# Haringey Safeguarding Adults Board

## Annual Report 2022/23

http://www.haringey.gov.uk/safeguardingadults

# Contact Information

Haringey is asking all residents to challenge abuse wherever it exists and to report it if they believe any person might be suffering abuse in any form. Safeguarding residents is one of the most important parts of our work. While many people are well cared for, some may be at risk of abuse or neglect.

Abuse can happen in a number of ways. Those most at risk include people with mental health problems, disabilities, dementia or those who are physically frail. It can also take place anywhere - often where someone should feel safe - and can be perpetrated by people they think they can trust, like a relative, friend or professional.

## What should you do if you suspect someone is being abused?

If you or the person you are concerned about is being mistreated, you can make a referral to Adult Social Care via the First Response Team.

## First Response Team

**firstresponseteam@haringey.gov.uk**

**020 8489 1400**

When you report a suspected abuse, you do not have to give your name, but if you do, it will not be given to the people involved. All suspected incidents of abuse will be investigated fully and appropriately.

## Other ways to get in touch

Contacting the council online is now much quicker than speaking to an agent or emailing us. Go to our self-service online tool **https://www.haringey.gov.uk/contact-haringey-council**


## Out of Hours Service

**020 8489 0000** (5pm to 9am Monday to Fridays, and all day at weekends and bank holidays). This number can also be used for the children and adult social care emergency duty teams.

### Emergencies and non-emergencies

For emergencies and serious incidents requiring the police, fire brigade or ambulance service please call **999**.
For non-emergency police advice or assistance please call **101**
For non-emergency medical advice or assistance please call **111**

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# Introduction from the Chair of the Haringey Safeguarding Adults Board

It is with great pleasure I present to you the annual report of the Haringey Safeguarding Adults Board (HSAB) for the year 2022/2023. The purpose of this annual report is to provide an overview of our safeguarding activities and progress made during the 2022/2023 period. It aims to inform our partners and community about the work we have undertaken, the impact we have achieved, and the lessons we have learnt. By sharing this information, we aim to foster transparency, build trust, and enhance collaboration with our partners and the wider community.

Over the past year, the HSAB has encountered a range of challenges to protect and promote safeguarding and the well-being of adults in Haringey. These challenges have included evolving patterns of abuse, emerging safeguarding concerns related to the digital realm, the impact of the global pandemic, and the cost of living crisis which has exposed vulnerable individuals to increased risks and barriers to support.

In response to these challenges, we have been actively engaged in assessing the effectiveness of our safeguarding practices to ensure the safety and well-being of adults at risk. Recognising the importance of collaboration and shared responsibility, we have worked closely with our partners.

As part of our commitment to transparency and accountability, the HSAB is undertaking a consultation on its Adults Safeguarding Strategy 2023-2028. We believe that incorporating the views and insights of the community is vital in shaping our strategic direction for the next five years. Through this consultation, we aim to gain a deeper understanding of the needs, concerns, and aspirations of those we serve, ensuring that our future plans are inclusive, responsive, and grounded in the lived experiences of adults at risk.

With the insights gained from the consultation process, we will develop a robust strategy that outlines our vision, objectives, and key initiatives for safeguarding adults over the next five years. This strategy will be accompanied by an annual delivery plan, enabling us to monitor progress, evaluate outcomes, and adapt our approach in response to emerging challenges.

Looking ahead, we are committed to continuing our collaborative efforts with our partners to further strengthen our safeguarding practices. Together, we will focus on developing innovative interventions, improving information sharing and coordination, and enhancing the capabilities of our workforce to address the evolving challenges facing vulnerable adults.

In conclusion, I would like to thank our partners, and the community for their support and collaboration. We firmly believe that by working together, we can create a safer and more inclusive environment for all adults at risk in Haringey.

**Dr Adi Cooper** (HSAB independent Chair)

# 1. Introduction

The Haringey Safeguarding Adults Board (HSAB) Annual Report 2022/23 outlines the work of the Board over the last twelve months and how partner agencies have worked together to improve the safety of adults at risk of abuse. The report contains details of how safeguarding has been promoted and developed over the last year through the Board and its subgroups. The report also describes how the Board intends to continue this in the future. Contributions were sought directly from board members, chairs of subgroups and other relevant partnerships.

## 1.1 The Haringey Safeguarding Adults Board

The HSAB is a statutory body established by the Care Act 2014. It is made up of senior people from organisations that have a role in preventing the neglect and abuse from adults. Its main objective is to protect all adults in its area who have needs for care and support and who are experiencing or at risk of abuse or neglect against which they are unable to protect themselves because of their needs.

The work of the Board is driven by its vision is that Haringey residents are able to live a life free from harm, where communities have a culture that does not tolerate abuse; work together to prevent abuse; and know what to do when abuse happens.

Legislation requires:

- That local councils have a duty to promote the well-being of carers; previously their duty of care was only made to the users of the care services.
- That anyone receiving care and support from a regulated provider which has been arranged by the council will be covered by the Human Rights Act 1982[1].
- That councils must enable users or potential users of care services to access independent financial advice on their care funding; and
- The introduction of a new appeals system for care users to appeal against council decisions on eligibility to care and care funding.

The Board meets to review and discuss safeguarding activity and consider ways that it can help to improve safeguarding practice and keep adults with care and support needs safe from abuse and neglect. The Board is not responsible for the delivery of any services but those agencies who do plan and deliver services locally, are represented on the Board.

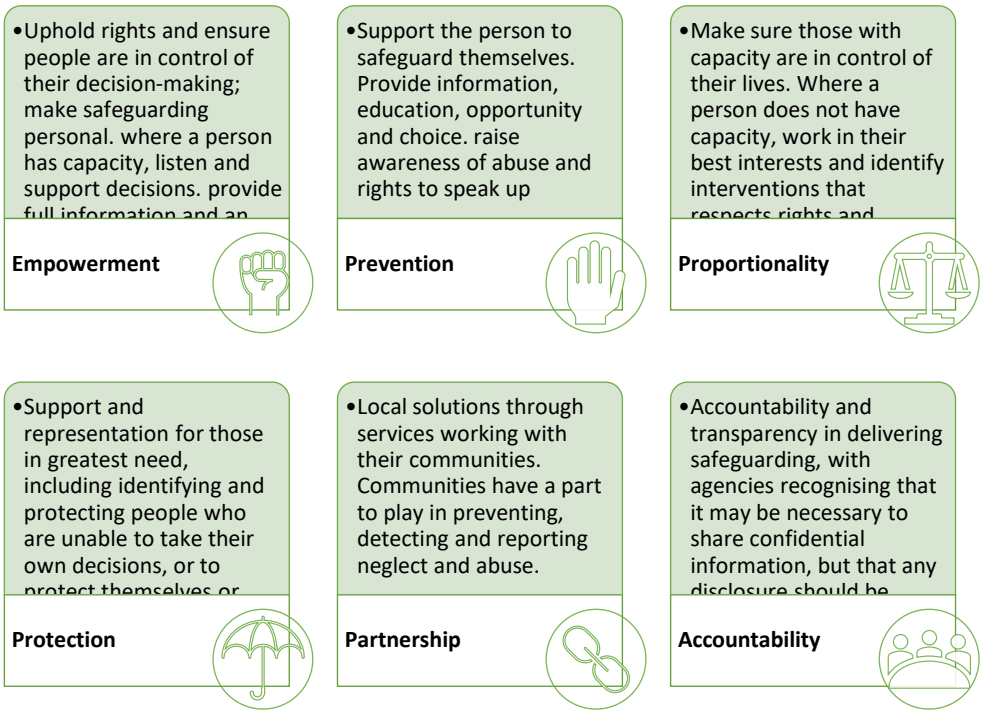
As a London Borough, Haringey works towards the Pan London Procedures for Safeguarding Adults; formally, known as **London Multi-agency Adult Safeguarding Policy & Procedures April 2019**[2]. This document unpins practice and process across

[1] Human Rights Act 1998 (legislation.gov.uk)
[2] London Multi-Agency Adult Safeguarding Policy and Procedures – LondonADASS

all of London. Including, an Information Sharing Agreement (ISA) contract across all agencies.

The overarching purpose of the HSAB is to help and safeguard adults with care and support needs. It does this by:

- Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Assuring itself that safeguarding practice is person-centred and outcome focused.
- Working collaboratively to prevent abuse and neglect where possible.
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred; and
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.
- The work of the HSAB is underpinned by the safeguarding principles which were set out by the government in the statutory guidance accompanying the Care Act 2014. The following six principles apply to all sectors and settings including care and support services. The principles inform the ways in which we work with adults and each principle holds equal importance in the effective safeguarding of adults.




These six principles form the basis of our work and our Strategy, in which we set ourselves, the partnership and community specific actions to prevent and respond to abuse. The HSAB framework is built around the four statutory SAB purposes under the Care Act 2014; Practice, Prevention, Responding to abuse and neglect, and Learning and Improvement.

## 1.2 Governance and Membership

The HSAB is a partnership of statutory and non-statutory organisations, representing health, care and support providers and the people who use those services across the borough. It is made up of over 20 partners and at times invite guest speakers and additional attendees as relevant matters arise. The Board is facilitated by an independent Chair who is accountable to the Chief Executive of Haringey in chairing the HSAB and overseeing its work programme. However, the Chair is accountable only to the Board for the decisions taken in that role. The role of Vice-Chair is undertaken by the Director of Adults and Health.

The partnership meets quarterly and have the following statutory responsibilities under the Care Act 2014:

- Ensure Statutory Partners are appropriately represented on the SAB.
- Develop and produce a 3-year Strategy Plan in order to direct the work of the Board that reflects priorities.
- Publish a SAB annual report highlighting the Board's progress and achievements in meeting stated objectives in the Strategic Safeguarding Plan and ensuring this is widely reported across partner agencies and organisations.
- Learn from the experiences of individuals, through undertaking Safeguarding Adult Reviews (SAR) in accordance with the national guidance of best practice and the Board's SAR protocol.

