Haringey Safeguarding Adults Board

Annual Report 2023/24

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

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1. FOREWORD

Dr Adi Cooper
Independent Chair of the Haringey Safeguarding Adults Board

It is with great pleasure I present to you the Haringey Safeguarding Adults Board (HSAB) Annual Report for 2023/2024. This report provides an overview of our activities, achievements, and the challenges we faced over the past year, as we continue to deliver our commitment to safeguard vulnerable adults in our community.

Over the last year, the Board has worked diligently to strengthen safeguarding practices, ensuring they are robust, inclusive, and responsive to the needs of those we serve. Our collective efforts are guided by the principles of the Care Act 2014 and these principles form the cornerstone of our strategic vision, strategy and plans.

One of the key highlights of the past year has been the comprehensive consultation on our Strategic Plan for 2023-2028, co-produced with representatives from local groups. We recognised the importance of engaging with our community, residents, service providers, and partner organisations to shape the future direction of adult safeguarding in Haringey. The feedback we received has been invaluable in refining our strategic priorities and ensuring that our efforts align with the community's expectations and needs.

In addition, we published two critical Safeguarding Adult Reviews (SARs): the Steve SAR and the Paulette SAR. The Steve SAR highlighted the need for better coordination in housing accessibility, multi-agency meetings, and health support services, while the Paulette SAR underscored improvements in Deprivation of Liberty Standards, care home quality assurance, and the provision of specialist wheelchair services. In response, we have enhanced our Multi-Agency Solutions Panel (MASP), improved interagency communication, and raised awareness on self-neglect through extensive training and procedures. Looking ahead to 2024/25, we plan to commission and undertake two new SARs, ensure the effective dissemination of learning from SARs, and rigorously review new referrals to maintain high safeguarding standards

As the Independent Chair of the Haringey Safeguarding Adults Board, I am grateful to everyone who helped to shape the strategy and everyone who has worked and continues to work to keep people safe in Haringey.

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 risks and harms facing vulnerable adults in Haringey.

2. Introduction

The Haringey Safeguarding Adults Board (HSAB)

The HSAB is a statutory body established by the Care Act 2014. It consists of senior representatives from various organisations involved in preventing the neglect and abuse of adults. The primary objective of the Board is to protect adults with care and support needs who are at risk of abuse or neglect and unable to protect themselves due to their needs.

Vision and Objectives:

- The HSAB's vision is for Haringey residents to live a life free from harm in a community that does not tolerate abuse, works together to prevent it, and knows what to do when it occurs.
- The Board aims to ensure local safeguarding arrangements are in place, safeguarding practices are person-centered and outcome-focused, abuse and neglect are prevented collaboratively, and timely, proportionate responses are given when abuse or neglect occurs.

Operational Framework:

- The HSAB is not responsible for service delivery but works with agencies that plan and deliver local services.
- Haringey follows the **Pan London Procedures**[1] for Safeguarding Adults, ensuring standardised practices and an Information Sharing Agreement (ISA) across all agencies.

Core Functions:

- Ensure local safeguarding arrangements are in place as per the Care Act 2014.
- Ensure safeguarding practice is person-centered and outcome-focused.
- Collaborate to prevent abuse and neglect.
- Ensure timely and proportionate responses to abuse or neglect.
- Continuously improve safeguarding practices to enhance the quality of life for adults in the area.

Safeguarding Principles

The HSAB's work is guided by six key principles outlined in the Care Act 2014, these principles are foundational to effective safeguarding and apply across all sectors and settings, including care and support services.

Governance and Membership:

The HSAB is a collaborative partnership comprising statutory and non-statutory organisations, including health, care, and support providers across the borough. The

[1] London Multi-Agency Adult Safeguarding Policy and Procedures – LondonADASS

Board includes over 20 partners and occasionally invites guest speakers and additional attendees to address relevant issues. It is led by an independent Chair accountable to the Chief Executive of Haringey for chairing the HSAB and overseeing its work programme, while decisions made in the role are accountable solely to the Board. The Vice-Chair role is held by the Director of Adults and Health.

