- There is generally a clear plan throughout the enquiry
- Information is robustly gathered and analysed
- There is clear management oversight and supervision is often enhanced with a reflective approach.
- Safeguarding enquiries often lead to a positive outcome for the adult at risk

She also pointed out some areas for development

- Some drift is occurring on some enquiries
- Some gaps in the recording of cultural and communication needs of the adult at risk and the consideration of advocacy
- Better consistency needed in the completion of enquiry reports
- Some room for improvement in the completion and recording of capacity assessments
- Feedback to the referrer on closure

This open and reflective feedback is a strength for Harrow. This may be an example of good practice for other agencies in Harrow to follow.

Case Review

In 2019 HSAB conducted a local review in relation to a fatal fire which resulted in the death of an 82-year-old lady. During this past year, the partners have sought to ensure that the two learning points from the review have become embedded practice. They were

- Ensuring the provision to the fire brigade of information from a partner who is in receipt of a threat to cause fire and
- Developing better engagement techniques when a service user refuses to cooperate with an assessment.

In the latter part of 2020 HSAB agreed that it was going to conduct a review into the death of a middle-aged lady who died in conditions of self-neglect. This case will be conducted in partnership with HSCB and will be concluded in the coming year.

HSAB communicates its work to its partners and the wider community in a number of ways. Our regular newsletter is a well-received and widely read circulation. In the past year we have covered items as diverse as;

- Lessons from safeguarding adult reviews
- Regular updates on the unfolding story of the cruelty inflicted on autistic adults at Mendip House
- Dignity Action day
- How to recruit and ensure safe staff
- How to report illegal car washes (places where slavery and trafficking are too common) through an app.
- County Lines – the recruitment of vulnerable people by criminal gangs who exploit them for criminal purposes
- Self-neglect
- The office of the Public Guardian

See https://www.harrow.gov.uk/adult-social-care/staying-safe?documentId=13072&categoryId=210263

Learning Disability Mortality Reviews (LeDeR)

The Learning Disability Mortality Review Programme (also known as LeDeR) was established in 2015 to drive improvement in the quality of health and social care service delivery for people with learning disabilities (LD) by looking at why people with LD typically die much earlier than average. The programme was commissioned by the Health Quality Improvement Partnership on behalf of NHS England and was led by the University of Bristol's Norah Fry Research Centre. Through local retrospective reviews of the deaths of all of those aged 4 or over who had a learning disability, health and social care professionals, and policymakers have been supported to understand causes of death and to identify amenable factors contributing to the overall burden of excess premature mortality for people with learning disabilities. The programme has identified variation and best practice and made several recommendations to improve services nationally.

The project is led by the Clinical Commissioning Group and in Harrow, we team up with Brent partners to conduct joint meetings and other activities. This makes sense because we work with many of the same Health providers and therefore an issue or a lesson in one borough is likely to be relevant to both.

In 2019-20:
Nine cases were referred for review
Six reviews were completed (but this included three for the previous year)
Five cases have been allocated and await completion
One is yet to be allocated.

A significant problem in Harrow as in other areas is the difficulty that trained reviewers experience in being released by their employer organisation to conduct reviews. So, while we have five trained reviewers only two were able to commit to a review in the past year.

There is a comprehensive Harrow LeDeR action plan which is seeking to improve knowledge of the programme across the relevant workforce, develop better preventative strategies for primary care and other health providers and encourage reviewers and their employers to find effective ways of ensuring that trained reviewers can be used for reviews without compromising other work.

Harrow Council Safeguarding Assurance and Quality Team set up a series of training sessions for care home providers (and other interested parties) to raise awareness about sepsis. This followed a National LeDeR finding that sepsis is too often overlooked as a factor in cases where learning disabled people die. 350 professionals attended in 2019-20.

Case study; partnership working, Jenny

The police conducted a welfare check by Police to an elderly lady (Veronica) who had called in a distressed and confused state. Hearing noises from upstairs they investigated and discovered a younger woman (Jenny) in an extremely neglected condition. She had not washed herself or changed her clothes for many years. Her toenails were overgrown, her hair was matted and her skin was extremely unclean.