The work of the Board is steered by an executive group of senior safeguarding leads from the three statutory agencies, London Borough of Haringey, North Central London Integrated Care Board (NCL ICB) and the Metropolitan Police for Enfield and Haringey.

The HSAB has links to four other Strategic Partnerships in the Borough: The Community Safety Partnership (CSP), the Health & Wellbeing Board (H&WB), the Violence Against Women and Girls Strategic Partnership (VAWG) and the Haringey Safeguarding Children Partnership (HSCP).

# 2. Work of the HSAB and its Subgroups

The HSAB subgroups facilitate focused work in line with the objectives of the 3-year strategic work plan. Each subgroup is chaired by a member of the Board. There has been a significant amount of work undertaken and completed by the Board and by some of its subgroups during the period 2022-23 some of which is detailed below.

## 2.1 Safeguarding Adult Review Subgroup (SARs)

**Purpose:** The purpose of the SAR Subgroup is to consider referrals for any case which may meet the statutory criteria for a Safeguarding Adults Review (SAR)

under Section 44 of the Care Act 2014[3]. The Subgroup makes decisions according to the statutory criteria, arranges and oversees all SARs, and ensures SAR recommendations are made and messages disseminated to all SAB partners so that lessons are learned from these cases.

The Care Act 2014 requires SABs to arrange a SAR when a case meets the mandatory criteria: that is, when an adult with care and support needs in its area dies as a result of abuse or neglect whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult, or if the same circumstances apply where an adult is still alive but has experienced serious abuse or neglect.

The HSAB may also arrange a discretionary SAR in other situations where it believes there will be value in doing so. SARs are undertaken to ensure that relevant lessons are learnt, professional multi-agency safeguarding practice is improved, and to do everything possible to prevent the issues raised happening again.

### 2.1.1 SAR's published in 2022/23

The SAR Subgroup has not published any SARs in 2022/23 but has continued to discuss cases, making clear decisions about referrals meeting the SAR criteria and progressing those cases for independent review where the SAR criteria are met.

### 2.1.2 SAR referrals

Four SAR referrals were received for consideration during 2022/23. One referral is still under consideration alongside ongoing parallel investigation processes. Another referral did not meet the mandatory criteria for a SAR and a single agency review was recommended. The remaining two referrals were found to meet the SAR criteria. This resulted in the initiation of a SAR in January 2023 using a traditional SAR methodology, and development of terms of reference for a second SAR to be undertaken in 2023/24, utilising significant event analysis and information from a related Learning Disabilities Mortality Review (LeDeR).

In line with previous years, two SAR referrals received by the SAR Subgroup in 2022/23 involved suspected self-neglect. The other two SAR referrals cited different types of suspected abuse, including physical, discriminatory and organisational abuse as well as neglect and acts of omission. The SAR referrals received this year also reflect the previously identified trend of referrals being made regarding adults who have died at a relatively young age: two referrals were for people in their 50s; one in their 30s and one in their 20s. The SAR Subgroup will continue to monitor trends in referrals through the collection of

[3] http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

information about each person's protected characteristics within the SAR referral form.

### 2.1.3 Safeguarding Adults Reviews (SARs)

During 2022/23, one Safeguarding Adults Review was initiated and is expected to report in 2023/24. The Steve SAR has been completed, and the SAR Subgroup is in the process of finalising the SAR report ready for publication and dissemination of learning across partner agencies. Work has also been undertaken with SAB partners to implement learning from two Safeguarding Adults Reviews (SARs) completed last year.

In 2023/24, there will be a renewed focus on working collaboratively with partner agencies to ensure that learning from SARs leads to change and improvement.

### 2.1.4 SAR Subgroup Priorities for 2023/24

In addition to the consideration of new SAR referrals, the priority areas of work for the SAR Subgroup currently identified for 2023/24 are:

- Publication and learning dissemination of Steve SAR;
- Completing the SAR currently in progress and planning publication and learning dissemination;
- Commissioning a SAR (LeDeR) utilising significant event analysis;
- Piloting new and collaborative ways to monitor the implementation of recommendations from Haringey SARs;
- Developing an annual SAR learning event/campaign;
- Responding to recommendations and learning from SARs published by other SABs;
- Reviewing referrals for SARs and commissioning any new SARs.

## 2.2 Prevention and Learning subgroup

The subgroup oversees the delivery of the Haringey Safeguarding Adults Prevention Strategy 2017-2021, and development and coordination of multi-agency safeguarding adults training provision. The subgroup has responsibility for the Prevention Strategy's Delivery Plan to increase awareness of safeguarding and co-ordinate single and multi-agency safeguarding adults training. Work has concentrated on better understanding the data collected and what this means for prioritising preventative work and planning for a community awareness raising campaign.

### 2.2.1 Subgroup work in 2022/23:

- Raised profile of adult safeguarding though social media & workshops for adult safeguarding week.
- 3 multi-agency training days ran to improve legal literacy of practitioners and increase understanding of MCA in range of professionals and partner organisations
- Contributed to skills development of professionals working with those alcohol or substance dependent (Blue Light project training).
- Intelligence and feedback gathered from range of Bridge Renewal Trust (BRT) voluntary sector partners to identify barriers to reporting safeguarding concerns and how to improve avenues to report.
- Refreshed the evidence base and information in the Joint Strategic Needs Analysis (JSNA) for domestic abuse, undertook deep dive to better understand data.
- Programme of awareness raising delivered by the VAWG team across the borough.
- Re-launched fire safety awareness sessions at fire station for council staff and provider carers.

### 2.2.2 Case Studies

*North Middlesex University Hospital*

Accident and Emergency is the busiest department in the Hospital. Sometimes seeing over 700 patients come through the doors and seeking medical assistance in a 24-hour period. The senior nursing practitioners are allocated cases that are triaged. They often work autonomously, and are trained to risk assess, treat, refer to the appropriate medical team and discharge.

Since the Covid-19 pandemic, there has been a noticeable increase of domestic abuse cases. As a result, some staff members felt they lack the skills and knowledge in risk assessing and escalating. Domestic abuse training was delivered and working alongside staff risk assessing and safety planning in the A&E department for those who attend and disclose domestic abuse. As part of this training, discussions took place on the importance of risk assessing and safety planning, as well as information gathering. Since then, the referrals that come through safeguarding has improved significantly, and the service are able to safely decide on the next steps.

An example of this was a 43-year-old man, who presented to A&E with injuries to his neck and body. He disclosed domestic abuse, and his wife was the perpetrator. The clinical practitioners were able to keep him safe within the A&E department, assist him in contacting the Police, and as a multi-disciplinary team we were able to discharge him to emergency accommodation which was provided by the Local Authority housing team.

### *Haringey Police*

Staff at a care home reported an assault by a carer on a service user at a supported living provision The suspect was using the service user's own hand to hit him repeatedly in the face and this was captured on CCTV. Officers on scene took full details from the staff. They recognised the service users vulnerabilities and engaged with him in a manner to avoid distress.

The officers, using their training, recognised the need for a Merlin due to the allegation of abuse and the raised indicators on the vulnerability assessment framework). The Merlin was assessed by Haringey police MASH team using the toolkit and deemed to be a red ragging due to the immediate intervention needed. The lack of consent to share with Adult Social care was able to be overridden due to the safeguarding interests of the service user.

A detailed police investigation was completed which involved the obtaining of a number of witness statements, interrogation of CCTV and a caution and an interview with the suspect. The victim was particularly vulnerable and due to lack of capacity was unable to provide a video-recorded interview. The lack of a victim's account will often be a barrier to a prosecution however the officer in the case was determined to demonstrate the offence through the CCTV and it was clearly in the public interest.

As well as the police investigation, the safeguarding of the service users and other vulnerable adults was prioritised. Police worked together with Social Care to ensure that the suspect was immediately suspended and that the CQC was informed.

Due to the tenacity of the officer, the Crown Prosecution Service supported the casefile, and the suspect was charged with Ill treatment by a care worker. This investigation showed multi-agency working throughout the 10-month investigation and a result which was clearly in the public interest. Various departments within the police (Uniform Response Team, Community Safety Unit and MASH) also worked effectively together and utilised their training to collectively produce a positive result which safeguards not only the individual concerned but other service users in the future.

## 2.3 Quality Assurance Subgroup

The purpose of the Quality Assurance (QA) Subgroup is to support HSAB to fulfil its remit of ensuring local safeguarding arrangements are effective and deliver the outcomes that people want. This group works to the HSAB Quality Assurance Framework (QAF) based on understanding adult at risks experiences; knowing what impact safeguarding has had; and working together.

### 2.3.1 Analysis of Performance Data

Continued to refine and improve the multi-agency adult safeguarding dataset (see performance section) to enable the partnership to be informed of local adult safeguarding activity and better placed to identify trends and patterns that the intelligence may highlight; and continued to liaise with other subgroups and working groups to ensure a joined up and consistent approach to the work is undertaken. A number of deep dive exercise have been carried out during the year looking into domestic abuse, self-neglect case and financial abuse cases.

### 2.3.2 Quality of Care Providers

The subgroup has continued to monitor the quality of care providers in all sectors to assure the Board that services provided and commissioned on behalf of Haringey residents meet specified quality standards, can prevent safeguarding incidents and respond effectively when they occur. Adult Social Services and the NCL ICB continues to commission only with providers that are rated 'Good' or 'Outstanding'. Such robust commissioning and procurement processes coupled with QA visits and input from the NCL ICB, and local authority has increased the number of Council commissioned 'Good' services located in Haringey.

### 2.3.3 Multi-Agency Quality Assurance Framework (QAF)

The HSAB has a duty to ensure the effectiveness of what organisations and agencies do in order to safeguard and promote the safety and wellbeing of adults at risk in the Borough. Effective work in this area will contribute towards achieving better outcomes for adults at risk and protection them from significant harm.