Key Responsibilities:

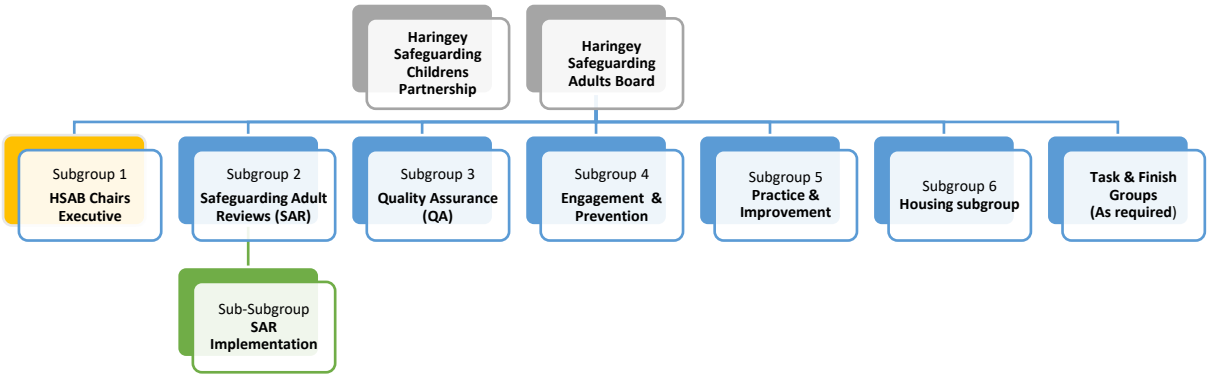
- Ensure appropriate representation of statutory partners on the SAB.
- Develop and implement a five-year Strategic Plan reflecting the Board's priorities.
- Publish an annual report detailing the Board's progress and achievements, widely disseminated among partner agencies and organisations.
- Conduct Safeguarding Adult Reviews (SARs) to learn from individual experiences, following national best practice and the Board's SAR protocol.

Operational Structure:

The Board meets quarterly and is guided by an executive group of senior safeguarding leads from the London Borough of Haringey, North Central London Integrated Care Board (NCL ICB), and the Metropolitan Police for Enfield and Haringey.

Strategic Partnerships:

HSAB maintains links with 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).



3. Haringey Safeguarding Adults Board Strategic Plan 2023-2028 Consultation

The HSAB embarked on a consultation with the aim of engaging residents, community organisations, service providers, and other stakeholders in shaping the future direction of adult safeguarding in the borough. Through various channels and methods, including an online questionnaire and drop-in sessions, we sought to gather diverse perspectives and experiences related to adult safeguarding.
This section of the annual report highlights the key themes, concerns, and recommendations that emerged from the feedback received. It provides an overview of the community's views on the current state of adult safeguarding.

The Board is required under the Care Act 2014 to publish a strategic plan. The Care Act 2014 requires Safeguarding Adults Boards (SABs) to ensure that vulnerable adults are safe, and that agencies work together to promote their welfare. The guidance explains how local authorities and other organisations should protect adults at risk of abuse or neglect and what SABs are expected to do.

3.1 The consultation

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

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

The public consultation started on 15 May 2023 and ran until 3rd July 2023. Given the statutory requirement to consult with key stakeholders and local communities, corporate Council communication channels were used to ensure that stakeholders and residents were aware of the consultation.

3.1.1 Summary feedback from the consultation:

- **Stakeholder Engagement:** The consultation process successfully engaged a diverse range of stakeholders, including professionals, service users, and community members. Their valuable feedback and perspectives have provided insights into the priorities and challenges related to safeguarding adults in the Haringey area.