Jenny was hiding in a small box room underneath a blanket and there was no obvious sign of any food or drink being available. The Police called an LAS ambulance which attended very quickly. There were concerns about Jenny's health and subsequent enquiries revealed that she had not seen a doctor for many years and was not registered with a GP practice, nor claiming any benefits. Despite not being registered at the Surgery, Veronica's GP left her afternoon surgery at short notice to see Jenny to assess and prescribe any urgent medication.

A social worker from Harrow's Adult Social Care Team and a colleague from the safeguarding team worked together to identify a suitable alternative place with on-site support for Jn to live which was provided on the same day by a local care provider. This example shows how the Police, LAS; Harrow Council's Adult Social Care and safeguarding teams, General Practitioners and local care Providers work together to meet the needs of the most vulnerable. Jenny is now living in a suitable flat with support and can claim relevant benefits.

HSAB Partner approach to our priorities

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

Domestic Abuse

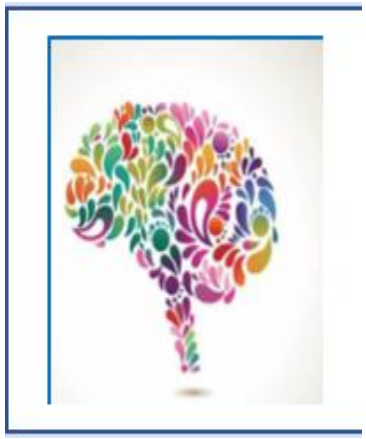
Royal National Orthopaedic Hospital; has trained staff in how to be confident in completing the nationally accepted ***SafeLives*** risk assessment process. This ensure that patients and their families who are impacted by domestic abuse are quickly identified and directed to the help they need.

London North West University Hospital Trust; has integrated certain aspects of the work of their psychiatric department, the substance misuse service and the safeguarding (children and adults) service to ensure that complex cases where domestic abuse is part of a mix issues are identified and the appropriate services provided

The Metropolitan Police; has set up a team to identify and take action against the most prolific and harmful domestic abuse suspects. These are people who move from relationship to relationship or frequently come to notice for their interpersonal acts of violence or threatening behaviour.

Central North West London NHS Healthcare Trust; has appointed a domestic abuse coordinator to oversee the quality and consistency of this wok across the whole trust area.

Mental Health and Wellbeing



Mind in Harrow (MiH) has trained and mentored two service users to present to the HSAB and to lead sessions at a National conference on the user experience. MiH has also inducted and trained 50 new volunteers

Central London Community Healthcare NHS Foundation Trust; has integrated into its training on a module on the vulnerability of learning-disabled adults to criminal exploitation specifically issues such as cuckooing (where a criminal gang takes over a vulnerable person's accommodation to further their criminal exploits)

Central North West London NHS Mental Health Trust; has adapted its mental health referral process to ensure that it can work effectively with a wide range of Local Authorities (LA). It has established a single point of contact, which reviews all CNWL safeguarding concerns to ensure high quality referral to the appropriate LA. CNWL has revised its referral pathway and forms to ensure an appropriate response to safeguarding concerns from external providers. The single point of access reviews all CNWL safeguarding including Merlins to ensure a robust high quality service is delivered in a timely manner with the support of the responsible mental health teams

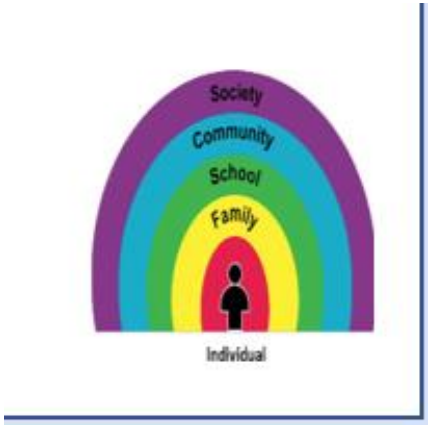
London North West University Hospital Trust; has developed a number of ways of to deal holistically with mental health and wellbeing. They have linked up old age psychiatry and dementia work. They have also developed a way of holistically assessing those presenting with self-harm, trauma and bereavement.

The Metropolitan Police; has agreed the establishment of a "suicide hub" which will bring together and analyse data from completed suicides with a view to preventing suicide and making London a "zero-suicide city".