The Quality Assurance Framework was revised in 2022, it acts as the mechanism by which the Board hold local agencies to account for their safeguarding work, including prevention and early intervention. The QAF aims to, through a variety of means, provide a robust framework for understanding how effectively adults at risk of harm and neglect are protected, how well partners are working together to do this, and where safeguarding arrangements could be improved to ensure better outcomes for those adults at risk.

### 2.3.4 Multi-agency case file audits

The QA subgroup identified self-neglect as the area of focus for the multi-agency case file audit. In January 2022 a redrafted audit tool and guidance was presented and approved at the QA board.

A workshop was held in December 2022 to discuss the audit findings and to look at learning. The key themes that came out of the workshop were Making

Safeguarding Person (MSP); Mental Capacity; Safe Discharge; and Timeframes. A number of actions have been developed following the audit and has been shared with relevant partners.

### 2.3.5 Haringey Joint Establishment Concerns Procedure

The subgroup reviewed and refreshed the Haringey Joint Establishment Concerns Procedure. The procedure is a framework for managing investigations of care providers delivering support to vulnerable adults. It is rooted in the Care Act 2014, aiming to make safeguarding a personalised experience aligned with the outcomes identified by adults at risk. The procedure responds to concerns raised in various reports, incorporating lessons from SARs, the Winterbourne View Private Hospital report, and the Francis Report, among others. It emphasises principles such as empowerment, prevention, proportionate response, protection, partnership, and accountability, promoting transparency and collaboration with care providers to ensure safe, high-quality care for vulnerable individuals.

### 2.3.6 Managing Provider Failure and Other Service Interruptions Procedure

The subgroup reviewed and refreshed the Haringey Managing Provider Failure and Other Service Interruptions Procedure which is designed to address the impact of business failure in registered care providers on individuals' well-being. This procedure is in response to the Care Act 2014 and places emphasis on early risk identification and proactively supporting providers to prevent business failure. It ensures continuity of care and support for people receiving services in Haringey, regardless of their residence, funding, or provider's contractual arrangements. The council will meet care and support needs based on previous assessments, requesting additional information when necessary, and offering a range of services, while involving the relevant adults and carers in decision-making to minimise disruption in line with the well-being principle.

### 2.3.7 Haringey's Multi-Agency Section 42 Enquiry Framework and Guidance

The subgroup reviewed and refreshed the Joint Section 42 Enquiry Framework. The purpose of this framework is to guide all staff managing or conducting a Statutory Safeguarding Adult Enquiry under Section 42 of the Care Act 2014. It comes into effect when the Local Authority determines that the criteria for such an inquiry have been met.

The Section 42 Enquiry Framework sets out the duties and responsibilities for safeguarding, addressing situations where adults may be experiencing abuse, neglect, or exploitation. It highlights the importance of sharing information with

the local authority when concerns arise, even if shared with other agencies. The document also provides guidance for immediate actions to ensure the safety of the adult, such as reporting crimes or risks, safeguarding potential evidence, and involving relevant agencies as needed. The framework aims to promote the well-being of adults while conducting thorough investigations into abuse or neglect, always respecting the adult's wishes and involving them in the process. It also addresses cases where the adult lacks capacity and consent, highlighting the need for action when the risk to others or the public interest is at stake.

### 2.3.8 Haringey's Multi-Agency Self-Neglect and Hoarding Procedure

The subgroup reviewed and refreshed the Multi-Agency Self-Neglect and Hoarding Procedure. Its purpose is to guide organisations dealing with residents who exhibit self-neglect or hoarding behaviours, aiming to provide support and minimise risk. The procedure emphasises multi-agency partnership working, person-centered assessment and engagement, and safeguarding. The document outlines specific aims and objectives, such as coordinating a joint approach, developing an understanding of the psychological reasons behind self-neglect or hoarding, and improving individuals' quality of life.

### 2.3.9 Haringey Safeguarding Adult Partnership Audit Toolkit (SAPAT)

Members of the Board attended the SAPAT challenge event on 21st April 2022. All board partner organisations were asked to complete the updated SAPAT which has been developed by the London Chairs of Safeguarding Adults Boards (SABs) Network and NHS England London. It reflects statutory guidance and best practice. Voluntary & non statutory board members were asked to complete a different questionnaire. It was developed in response to concerns that the core SAPAT was not appropriate for voluntary and non-statutory Board members.

The purpose of the tool is to provide the HSAB with an overview of the Safeguarding Adult arrangements that are in place across the locality identifying what is working well and the areas that need improving.

Discussions took place on the challenges that the Board faced and how learning from each other and information sharing could be achieved. The event was attended by colleagues from Enfield Safeguarding Adults Board to provide a peer review aimed to develop our levels of assurance and improvement and to assist the Board in identifying priorities for our strategic priorities over the next twelve months.

A summary of key achievements highlighted in the partnership:

- Partnership response to the Covid-19 pandemic.
- Development of the Transitional Safeguarding Protocol.
- Partnership meetings with the Haringey Safeguarding Childrens Partnership (HSCP).
- Ongoing domestic abuse working group with all relevant partners.
- The continued work around SAR's the last 12 months has shown how positively the partnership can work together in bringing about systemic change in how we support our residents.
- Support to the Acute in terms of prioritising safeguarding responsibilities verses clinical responsibilities.

A summary of key challenges over the coming years:

- COVID recovery; challenges with backlogs and stretched resources.
- Learning from SAR's: continue to see reoccurring issues (mental capacity, risk, legal literacy etc) in practice and how systems operate.
- How do we measure impact and outcome of SAR learning.
- Workforce safeguarding roles and responsibilities to meet changing demand. Capacity issues and reduced staff levels.
- Consultation, planning and implementation of the new Liberty Protection Safeguards (LPS).
- Transitional safeguarding and managing increase in mental health cases moving to adult services.
- Imbed the Think Family Approach to safeguarding.
- The impact of the changing health landscape and move to an Integrated Care System (ICS).

## 2.4 Joint HSAB/Haringey Safeguarding Childrens Partnership (HSCP)

The HSAB and the Haringey Safeguarding Childrens Partnership (HSCP)* meet biannually to ensure joint collaborative working across both agencies. The main objective is to ensure that all agencies work together for the purpose of improving local safeguarding and promoting welfare of children and adults in care and support needs at risk in Haringey. It is worth noting that each Board has their own existing lines of accountability for safeguarding and promoting the welfare of children and adults by their services.

*The HSCP provides the safeguarding arrangements under which the safeguarding partners and relevant agencies work together to coordinate their safeguarding services. The partnership is responsible for identifying and responding to the needs of children in Haringey, commissioning and publishing local child safeguarding

practice reviews and providing scrutiny to ensure the effectiveness of the safeguarding arrangements.

### 2.4.1 Transitional Safeguarding

In July 2022, the joint HSCP and HSAB endorsed the new Transitional Safeguarding Protocol. The aim of the protocol is to develop a multiagency approach to preparing young people for adulthood that enables a transitional safeguarding response to support the most vulnerable young people and adults in Haringey who are at risk of abuse and exploitation. It aims to reach and influence the practice of all operational staff and managers as well as inspire senior leaders in their visioning and commissioning of future services.

The implementation of this protocol and action plan will lead to assurance for both the safeguarding adult board and safeguarding children partnership of a more effective multiagency approach for young people, enabling earlier identification of risks and responses that embed transitional safeguarding as an integral strand of the Preparing for Adulthood pathway.

### 2.4.2 Think Family Protocol

The Joint Board endorsed the Think Family protocol in July 2022. Think Family is Haringey's approach to working with its services and partner agencies to provide help, care and advice to families in the borough, particularly those with the greatest and most complex needs. It seeks to encourage everyone involved in supporting individuals to think about the needs and the situation of the whole family around them.

The overarching goal of the Think Family approach is to improve outcomes for Haringey's children and families by maximising the efficiency of local services through a focus on thinking and working together with the whole family. Its principles are intended to underpin all the support given to families across all services and agencies, including our response to 'Troubled Families' – and demonstrate the links.

### 2.4.3 National Review of Child Protection

In January 2023, the joint Board reviewed the National Review of Childrens Social Care. The review and its final recommendations have presented as a once in a generation opportunity for radical change (like the *Children Act 1989* was). The report calls on the Government to be ambitious for children and to play a more active role in creating the conditions for success by designing and delivering on a range of services to profile children's rights, set clearer outcomes for the way they live their childhood in the UK.

The findings recognise the context within which children's services operate, the impact of poverty and wider policy decisions on families and consequently on social care e.g., welfare, immigration, drugs, CAMHS and domestic abuse, both on children's lives and the need for help and support in communities. The joint Board will be discussing this further in 2023.

### 2.4.4 Impact of Poverty/Cost of Living Impact

An impact of poverty coordinating group has been set up which brings together relevant senior officers from across different parts of the council and aims to ensure that there is a coordinated approach to responding to cost of living pressures, and to plan and manage risks.

In addition, there is also a partnership forum which brings together a range of statutory and voluntary sector partners with responsibility for offering financial advice and assistance to residents. The aim of this group is to identify practical areas where we can better work together to respond to debt and financial hardship.

There has been a series of community sessions run across the borough led by cabinet members. Further sessions undertaken with local voluntary sector organisations, local Food Network and a range of other partners.

Data gathering exercise on increased demand and profile of residents approaching the council for help will be put in place in 2023.

### 2.4.5 The National Child Safeguarding Practise Review Panel

The National Child Safeguarding Practise Review Panel completed a phase one report in October 2022 on safeguarding children with disabilities and complex health needs in residential settings. The review sets out recommendations and findings for national government and local safeguarding partners to protect children at risk of serious harm. It examines allegations of abuse and neglect to children living in three private residential settings located in Doncaster and operated by the Hesley group. Local Authorities have been asked to ensure that quality and safety reviews are completed for all children with complex needs and disabilities currently living within placements to ensure they are in safe quality placements. Findings from the reviews were presented to the HSCP to use the learning to ensure the right improvements are made to practice and systems locally.