- **Vision Statement:** The proposed vision statement for the HSAB, focusing on protecting and promoting the well-being of adults with care and support needs, received overall agreement and support. However, concerns were

expressed regarding the effectiveness of partnership working and the need to ensure service users are at the heart of services.

- **Priorities:** The identified priorities of Prevention & Awareness, Learning, Reflection and Practice Improvement, and Safeguarding & Quality of Services have garnered positive responses and general agreement. However, there were suggestions to provide more training and accessible materials for care staff.

- **Communication and Engagement:** Suggestions for improving communication include utilising multiple channels such as newsletters, phone calls, and post, as well as engaging with residents, carers, and community organisations. There was also a call for more transparency and feedback regarding safeguarding incidents and outcomes.

- **Diversity and Inclusion:** The consultation highlighted the diversity of respondents in terms of ethnicity, disability, sexual orientation, and gender. This underscores the importance of inclusive safeguarding practices that address the specific needs and challenges faced by different groups within the community.

Overall, the consultation provided valuable insights and perspectives, reinforcing the commitment to protect and support adults with care and support needs in Haringey. By incorporating the feedback received, the HSAB has strengthen its efforts to create a safer and more inclusive environment for vulnerable adults, prevent abuse and neglect, and improve the overall well-being of the community.

3.2 The Haringey Safeguarding Adults Board Strategic Plan 2023-2028

The Board has developed the strategy for the next five years which will be driven by annual delivery plans. Our annual plans set out how we will seek to promote safeguarding, quality of services, raise awareness, and how we will help to protect people with care and support needs at risk of abuse and neglect.

The annual delivery plans have two main purposes:

1. **Specify the actions required by the Board and each of its member agencies to implement the strategy, and**
2. **Inform the local community and all interested parties, including practitioners, about the work programme of the Board**

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.

The objective in the strategy supports 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.

Link to the Haringey Safeguarding Adults Board Strategic Priorities 2023-2028: https://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/haringey-safeguarding-adults-board-sab#strategicplan

4. Work of the HSAB and its Subgroups

4.1. Work of the HSAB and Partners

4.1.1 Safeguarding Referral Analysis and Service Improvement

The Board was updated on the analysis of safeguarding referrals and the progress of service improvement initiatives in Haringey Adult Services.

Safeguarding enquiries are pivotal in determining the facts of incidents, understanding the adult's preferences, assessing protection needs, preventing further harm, and deciding subsequent actions. The First Response Team (FRT) screens initial safeguarding reports, ensuring comprehensive information and consent are obtained, while also providing initial advice and direction.

Cases requiring further attention are triaged by the Safeguarding Team, prioritising actions based on urgency and ensuring all referrals adhere to "Making Safeguarding Personal" principles regarding consent. Section 42 enquiries are conducted when it is established that the individual has care needs, has experienced or is at risk of abuse/neglect, and cannot protect themselves due to their care needs.

Haringey consistently handles approximately 150 safeguarding concerns per month, with 59% resolved within two weeks. About 25% of cases progress to formal Care Act 2014 (Section 42) enquiries.

Current Service Improvements

To enhance responsiveness, the Assessment and Safeguarding Service has implemented a duty system with dedicated social workers and management available daily (Monday to Friday). This structure enables swift responses, urgent assessments, face-to-face evaluations, and immediate safeguarding plans, supported by ongoing telephonic guidance.

4.1.2. Safeguarding Adults Training and Development 2022/23

The following update details the safeguarding learning and development activities conducted during the financial year 2022/23 by partners represented at the HSAB. This marks the return of comprehensive reporting to the HSAB, which was suspended during the Covid-19 pandemic when only essential training activities were prioritised.

In the reported period, there was significant progress in safeguarding training efforts. A total of 5,997 employees completed Level 1 training, reflecting a notable 28% increase compared to the 2019 activity. Additionally, 6,738 Level 2 training places were delivered across partner organisations.