The Clinical Commissioning Group alongside the other CCGs of North West London have developed a partnership of practice with acute and community mental health service providers and general practitioners. This shares expertise , standardises our approach and enables existing and emerging safeguarding issues to be managed better

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



Central North West London NHS Healthcare Trust;

- has adopted a modern slavery statement to educate their community workforce on the signs to look for. During the year CLCH made 12 referrals to appropriate LAs.
- has delivered Prevent training to 100% of all eligible staff.
- has developed flagging tools for identification in electronic records of vulnerability, e.g. going missing repeatedly, learning disability.
- Has developed guidance for staff to help them advise sexually vulnerable adults and young people on boundary setting.

Harrow Council; has made a lot of use of the Rescue and Response resources made available to London through a MOPAC (Mayor's Office for Policing and Crime). This project helps young adults break out of the cycle of gangs and criminal exploitation.

The Metropolitan Police; used officers from the serious violent crime task force to visit gang impacted offenders during the early stages of the Covid lockdown (March 2020) to offer them rehabilitative options as a way out of a life of gangs and crime.

London North West University Hospital Trust; has developed a weekly ***Safety – Net*** meeting in the Emergency department to ensure that appropriate cases are assessed for contextual safeguarding indicators and that proper referrals and assistance are made and offered.

Appendix 1

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

HSAB Training Attendance 2019 - 2020; Partner Agencies

Harrow Council Internal	45
Health	4
Statutory (other)	12
Private	76
Voluntary	24
HSAB Board Development	100
SGA Team Development	28
Partner Training: CCG	27
Total	**316**

Harrow Council Safeguarding Adults Team Training (Internal and External)

BIA (Best Interests Assessor) Training - Legal Updates	30
Domiciliary Care Agency Staff / Providers	55
Harrow Action on Disability (HAD) Staff & Volunteers	29
Harrow College Staff	22
Harrow Equalities Centre - Community Groups	15
Liberty Protection Safeguards Conference	98
Liberty Protection Safeguards Training	20
MIND in Harrow Staff & Volunteers	34
Provider Forums	37
Total	**340**

Workshops, Conferences and Other Events

Mental Capacity Act (Master Class)	18
Mental Capacity and Deprivation of Liberty Safeguards	22
SAB/SCB Joint Conference - Mental Health, Self-Harm & Suicide Awareness	177
Safeguarding Adults for Providers (Two identical sessions)	110
Scams, Fraud & Adults at Risk (World Elder Abuse Action Day 2019)	136
Total	**463**

Grand Total	1119

Appendix 3 **HSAB Attendance Record 2019-2020**

Organisation	Total attended
HSAB Chair	100%
Brent and Harrow Trading Standards	66%
Harrow Council - Housing Department	33%
London Ambulance Service	0
London Fire Service	33%
Westminster Drug Project	66%
Harrow Council - Adult Social Services	100%
Harrow Council - elected portfolio holder	100%
Harrow Council - shadow portfolio holder	0
Harrow Council – People Services/Children's Services	100%
Harrow Council – Business Intelligence	66%
Harrow Council – Principal Social Worker	33%
Mind in Harrow	66%
NHS Harrow (Harrow CCG)	100%
CLCH NHS Trust (Harrow Provider Organisation)	100%
London North West Healthcare University Hospitals Trust	100%
Harrow CCG – clinician	100%
Local Safeguarding Children Board (HSCB)	100%
Royal National Orthopaedic Hospital	66%
Metropolitan Police – Harrow (Vice Chair)	100%
Age UK Harrow	33%
Harrow Mencap	100%
CNWL MH Trust	66%

Harrow Association of Disabled People	33%
Public Health	0
Department of Work and Pensions	0
In attendance	
Care Quality Commission (CQC)	0
Healthwatch Harrow (NB. other Board members e.g. from Harrow Mencap and Mind in Harrow are also Healthwatch Harrow members)	0

Appendix 4 **Finance**

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

Organisation	**Contribution**
Harrow Council	£100,000
Harrow Clinical Commissioning Group	£11,000
London North West University Hospitals Trust	£5,000
Royal National Orthopaedic Hospital	£5,000
London Fire and Rescue Service	£500
Metropolitan Police	£5,000