A joint report will be presented at the next joint session on current themes, issues and learning regarding organisational/ institutional abuse and measures taken in response to the concerns raised in the Hesley group report and relevant SARS.

# 3. Safeguarding Performance - Adults Activity 2022/23

## 3.1 Introduction

The Council collects information about safeguarding adults work in Haringey, so we know how well people are being safeguarded. This information helps the HSAB decide what their priorities should be.

Data in relation to all safeguarding issues is monitored both locally and nationally. All safeguarding concerns and enquiries are recorded and coordinated by Haringey Council. Progress from initial concern through to conclusion is monitored for timeliness and quality across a wide variety of measures, including the nature and location of harm, service user group, outcomes, age, gender, ethnicity, etc. This information is scrutinised by the Quality Assurance Subgroup who report key issues and trends to the HSAB.

The Care Act 2014 sets out the statutory duties and responsibilities for safeguarding, including the requirement to undertake enquiries under Section 42 (s42) of the Care Act to safeguard people. Below and on the next page is a summary of safeguarding activity recorded during 2022/23 for both safeguarding concerns raised, and s42 enquiries undertaken.

### 3.1.1 What do we mean when we say 'concern'?

When someone reports a concern about abuse or neglect of an adult with care and support needs, it is known as a **safeguarding concern**. A safeguarding concern that goes on to be investigated is known as an **enquiry**.

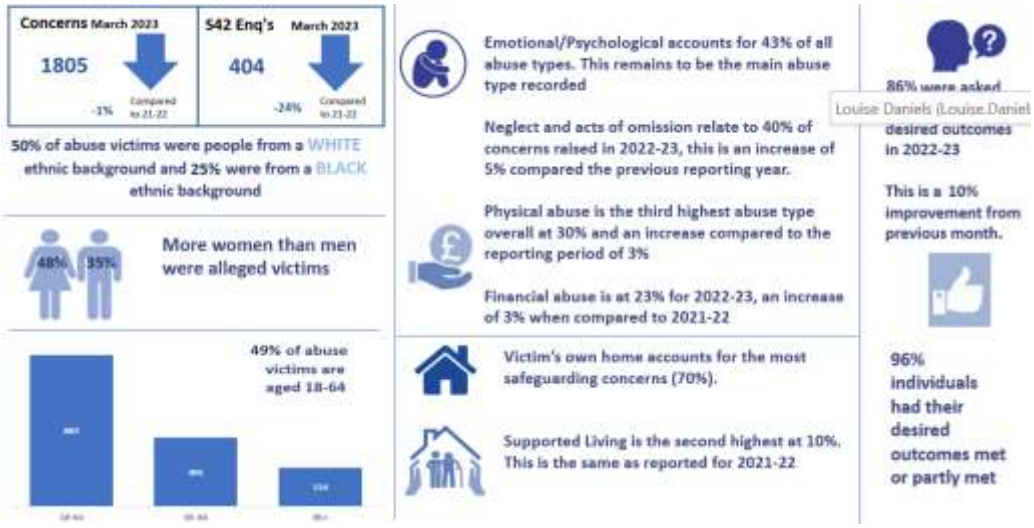
### 3.1.2 What do we mean when we say a section 42 enquiry?

There are two different types of safeguarding enquiry, depending on the characteristics of the adult at risk: If the adult fits the criteria outlined in s42 of the Care Act 2014, then local authorities are required by law to conduct enquiries. These are referred to as ***Statutory Safeguarding Enquiries***. Local authorities will sometimes decide to make safeguarding enquiries for adults who do not fit the s42 criteria. These enquiries are not required by law and are referred to as ***Non-Statutory Enquiries***.

The number of referrals that are assessed as not meeting the criteria for s42 are still significant, they are known as 'Other' safeguarding concerns. The safeguarding service performs an important role in identifying safeguarding concerns that should progress to a s42 enquiry, undertaking these enquiries and ensuring that any further actions required are progressed, such as referral for a Safeguarding Adult Review (SAR). The service also takes responsibility for

significant preventative action, such as a referral to other services or support, where a s42 Enquiry is not required, so that Other safeguarding concerns are managed appropriately.

**Definition of 'Other Safeguarding Enquiries' -** Those enquiries where an adult does not meet all of the s42 criteria (***Non-Statutory Enquiries***), but the local authority considers it necessary and proportionate to have a safeguarding enquiry. Whilst each local authority has the jurisdiction to decide what Safeguarding activity, they undertake for adults who do not meet the s42 criteria, some examples could include safeguarding to promote an individual's well-being as related to the areas in Section 1 of the Care Act, or for carers who do not qualify for s42. *(Source: SAC guidance NHS Digital).* The doubling of 'Other' or non-statutory safeguarding shown in the data is evidence that despite a concern not being defined as a s42, staff are undertaking activity to ensure the safety and wellbeing of residents.

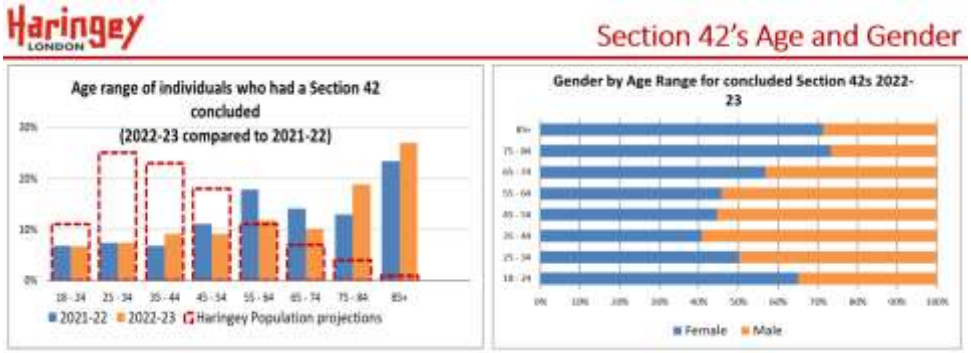



The number of safeguarding concerns has decreased by **1%** in 2022-23 compared to previous year. The number of Section 42s (S42 Enq's) decreased by **24%** from last year although the proportion of concerns leading to S42s has increased to **35%** in 2022-23 compared to **24%** in previous year.

### 3.1.3 Age of individuals involved in safeguarding concerns and s42 enquiries

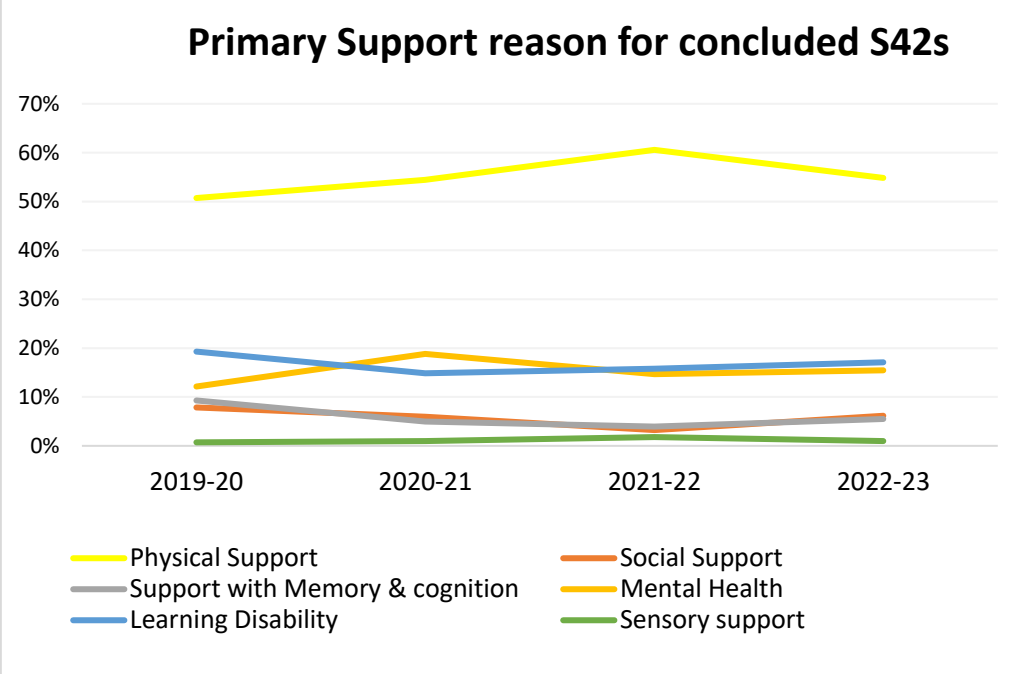
The data below shows that age plays an important role in determining whether a concern progresses to an enquiry. In short, concerns involving people over the age of 64 are much more likely to progress to enquiry than concerns involving people under the age of 64.

National and regional data* supports females being the highest proportion of concerns raised, varying from 55% to 60% of females against 42% to 39% of males with commenced a s42 enquires.




68% of individuals with a Section 42 enquiry are aged 55 and over, overrepresented when comparing to Haringey's adult population.

58% of individuals with a Section 42 enquiry are Female, a 2% increase compared to 2021-22.
In females we have seen an increase in % for those aged 65+
In males, whilst the highest % is for those aged 85+, there has been an increase in % for those aged 25-54




- Physical support remains to be most common type of Primary support reason, followed by Learning Disability and then Mental Health.
- Social Support has seen the biggest increase in % (3%), Social support consists of the following; Asylum Seeker Support, Substance Misuse Support, Support for Social Isolation / Other & Support to Carer.

### 3.1.4 Ethnicity of individuals involved in s42 enquiries

Year on year the ethnic background of people for whom a safeguarding concern has been raised remains similar, with the two main ethnic groups being White and Black/African/ Caribbean/Black British.