Background

The adoption of e-learning and video materials remained prominent throughout the year, complementing the return of in-person and live online training formats. This hybrid approach ensured accessibility and flexibility in training delivery, accommodating varied organizational needs and participant schedules.

Beyond internal training for employees, partner organisations expanded their roles by delivering safeguarding-related training to residents, volunteers, and other stakeholders. This approach not only broadened community awareness but also optimised resources by reducing reliance on external trainers.

The year featured an inclusive all-partner event, facilitating shared learning and process improvement following safeguarding incidents. Such initiatives reinforced collaborative efforts in enhancing safeguarding practices across the community.

A highlight of the year was the delivery of the POW (Protect Our Women) Programme by Solace Women's Aid, targeting young people and professionals on essential topics such as consent and healthy relationships.

Post-training evaluations highlighted practical applications of learning, informing future training strategies and enhancing safeguarding protocols. Ongoing case file audits contributed to identifying evolving learning needs and ensuring alignment with best practices.

The 2022/23 period showcased a robust commitment to safeguarding learning and development among SAB partners. Increased participation in Level 1 training, coupled with diversified training approaches and community outreach efforts, underscored the collective dedication to fostering a safer environment for all residents and stakeholders.

Looking Ahead

Multi-agency training remains a pivotal focus for the HSAB, integral to the subgroups delivery plan. Efforts will concentrate on empowering the community and voluntary sectors to identify and report instances of adult abuse effectively.

Below are a range of case study examples from agencies represented at the Prevention and Learning subgroup.

Case Study 1 – North Middlesex University

North Middlesex University Hospital's Accident and Emergency department is the busiest within our facility, often accommodating over 700 patients seeking medical assistance in a 24-hour period. Senior nursing practitioners in this department manage triaged cases autonomously, conducting risk

assessments, providing treatment, referring patients to appropriate medical teams, and facilitating discharges.

Recently, I received a request for face-to-face training in domestic abuse following an observed increase in such cases since the Covid-19 pandemic. Staff expressed a need to enhance their skills and knowledge in risk assessment and escalation protocols. In response, I conducted domestic abuse training sessions and collaborated with staff on risk assessment and safety planning for patients disclosing domestic abuse in A&E.

During these sessions, we emphasised the critical importance of thorough risk assessment, safety planning, and information gathering. Subsequently, there has been a noticeable improvement in referrals to safeguarding services. This approach allows us to make informed decisions, such as whether to admit patients for social care, involve law enforcement, or safely discharge them, all while maintaining a personalized approach and adopting a 'think-family' perspective.

An illustrative case involved a 43-year-old man who presented at A&E with injuries to his neck and body, disclosing domestic abuse by his wife. The clinical team swiftly ensured his safety within the department, facilitated contact with the police, and collaborated with a multidisciplinary team to arrange emergency accommodation through the Local Authority Housing Team before his discharge.

Case Study 2 – Housing Related Support: Working in Partnership

The ongoing delivery of training across multiple quarters has enhanced our understanding of the intersection between homelessness and safeguarding, fostering effective practices throughout our partnership to identify and respond to safeguarding concerns. The following case illustrates our collaborative approach in safeguarding individuals accessing our services:

Our initial encounter with A occurred when he sought assistance at our service as a street homeless individual. He presented with poor hygiene and was visibly hungry. Despite language barriers—A spoke no English and was from Bulgaria—we provided him with clean clothing, a shower, and hot meals, which helped him feel more at ease. Although we arranged for a Bulgarian interpreter, A seemed unable to communicate effectively, often responding with "yes" and nodding without understanding the questions posed. While it was evident that A was homeless, we faced challenges in completing a Streetlink referral due to these communication barriers and our inability to determine his exact sleeping location. We notified the Street Outreach Team (SORT), who agreed to monitor the area for A's presence. Over the following weeks, A returned to our service regularly, utilizing our facilities and accessing food. Despite attempts using translation lines and Google Translate, effective communication remained elusive.

Noticing that a staff member from the adjacent corner shop was interacting with A, I approached them to join us at the drop-in centre and act as an

interpreter. This interaction enabled us to gather more information and successfully complete a Streetlink referral, providing A with blankets and warm clothing to endure the cold weather. Through this conversation, we learned that A had been promised work in the UK after receiving a plane ticket from Bulgaria but was abandoned upon arrival, forced to work without pay at the Bulgarian shop next door. When asked about returning to Bulgaria, A expressed reluctance, citing his lack of belongings and desire to remain in England for work opportunities.

The shop's staff member, acting as an "interpreter," also disclosed that A was dependent on alcohol and that the shop was supplying him with alcohol. We promptly referred A to HAGA for support with alcohol dependency and initiated Modern Slavery and inter-agency safeguarding referrals. Further outreach to the Salvation Army confirmed suspicions of human trafficking, prompting us to refer A to them for comprehensive assessment and ongoing support.

This case exemplifies our commitment to safeguarding vulnerable individuals through collaborative efforts and timely interventions across agencies, ensuring comprehensive support for those in need.

Case Study 3 – Whittington Health

There has been a noted decrease in safeguarding adult referrals from specific services within Whittington Health. To address this, a weekly drop-in session was implemented for staff to discuss any concerns related to safeguarding adults or the Mental Capacity Act. This initiative has resulted in an increase in the number of safeguarding adult concerns being reported.

Regular face-to-face safeguarding adult training sessions continue to be offered, with a minimum of two sessions held each month. The number of safeguarding adult concerns has notably risen since the onset of the pandemic, and this upward trend is expected to continue into the next reporting year ending March 31, 2023.

A 28-year-old woman was brought to the hospital by her boyfriend and his brother. The woman did not speak English, and her boyfriend acted as her translator. According to him, she had arrived in the UK six weeks prior to be with him.

Upon examination, the woman was found to have first and second-degree burns on the back of her legs up to the knee. Initially, the boyfriend claimed these injuries occurred when she accidentally ran herself a hot bath without realizing the temperature. However, he later admitted that she had fallen asleep in a very hot bath, and he had pulled her out.

Staff members were highly suspicious of these conflicting accounts, leading them to involve the police. Subsequently, both men were arrested in connection with the incident.

This case underscores the importance of vigilance and prompt action in safeguarding adult cases, ensuring thorough investigations and appropriate interventions to protect vulnerable individuals.

Case Study 4 – Haringey Police Service

Staff at a care home reported an assault by a carer on a service user (TO) 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 TO's 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 'Bragging' (against blue, red, amber and green BRAG risk assessment) 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 TO.

A detailed police investigation was completed which involved the obtaining of a number of witness statements, interrogation of CCTV and a caution+3 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 TO and other vulnerable adults was prioritised. Police worked together with Social Care to ensure that the suspect was immediately suspended and that the Care Quality Commission 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.

4.1.3. Safeguarding People Facing Homelessness and Rough Sleeping

The 2022/23 annual report was presented to the HSAB to provide assurance that measures are in place to safeguard vulnerable adults at risk due to homelessness and rough sleeping. It outlined the strategic context, local homelessness profile, and key initiatives, and priorities for the coming year.

Some Key Highlights:

Adult Homelessness in Haringey

- Assessments and Duties: From April 2022 to March 2023, 1420 single people were assessed and owed a prevention or relief duty. Temporary accommodation was provided to 134 individuals, and 56 cases were accepted for main homelessness duty.
- Prevention and Relief: The service prevented or relieved homelessness for 779 people, either by helping them remain in their accommodation or by securing alternative housing.

Co-production in Single Homelessness

- Approach: The service has been embedding a co-production approach to better understand and meet residents' needs by involving them in decision-making processes.
- Rough Sleeping Strategy: The new Rough Sleeping Strategy was co-produced with staff and individuals with lived experience, described as best-practice in strategy design. A Peer Scrutiny Panel will assess the strategy's efficacy annually.