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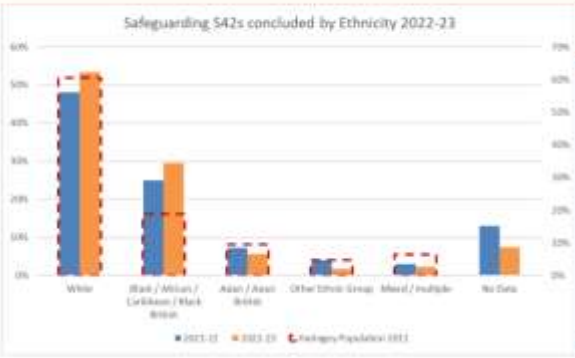
## Ethnicity





53% of individuals who had Section 42 concluded are White, a 5% increase compared to previous year almost in line when compared to Haringey's population. 30% are Black, also an increase of 5% from previous year but over-represented when compared to the Haringey population 19%.

Most white individuals were British (57%), followed by Greek Cypriot (9%) and Irish (7%)

Most black individuals were Caribbean (49%), followed by Black British (22%) and African (14%)

Most Asian individuals were Indian (35%), followed by British Asian (18%) and Bangladeshi (12%)

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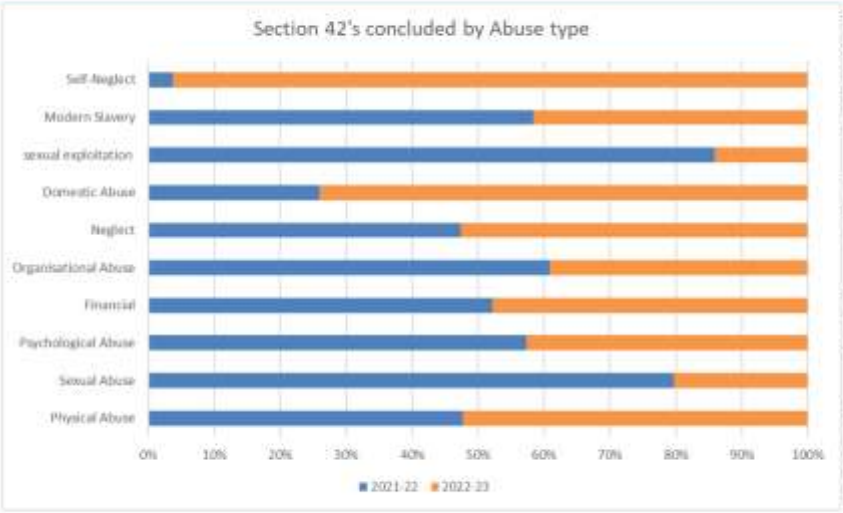
## Abuse Type




Proportionately Neglect and Acts of Omission account for the majority of risk types, accounting for 39% of all risk types in 2022-23, up from 35% in the previous year.

There has been an increase in Domestic abuse cases (3%) higher than previous year.

There were 37 cases of self-neglect cases compared to 1 recorded the previous year.

We have seen a decrease in the following abuse types: Sexual Abuse (2%), Psychological abuse (7%), Financial (2%)

### 3.1.5 Section 42's concluded by location of abuse

Abuse can happen anywhere: for example, in someone's own home, in a public place, in hospital, in a care home or in college. It can happen when someone lives alone or with others. It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether others have witnessed abuse and the role of family members and paid staff or professionals.

National and Regional data show a similar pattern within the home being the most likely area that abuse occurs, followed by care homes, community and then hospital.

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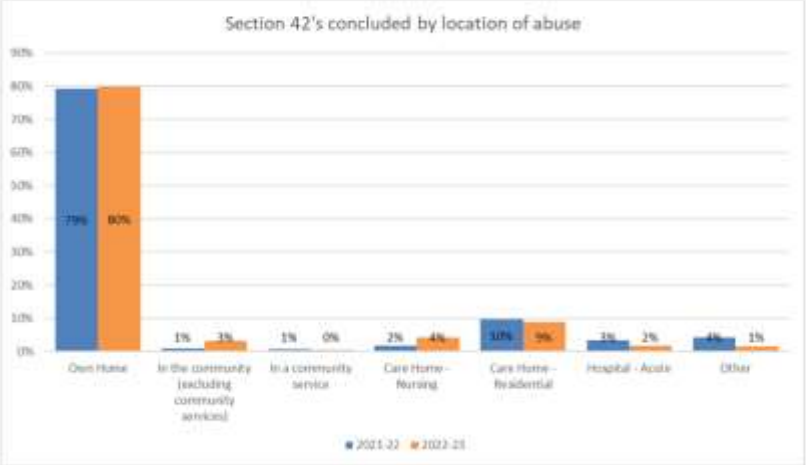
## Abuse Location




The home of the adult at risk accounted for **80%** of the risk locations in 2022-23, an increase of 1% from previous year.

'In the community (excluding community services)' and the abuse location in 'care home nursing' both increased by **2%** this year.

In a community setting, care home residential and hospital location all decreased by 1% in 2022-23

### 3.1.6 Risk outcomes

At the conclusion of a S42 enquiry, where a risk was identified during the Enquiry, an outcome concerning the status of this risk is recorded.

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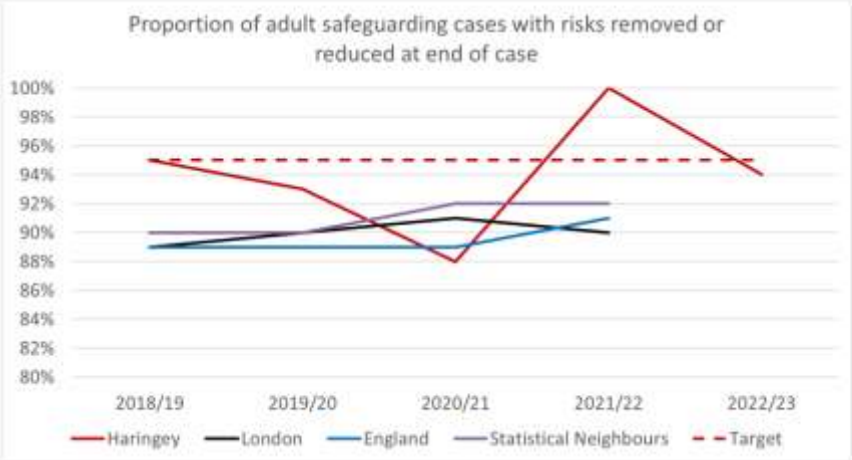
## Safeguarding Risks

Amber

Outcome 7. **All adults are able to live healthy and fulfilling lives, with dignity, staying active, safe and connected in their communities**

**Borough Plan indicator:** Proportion of adult safeguarding cases with risks removed or reduced at end of case

**Target:** 95% removed or reduced, with an increased proportion removed




In Haringey **94%** of the safeguarding cases concluded had their risks either removed or reduced in 2022/23, just below the end of year target but still higher than the London, statistical neighbours and national average.

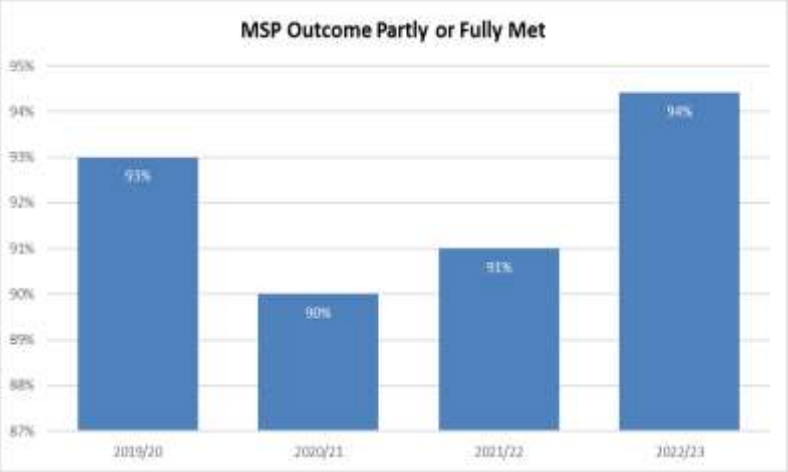
### 3.1.7 Making Safeguarding Personal (MSP)

Making Safeguarding Personal (MSP) is intended to make safeguarding more person-centred, develop more meaningful engagement of people in safeguarding and improve outcomes. It enables staff to spend time with people, asking them what they want by way of outcomes at the beginning and throughout the safeguarding process.

MSP is challenging work, not least because not all vulnerable people have the capacity to decide what is in their best interests and may need assistance to do so. As a result, there is a focus on increasing the knowledge and understanding of staff to ensure they undertake Mental Capacity Assessments (MCA) and that the best interest process is followed, including the use of independent advocacy as best practice.

The proportion of people asked about their making safeguarding personal desired outcome is **86%** in 2022-23, this is a 4% behind the target of 90%.

The person's desired outcome may not always be achievable. During 2022-23 we recorded **94%** outcomes met or partially met. This is an increase of **3%** compared to last year where **91%** of individuals who had a s42 concluded were asked and their outcomes were expressed.




# 4. Looking Ahead for 2023 and Beyond

Our partnership in Haringey is committed to working to a set of values that support our core purpose to protect those adults who are and who may become at risk. We achieve this through working closely with other strategic partnerships in Haringey. Working this way means we can focus with equal measure on tackling adult abuse where it occurs and play our part in promoting an environment where abuse is prevented. Our board is well supported, and commitment from partners is strong in driving ongoing improvement. The current 3-year (2018-21) Strategic Plan has come to an end and in 2022 plans commenced on putting together a new 5-year plan.

## 4.1 The HSAB Strategic Plan and Strategic Priorities 2023-2028

Developing a comprehensive safeguarding adult strategy is crucial for ensuring the safety and wellbeing of vulnerable adults. The new strategic plan will provide a long-term plan to address the needs of vulnerable adults and promote a culture of safeguarding within the community.

The plan is being developed through co-production work with the Joint Partnership Board (JPB) and other partner agencies on the Board and have aligned the proposed priorities using our joint experience from delivery of the last 3 year plan. The proposals also emerge specifically from learning from peer challenges, Safeguarding Adults Reviews (SARs) and outcomes from the annual Board challenge event.