Rough Sleeping Profile

- Statistics: In 2022/23, 304 people were seen sleeping rough, an increase from 268 in the previous year but a decrease from 405 in 2020/21.
- Demographics: In Q4 of 2022/23, 90 people were seen sleeping rough; 37 were only seen once, and 13 were long-term rough sleepers. Of these, 40% were UK nationals, 28% EU nationals, and 32% non-EU nationals. The majority (83%) were male.

Target 1000

- Vulnerable Individuals: The Target 1000 initiative reduced the number of highly vulnerable rough sleepers from 34 in 2021/22 to 12 in 2022/23. These individuals receive intensive support, with 10 of the 12 now in accommodation.

Mulberry Junction

- Increased Use: There was a 415% increase in unique visitors from Q4 2021/22 to Q4 2022/23. The service has seen more young people and individuals with complex needs.
- Service Enhancements: Improvements in staff training and inclusive policies have enhanced service quality. The facility hosts 16 different services or groups and operates beyond standard office hours.

Deaths

- Statistics: Annually, around 8 homeless individuals die in Haringey, typically in hospitals or supported accommodation. The mean age at death in 2022 was 43. Most had drug or alcohol dependencies, with 33% having a history of rough sleeping.

Thematic Safeguarding Adult Review

- Implementation: Following the 2019 deaths of three homeless individuals, a comprehensive approach to implementing the review's recommendations has been adopted. Key actions include the recruitment of a social worker and quarterly reporting on decision panel outcomes and the Homelessness Reduction Act 2017 implementation.

Priorities for 2023-24

- Co-produce Rough Sleeping Strategy (2023-27)
- Reinstating Emergency Accommodation at Clarendon
- Developing bespoke social care interventions for those with rough sleeping histories
- Supporting vulnerable people with No Recourse to Public Funds (NRPF)
- Developing new supported accommodation and implementing targeted health funding

4.1.4. Violence against Women and Girls (VAWG)

The borough has one of the highest rates of reported domestic abuse across London. During the period April 2022 to March 2023, the rate of domestic abuse offences reported for Haringey was 11.4 per 1,000 of the population, which equates to 3,046 offences. Of these offences, 779 (25%) were reported as domestic abuse violence with injury. When comparing with neighbouring boroughs, Enfield reported the highest number of domestic abuse offences (4,016) and the greatest number of domestic abuse violence with injury offences (985). Camden had the lowest number of domestic abuse offences (2,210) and domestic abuse violence with injury offences (512).

The VAWG team in Haringey have forged key partnerships with voluntary and community sector organisations including the Bridge Renewal Trust (BRT) and the health sector including local hospitals, GPs, and pharmacists in order to support victims and perpetrators. Through the expansion of these partnerships and engagement with private sector organisations, the VAWG service in Haringey is continuously building its capacity and resource. The VAWG team actively engage with Pan London services which are funded by MOPAC. These services include the Ascent Partnership and joint commissioned services, such as the Wiser service, which was developed in partnership with other local authorities.

Through its multi-agency approach and the alignment of key resources, the Haringey VAWG service strives to meet the needs of victims and perpetrators, focusing on reducing the incidence of these crimes, which affect one in three women nationally.

Looking ahead

- Continue to develop partnership working arrangements between providers to ensure that co-ordinated interventions around VAWG are in place across health, police, education, housing, social care and voluntary and community groups.
- A whole system wide approach to domestic abuse is taken to address the multi-faceted and interrelated needs of victims while enabling access to multiple types of support.
- Haringey VAWG team continue to work with stakeholders, the community and survivors to develop an improved understanding of the profile of victim/survivors of VAWG in the borough.
- Further analyse to better understand the implications of the cost of living crisis on VAWG services and survivors with more focused analysis on ethnically minoritised populations.
- Increase and improve the awareness of the negative impact of VAWG on the local population, developing the referral pathway to best support victim/survivors experiencing domestic abuse.