Many of the recognised and emerging safeguarding issues and challenges such as; increasing incidence of domestic abuse, transitional safeguarding for young people, and safeguarding people who experience homelessness, require us to work

collaboratively with local partnership and other partnerships across London. There may also be some actions and themes which cannot be resolved locally, requiring regional and national escalation and discussion.

The objectives in the strategy will support different initiatives to address emerging safeguarding issues. By taking these steps, we can work towards a community where everyone can live a decent and fulfilling life, and where the most vulnerable members are protected from harm.

The following 3 draft priorities for proposal went out for consultation:

1. **Priority 1: Prevention & Awareness**
2. **Priority 2: Learning, Reflection and Practice Improvement**
3. **Priority 3: Safeguarding and Quality of Services**

### 4.1.1 How will we deliver the priorities?

The delivery of the priorities and objectives will be the responsibility of the Board's sub-groups, task and finish group and partners.

- **Chairs Executive Subgroup** provides effective leadership direction to the Board, to ensure that it operates efficiently and effectively, and that it delivers high quality safeguarding services to vulnerable adults in Haringey.
- **Quality Assurance Subgroup** supports the Board to fulfil its remit of ensuring local safeguarding arrangements are effective. Monitor and evaluate the quality and effectiveness of safeguarding policies procedures, practises and performance.
- **Safeguarding Adults Review Subgroup** considers referrals for any case which may meet the statutory criteria for a SAR under Section 44 of the Care Act 2014. The Subgroup makes decisions against the statutory criteria; makes arrangements for and oversees all SARs; and ensures recommendations are made and messages are disseminated to all partners so that lessons are learned.
- **Prevention and Engagement** will promote effective communication and engagement with the local community and relevant stakeholders; and to ensure that information about the HSAB's work, priorities, and initiatives is accessible and understandable to a wide range of individuals.
- **Practice Review Subgroup** will be ensuring that the recommendations and actions from Safeguarding Adult Review findings are acted upon; and improve the quality of safeguarding practise and ensure that vulnerable adults receive the support and protection they need.

### 4.1.2 How will the Strategic Plan link with the Haringey Corporate Delivery Plan 2022-2024

The Board Strategic Plan will be developed with links to the new Haringey Corporate Delivery Plan 2022-2024 (Adults, Health and Welfare Theme) replacing the Haringey Borough Pan 2019-2023[4]. The Delivery Plan includes the outcomes the Council is working towards as an organisation and the activity planned to deliver these outcomes.

In November 2022 Haringey Council launched the Haringey Deal. The Deal is all about forging a different way of working. This includes pledges to focus on building greater trust between the council and residents; learning when mistakes are made and putting things right quickly; empowering communities to make change happen for themselves; and finding new ways to share power with residents and communities. The Deal also recognises the critical importance of 'getting the basics right'.

There are some big challenges ahead for the HSAB and the Council including supporting residents through the cost-of-living crisis, dealing with the long-term impacts of the pandemic on resident's health and well-being; and striving to reduce the unacceptable inequalities in our borough, and ensuring every resident can live a secure, healthy, and fulfilling life.

The development of the Strategic Plan supports the foundations of the Haringey Deal for doing things together. We need to know our communities and start getting the basics right. Haringey communities are diverse and continuously changing, we need to develop a better understanding of who our residents are and how we can best work with residents.

# 5. Partner Statements

The agencies that make up the HSAB are all committed to improving their ability to prevent harm as well as to identify and react to allegations of abuse towards the people they work with. Every year, we ask our partners to write up their partner statements which highlights their key achievements throughout the year and what are the plans for the coming year. Details of how each partner has contributed to the work of the HSAB in 2022/23 can be found below.

## 5.1 Adult Safeguarding Adults Team

Overall, this has been a challenging year with increased demands on all service areas which does impact on our safeguarding activity. The SAB objective of protecting vulnerable adults health, wellbeing and human rights and enabling

[4] Priority 2 - People | Haringey Council

them to live free from harm, abuse, and neglect has been achieved by the Safeguarding Team in the following ways:

- Giving information and advice as and when appropriate; and
- Signposting to local and national organisations that support people in the community e.g., sexual abuse, domestic abuse, police, charities, other Council Departments / organisations.
- Undertaking Formal Care Act 2014 (Section 42) Safeguarding Enquiry initiated to ensure the following was undertaken:
- establish the facts about an incident or allegation;
- ascertain the adult's views and wishes on what they want as an outcome from the enquiry;
- assess the needs of the adult for protection, support, and redress and how they might be met;
- protect the adult from the abuse and neglect, as the adult wishes;
- establish if any other person is at risk of harm;
- make decisions as to what follow-up actions should be taken regarding the person or organisation responsible for the abuse or neglect.
- enable the adult to achieve resolution and recovery.

### 5.1.1 Challenges

- The volume of safeguarding referrals / Police MERLINS is significant and as a result the staff resources have been increased despite budget pressures and the difficulty of recruiting good quality qualified social workers.
- A duty system across the assessment and safeguarding service area has been introduced to focus on facilitating welfare visits and implementing immediate protection plans to keep people safe.
- There anecdotally appears to be a pressure to obtain partner interventions / resources to keep people safe when required such as long waiting times for ambulances to convey vulnerable adults to a place of safety, significant pressures on care home bed spaces (including increased costs) and welfare visits undertaken by police. A more robust liaison with the safeguarding representatives from various organisations has been required to ensure appropriate intervention is provided as and when needed; and they understand that the Safeguarding Team will cause other to do specific activities/actions (if/when appropriate) and the Safeguarding Team will provide Safeguarding Adult Manager (SAM) oversight.

### 5.1.2 Achievements

- The Team Management undertake presentations to other stakeholder groups to enhance their understanding of safeguarding and our respective roles and responsibility.

- The team has safeguarding policies, local guidance and procedures within the team that are in line with best practice.
- The team works effectively with other stakeholders, partners, and organisations to ensure they understand that Safeguarding is everyone's business and responsibility.
- The team adapt and respond to changes affecting how we safeguard adults in Haringey by being more proactive when engaging with other stakeholders whose resource / expertise is required.
- The team adhering to GDP arrangements and information sharing protocols when sharing information between service providers, agencies, and commissioners.
- The team endeavours to support / coordinate with other directorates in the Council and external parties / partners.
- The team endeavours to provide advice and guidance to other directorates and external parties; and seek advice, support, and guidance from externals partners / parties.
- The team will task others to conduct enquiries and will provide the Safeguarding Adult Manager (SAM) oversight.
- The Team will in some cases conduct direct enquiries by allocating a social care professional / practitioner or cause other to do so (if / when appropriate) and the Safeguarding Team provide Safeguarding Adult Manager (SAM) oversight.

### 5.1.3 External safeguarding audit ongoing service improvement work

Following the external audit of safeguarding adult services in 2021, a service development action improvement plan was put in place to address the recommendations and has since developed an ongoing service improvement plan. Further work undertaken:

- **Safeguarding Referrals:** A key area of work taken forward was the establishment of business object reports (i.e., reports that can be pulled directly from Mosaic, using live information). This is because we have had to revise our approach to help us track and monitor the handover between the FRT and Safeguarding Teams and the Progression of Urgent Referrals.
- **Risk Assessment and Allocation:** A further review of the staffing structure of the Safeguarding Team was completed and with use of short-term additional funding, means we have been able to recruit additional Senior Practitioners and Screening Officers to support the team.
- **Safeguarding Plan and Review of Plan:** This related to the time taken to conclude an enquiry with high numbers of cases being open over the local 28 days target. Performance reports were amended to monitor this at the last report it was noted that 76% of further enquiries were completed within the 28 days which is a significant improvement.

- **Performance Management and Reporting:** Following the audit, through ongoing review, changes have been made to both performance data being captured, monitored and shared. This has included an updated Safeguarding dashboard sent to Senior Managers and the leadership team.

#### *5.1.3.1 Service Improvement work:*

As well as the activity discussed above, the following are key elements of the ongoing service development:

- Review of Safeguarding pathways where LBH staff are embedded in integrated teams to ensure parity and consistency of response across the service areas. This will also assist in developing good practice as we move to ICS and localities.
- Review of LBH staffing structure to ensure both Safeguarding and Locality Teams have sufficient skills mix, staffing resource and leadership structures to provide consistent response to Safeguarding activity. This is also to be considered in the context of ICS development and the collective workforce we have across the system.
- Embed localities-based reporting and data collection. This to ensure localities are resourced sufficiently to manage demand and be kept under review.
- Transitional Safeguarding - work across the children's and adults board to focus on transitional safeguarding and how we ensure a stronger offer to our young adults. This work to be embedded as part of the transitions panel process?
- Further development of MASP at point of referral to be addressed via pathway reviews and use of themed multi-agency audits. This has been addressed in part by changes to the referral form.

### 5.1.4 Case study

**Psychological Abuse** - this was in relation to a mother who was looking after her young adult daughter that was 32 but had severe disabilities included emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation, or withdrawal from services or supportive networks.

**Outcome:** Working in partnership with several partner organisations, a clear protection plan implemented ensured that the adults voice was heard, her needs are adequately met and there is a regime that can provide feedback on her welfare and wellbeing should any concerns arise so that prompt action can be taken.

### 5.1.5 Looking ahead

The Safeguarding Team will continue to:

- Create safe environments for vulnerable adults through robust safeguarding practices and responses to concerns raised.
- Make sure all staff are trained, know how to respond to concerns and keep-up to date with policy and practice.
- Continue to undertake presentation to other stakeholders to enhance their understanding of the teams function and their respective roles and responsibility.
- To be aware of the signs of abuse or neglect.
- Recognise the signs of abuse and neglect.
- Record and report any concerns or incidents; and put in protection plans as appropriate.
- Report and or ask others to report immediate risks to the police by calling 999 when a risk or crime appears to have taken place.

## 5.2 North Central London Integrated Care Board

The ICB has worked collaboratively with our Safeguarding Adult and Safeguarding Children Partnership Boards across NCL, with local community teams and our borough voluntary services to provide support to those in greatest need during the cost of living crisis.

Information on resources and support was made widely available to NCL residents and staff via the NCL ICS Safeguarding webpage and the NCL ICB intranet safeguarding webpage'. See Link here: Support with the cost of living - North Central London Integrated Care System (nclhealthandcare.org.uk)

From a health perspective each Designated Professional works collaboratively with safeguarding leads across our health providers, including Primary Care, supporting them to provide additional training and support to ensure all staff recognise and report where they have a concern that an adult and/or child may be at risk of abuse, including from malnutrition and neglect, due to cost of living issues.

The North Central London Homeless Health and Care Community of Practice has been established to improve the support system for people experiencing homelessness (PEH) and connected to NCL. Improving the lives of those who are homeless requires collective and coordinated action from a range of partners across NCL, including the safeguarding team.

The aim of the group is to share ideas and good practice, identify challenges faced when providing care for PEH, and to collectively propose action plans to address issues raised.

### 5.2.1 Achievements

- NCL ICB has appointed a Director of Safeguarding to support the Chief Nurse in ensuring statutory requirements are met. The safeguarding team

comprises of Designated Nurses/Doctors/Professionals, Named GPs for safeguarding, Looked After Children and the Child Death Review Process Lead aligned to our five boroughs.

- The ICB has established a Safeguarding Strategic Oversight Group to strengthen internal assurance on the ICB Safeguarding strategy.
- In November 2022, the ICB hosted its first Safeguarding Adult and Children Conference, with a focus of safeguarding across lifespan.
- We have a well-established 'Quality oversight' forum, chaired by the Directors of Quality and Safeguarding, and attended by the Continuing Healthcare and Complex Individualised Commissioning (CHC/CIC) teams, along with our safeguarding colleagues. The purpose of the forum is to share local intelligence on providers where the ICB commissions packages of care for residents, including those with Mental Health, Learning Disability and Autism, as well as Children and Young people, ensuring that we place our residents with providers that can safely care for their needs.
- The ICB Quality and Safety committee (QSC) is a subcommittee of the ICB Board. Since its inception the QSC has reviewed the following safeguarding papers:
- Approval of NCL Safeguarding Adults and Safeguarding Children Policies.
- Overview of Maternity Services across NCL.
- Child Death Overview Panel 2021-22 Annual Report.
- 2021-22 NCL CCG Safeguarding Children and Adults Statutory Annual Report.
- An NCL safeguarding webpage was developed on the NCL GP website to supplement GP safeguarding forums and share best practice and information
- Safeguarding professionals offer support for Primary Care with complex safeguarding concerns. The Named GP and Designated Professionals support GPs with their participation in safeguarding reviews and audits.
- Haringey has a quarterly GP forum for training and discussion, and the ICB also hosts extra safeguarding webinars that GPs are invited to. Designated Professionals and Named GPs attend existing GP forums to promote Safeguarding Practice in Primary Care.
- The ICB Safeguarding Communication and Engagement Working Group raised awareness of international, national, and regional annual safeguarding events, and increased the understanding of safeguarding and access to support.
- Communication includes social media articles and signposting for the public, and webinars and articles for staff across the NCL health economy. The topics highlighted to staff on the intranet and in newsletters in 22/23 have been: Mental Health and Suicide Prevention: Dementia Awareness; Trafficking of people and Modern Slavery; Learning Disabilities; Domestic Abuse; Sexual Violence and Abuse; FGM Awareness and Online Safety.

### 5.2.2 Challenges

One of the key risks that the ICB has prioritised is sharing learning from Serious Care Reviews and Domestic Homicide Reviews. A Safeguarding System Learning Group has been established to take this work forward.

### 5.2.3 Looking ahead

- Further development of Safeguarding Governance framework and peer assurance for the ICB/ICS
- Training and development aligned to the intercollegiate document.
- Ensuring stronger safeguarding links with the CSP/SAB
- Embedding a Think Family Approach to safeguarding

Other **NHSE National Priorities** which are a focus for the ICB in 2023/24 include**:**

- Transitional safeguarding
- Contextual safeguarding
- Cost of living crisis
- Receiving and monitoring actions and themes from Safeguarding Self-Assessment (SAF) audits
- Mental Health

## 5.3 Haringey Metropolitan Police Service

The MPS and HSAB have common goals to prevent abuse. The MPS has continued to update the Public Protection Improvement Plan to deliver improvement across London, including Abuse and Neglect of Vulnerable Adults; Domestic Abuse, Stalking and Harassment.

### 5.3.1 Achievements

- Accredited specialist safeguarding course to all Public Protection officers and this remains ongoing for officers joining Public Protection.
- MPS has developed the Affinity Protocol, an evidence based problem-solving initiative that seeks to address recurring missing episodes, problematic volume and poor reporting approaches occurring at NHS Mental Health Service Providers and other hospital settings across London. The 9 Mental Health trusts across were onboard and the MPS has 9 SPoCs who liaise across BCU boundaries to fit Trust coverage. A new monthly data set feeds partnership meetings to address lost patient incidents reported as missing.
- Haringey MASH continues to provide input on continuous professional development days for all front-line officers in Haringey and Enfield, to support better data quality of Merlin reports.
- In collaboration with SafeLives**,** Domestic Abuse Matters Trainings were delivered to all frontline police officers across London. The training was developed to tackle the myths and misconceptions around domestic abuse

and most importantly build upon the valuable skills in existence across the Met to protect people at risk of harm.

- Operation Vesper launched to support the MPS VAWG strategy to reduce the number of open live rape investigations with the support of Crown Prosecution services. This has led a 2.1% increase of rape detections in the financial year of 2022-2023.
- There is now a cuckooing SPOC in the North Area who will collate all the active addresses of concern and work with the CMARAC and other partners to support vulnerable adults to protect their homes. Within this initiative we also now have a local cuckooing policy in place, in order that officers are clear on expectations and actions around these addresses.
- For Adult Safeguarding Week 1n November 22, our Vulnerable Adult Coordinator produced a guide for all North Area officers on adult safeguarding. This included information on care home investigations, financial exploitation, Modern Slavery, when/how to complete a Merlin and all the referral forms needed for the various multi-agency panels.
- Communication pathways have improved in relation to repeat survivors of RASSO offences who may be vulnerable, for example due to mental health concerns or a learning disability. A SOIT officer will now refer a case to the police Mental Health Team or the Vulnerable Adult Coordinator in order that they can be linked in with Adult Social Care or a Mental health Care Coordinator, to access the right support for the survivor.
- Operation Aegis Team, an organisation wide improvement project team to deliver improvement in Public Protection came to North Area BCU and spent 11 weeks to provide bespoke and enhanced support & coaching to all officers. 348 individual & small group support sessions were delivered to 731 officers across the BCU, along with bespoke briefings on risks assessments and investigative strategy.
- Face to face Mental health and Modern Slavery Training has been delivered to all Safer Neighbourhood Officers in the first quarter of 2023 improving awareness and also practice/procedure. MIND in Haringey have also funded and trained 192 NA officers in mental health First Aid. This is accredited course and equips the officers with a better understanding in how to identify and support a person in mental health crisis.
- In March 2023 NA implemented the Section 136 detention policy. This requires officers to consult a duty officer prior to using S136 (if safe and practicable to do so) and to call the Mental health advice line. This is encouraging officers to use the least restrictive option. As a result, we have seen a reduction of approximately 20% in the use of section 136. The Police Mental Health Team also work closely with BEH Trust to identity High Intensity Users where Trigger Plans will be produced to advise and guide officers with alternative options to section 136.
- Following new processes and consultation with our AMHP services we have also seen a reduction in Section 135 MHA warrants of 37%. This involves considering, with partners, another alternative avenues prior to a warrant application.

### 5.3.2 Cost of Living

- The Metropolitan Police Service (MPS) recognise the impact of cost of living crisis is having on families, especially in socially deprived communities. The financial strain on relationships can be evident and likely manifest into criminal offences, such as domestic abuse cases and fraud.
- We will address these challenges through effective intelligence gathering from our front line police officers and detectives; effective data sharing and referrals and collaborative approach with local partner agencies.
- Our front officers and detectives are trained in using the Vulnerability Assessment Framework (VAF). We would apply the framework on all contacts between the police and public. This would maximise opportunities for early intervention, especially for vulnerable adults. When signs and behaviours are identified using the framework, Merlin reports would be completed.
- The Haringey Multi-Agency Safeguarding Hub (MASH) continues to adhere strict guidelines on data sharing without delay with Haringey Adult Social Care; reviewed and quality assure the Merlin reports, identified risk to ensure timely referral.
- Recognising the most effective way to safeguard vulnerable adults are through collaborative working with our partners agencies. North Area Basic Command Unit (NA BCU) would ensure representations in our statuary partners meetings, including Community Multi-agency Risk Assessment Conference (CMARAC), Multi-agency Risk Assessment Conference for high risk domestic abuse; Multi-Agency Public Protection Arrangements; Safeguarding Adults Boards and other related working groups.
- NA BCU also dedicated Vulnerable Adult Coordinator work closely with both Haringey and Enfield Adult Social Care.

### 5.3.3 Challenges

- The MPS continued to face significant challenges which include austerity, changes in crime patterns and demographic across London. Mental health plays a significant role in public protection and diverting police resources to support the safeguarding. In March 2023, Met Officers detained 573 people under Section 136 of the Mental Health Act and many more under Section 135, the two most commonly used powers of detention where there are concerns that someone poses a risk to themselves or others.
- In London, it takes on average 14.2 hours in A&E and 8.5 hours at a health-based place of safety from the police arriving with a patient to medical staff taking over their care. It is estimated that Met officers spend well over 10,000 hours each month responding to mental health concerns and dealing with what should principally be health matters.

- MPS have addressed the concerns by launching the Turnaround Strategy which identified nine priorities. The strategy aims to deliver the change we need to see by improving our policing activities, our capability to reduce crime, and ensuring we deliver More Trust, Less Crime, High Standards.
- One of the key priority is to strengthen the work in Public Protection and Safeguarding. MPS will work continue to work closely with the NHS and other partners we will strive for an improved response to those in crisis, enabling us to focus on our policing role.

### 5.3.4 Looking Ahead

In the coming financial year, MPS will publish an updated version of Turnaround Plan which incorporates feedback from the public. The MPS will work closely with partners to adopt the Right Care, Right Person (RCRP) operational model, to ensure the individual receives the most appropriate care. Work remains ongoing on the review of MASH processes across London. The implementation of GoodSAM app across London to assist MPS in resolving missing person calls. The MPS initiative to utilise data and technology to target 100 most dangerous men in support of the violence against women strategy.

## 5.4 Barnet, Enfield, Haringey Mental Health Trust (BEHMHT)

Over the last financial year, we continue to gain assurance our staff are "Making Safeguarding Personal" by auditing Section 42 enquiries across the three Trust boroughs. Investigating the quality of protective measures implemented, evidence and effectiveness of multi-agency working. This has assisted in determining how practitioners are using best practice to maximise the chances of service users being protected and recovering from what they have experienced. We continue to "see the adult, see the child," with our think family agenda being well embedded within The Trust as we continue to work collaboratively with partner agencies to safeguard and protect children and adults.

Our continued delivery of safeguarding training to the PG diploma nursing students as part of corporate induction remains to gain positive feedback, plus bespoke training sessions in relation to our involvement in statutory reviews. The safeguarding team has also provided ongoing support to practitioners via refresher referral pathway training, this has built upon our training sessions held last year.

A Domestic Abuse and Sexual Safety Coordinator was appointed in August 2022. The Domestic Abuse and Sexual Safety Coordinator has supported delivery of a stalking masterclass in conjunction with the Stalking Threat Assessment Centre (STAC) psychologists; equipping staff to be able to effectively identify and respond to stalking, which widely acknowledged to be a key risk factor in cases of domestic homicide. This session was also delivered to partners across the Haringey

Safeguarding partnership, looking at supporting the coordinated community response. Due to low reports of men experiencing sexual abuse and barriers that men face in making a disclosure, we have facilitated a partnership wide workshop on 'Responding to Male Survivors of Sexual Abuse' with the Survivors Trust. Additionally, Specialist older people and domestic abuse workshops have been rolled out across older peoples, memory, and dementia services across the trust with Solace Women's Aid.

A Domestic Abuse and Harmful Practices drop-in surgery has been set up and operates on a weekly basis across the partnership, supporting frontline staff to understand risk and take proactive and positive steps in safeguarding people accessing BEH services.

### 5.4.1 Cost of living

The national cost of living crisis has had implications for safeguarding adults under the care of the Trust. Many households have been struggling with rising bills and food costs. These additional pressures may increase the risk of abuse, homelessness, decline in mental health, domestic abuse, neglect, self-neglect, and substance use.

- The Trust's Safeguarding Team have recognised these increased risks and have taken a number of steps to raise the profile of the team and safeguarding in general.
- Across BEH we now have 3 virtual advice drop in's for any practitioner who requires ad hoc advice and support.
- The safeguarding team continue to provide safeguarding supervision to the perinatal team, continually promoting safeguarding and risk posed to vulnerable babies and adults.
- We continue to promote safeguarding to all practitioners across BEH, we maximise our capacity by attending CPA's, team meetings and aways days, following this we can identify increased safeguarding adult alerts.
- We continue to measure the outcomes of our work via our internal reporting process, including auditing and analysis of the quality of safeguarding alerts.

### 5.4.2 Looking Ahead

The Trust will continue with its activities as outlined in section 1 to raise awareness of the Team and safeguarding in general.

Barnet, Enfield and Haringey MH NHS Trust and Camden and Islington Foundation Trust are both represented and an active partner in multi-agency forums overseeing safeguarding adults and key outcomes have oversight in the individual Trust's Safeguarding Committees (AKA Integrated Safeguarding Group (ISG) in BEH-MHT), which meet quarterly. The Safeguarding Committee/ISG is

chaired by the Chief Nurse, or Director of Nursing in their absence and is attended by appropriate Divisional representatives from across the Trust, relevant partner Designated Professionals for Safeguarding from North Central London Integrated Care Board (NCL ICB) and Local Authority colleagues as required.

The role of the Safeguarding Committee/ISG is to monitor relevant safeguarding information provided which includes information on safeguarding activity, training, supervision, Safeguarding Adult Reviews, Domestic Homicide Reviews, Serious Case Reviews, and other relevant data including that required by our partner NCL ICB/NCL ICS. The Safeguarding Committee/ISG reports into the individual Trust's Quality and Safety Committee.

Relevant policies, procedures and guidelines are in place to support and guide staff. These are available via the Trust's intranet and are publicised and promoted to staff as appropriate using various forms of communication. Allegations, complaints, and clinical incidents are investigated and monitored in order that necessary actions are taken, and any lessons learned are incorporated into ongoing supervision and training.

## 5.5 Whittington

Whittington Health is a member of the SAB and sub-groups. Increases in categories of alleged abuse such as self-neglect and/or financial abuse etc are raised by the Trust within this framework to ensure we are able to work with partners to address any increase in needs.

- Whittington Health has co-produced some videos for patients with a learning disability about what to expect at the hospital when attending the Emergency Department, Outpatients and having an operation. A training video has also been produced, in which our patients and expert staff members outline exactly what reasonable adjustments are required for people with a learning disability.
- We continue to deliver face to face training for level 2 safeguarding adults and continue to see an increase in numbers of referrals around safeguarding adult concerns as staff absorb this knowledge.
- Whilst the implementation of the proposed Liberty Protection Safeguards (LPS) has been postponed, Whittington Health were key members of both the National and regional Clinical Review Group (CRG) looking at gaps in knowledge and producing resources to assist agencies in having an awareness of their responsibilities in relation to the Mental Capacity Act 2005, and how to ensure Deprivation of Liberty Safeguards are considered for community patients too. This work also includes 16- and 17-year-olds.
- The continued increase in safeguarding adults' activity and complex hospital discharges has led to an increase in safeguarding adult resource within Whittington Health. It has been essential to ensure staff are aware of learning from Safeguarding Adult Reviews undertaken by the SAB, and the face-to-face

training offered for safeguarding adults is one route used to disseminate learning.

### 5.5.1 Case study

A concern was raised that a patient may be a victim of modern slavery due to the nature of the injuries he presented with, his living conditions, age, lack of knowledge of his locality despite being resident there for a significant period and general physical health. Placing the patient at the center of the concern in line with Making Safeguarding Personal (MSP), discussions were held with relevant agencies to ensure the patient could be safely discharged. This included liaising with the police and social services.

### 5.5.2 Looking ahead

- Maintain high compliance rate for safeguarding adults training.
- Continue to offer a visible and flexible consultation service to all staff and partners where appropriate.
- Look at the development of additional resources for staff around awareness of autism.

## 5.6 Bridge Renewal Trust

- We continue to provide support to voluntary sector groups via our online safeguarding training and other capacity building activities to the VCS in Haringey.
- During this year, 183 people have completed our online Basic Safeguarding Awareness Training, representing 24 Haringey organisations.
- We continue to face ongoing challenges around resourcing for Safeguarding within the VCS and its adequate promotion and embedding.
- We have continued to promote our online training and have worked with colleagues in the Council to look at ways to further understand the barriers to embedding safeguarding within VCS organisations. We held a Voluntary Sector Forum on this topic, attended by 23 VCS Groups.

## 5.7 Hornsey Housing Trust

- Working in partnership with foodbanks, the offer of warm spaces in communal areas and a shared service between four housing associations for a tenant officer to maximise income
- Improved tenants' income during the cost-of-living crisis. applications to foodbank and grant applications, partnership working with local community centres
- promotion of warm spaces, newsletters to tenants on how to save energy and keep warm. Sharing good practice with peers

- Shared tenant sustainment officer between 4 housing associations. partnership working with DWP and multi-agency working to support tenants.

## 5.8 Housing/Homelessness

- Have kept personal service charge as low as feasibly possible in the accommodation services that we deliver directly to minimise impacts on residents income
- Managed to keep a no rent night shelter open in hotel provision to ensure that we can keep as many people as possible off the streets whilst a suitable housing option is found for them.
- Significant pressures in trying to assist people in the borough with no recourse to public funds. Fortunately, the service has been able to run a temporary night shelter which has provided 15 bedspaces for vulnerable people who would otherwise be rough sleeping. This has allowed rapid access to assessment and support with health outcomes as well as immigration advice.
- HRS had a hospital discharge role in place working to ensure that there were housing options available. This role meant that zero people were discharged from hospital without a housing option. Additionally, it saved over £250k for the NHS by enabling discharge from hospital beds.
- Housing Needs have a allocated officer solely working on prison discharge to help to prevent release without a housing option available.
- Recently appointed a dedicated rough sleeping social worker with a focus on the Care Act 2014 and how people affected by rough sleeping are able to access support through it.
- Haringey has the highest number of rent-free bedspaces in London that are available for vulnerable people affected by rough sleeping and uncertain immigration status
- The delivery of the training over many quarters has led to an increased understanding of the intersection of homelessness and safeguarding, and the development of effective practices across the partnership to flag and respond to safeguarding concerns.

### 5.8.1 Looking Ahead

- To continue to embed the rough sleeping social worker and to be able to deliver measurable outcomes to feed in an evidence based way into best practice and removing barriers for vulnerable adults.
- To continue with a program of opening additional supported accommodation services for those experiencing the most complex support needs as well as the most vulnerable young people experiencing homelessness with some level of learning difficulties.
- An ongoing commitment to developing gendered responses to safeguarding women experiencing homelessness.