4.1.5. London Fire Brigade Home Fire Safety Visit (HFSV) Strategy (presented to the HSAB)

The London Fire Brigade (LFB) has introduced a new Home Fire Safety Visit (HFSV) strategy effective from April 3, 2023. This strategy aims to allocate the majority of LFB's safety advice resources to the most vulnerable Londoners, thereby enhancing fire safety measures across the community.

Home Fire Safety Visits (HFSVs)

LFB conducts Home Fire Safety Visits across London, offering personalised fire safety advice at homes. In addition, an online Home Fire Safety Checker tool is available to provide tailored advice to keep homes safe. This online checker is free and easy to use.

Key Features of the New HFSV Strategy

- The new strategy focuses on prioritising the most vulnerable individuals for HFSVs.
- Individuals are categorised based on risk levels, with a specific focus on identifying those at very high risk.

Actions for Partner Agencies

Partner agencies play a crucial role in identifying and referring very high-risk individuals for immediate HFSVs. Agencies should refer individuals who meet the very high-risk criteria immediately by calling 0208 536 5955, a new 24-hour phone number available for blue light partners and local authorities. This ensures that homes can be visited within 4 hours.

Those who fall into lower risk categories can use the online Home Fire Safety Checker tool for tailored fire safety advice.

Communication and Outreach

LFB will run information campaigns about the online Home Fire Safety Checker tool once the new strategy is in place. Partners are encouraged to share this information through social media, newsletters, and other channels. LFB will provide content for these campaigns and requests the best contact details within partner organizations to facilitate this communication.

The new HFSV strategy by LFB represents a significant step towards improving fire safety for the most vulnerable members of the community. Through collaborative efforts with partners such as HSAB, LFB aims to ensure that every individual at risk receives the necessary support and resources to maintain a safe living environment.

4.1.6. Persons in Positions of Trust (PIPOT)

The HSAB has implemented the Person in Position of Trust (PIPOT) guidance to provide a comprehensive framework for managing allegations against individuals in positions of trust. The aim is to manage risks based on assessments of abuse or harm to adults with care and support needs. This guidance was agreed upon by the HSAB at its board meeting in January 2024, with an expectation for all partners to establish their own PIPOT policies and report back to the board to ensure consistent and reliable safeguarding practices.

The guidance aligns with the Care Act 2014 and subsequent statutory guidance, setting expectations for how allegations against PIPOTs should be notified and addressed. It underscores the importance of local authorities ensuring that service providers have robust processes for preventing and responding to abuse or neglect.

The guidance aims to ensure appropriate actions are taken when managing allegations against PIPOTs, whether related to their employment, private life, or other capacities. It applies to Local Authorities, partner agencies, and commissioned services, mandating clear procedures for responding to allegations.

4.1.7. NCL Learning from the LeDeR Local and National Report

Background and Introduction to the LeDeR Programme

The Learning Disabilities Mortality Review (LeDeR) Programme is a national initiative designed to review the deaths of people with learning disabilities (LD) and autistic people. Its aim is to identify patterns and learn from these deaths to enhance the quality of health and social care services for these populations. Through systematic reviews, the programme seeks to highlight any issues or areas for improvement to prevent premature deaths and promote best practices.

- In 2022/23, there were 67 death notifications for individuals with a primary diagnosis of LD in NCL. Four of these deaths were children, now managed by the Child Death Overview Panel (CDOP) team, and one notification was recorded as out of scope.
- **Diagnosis Data:** No reported deaths were identified for autistic individuals without a primary LD diagnosis.
- **Focused Reviews:** 24% of focused reviews indicate that deaths may be from the BAME community or due to respiratory concerns or cancer, areas of focus since the 2021/22 report. Concluding the annual report without these reviews would mean 76% of notified deaths in 2022/23 would not be considered.

4.1.8. Multi-Agency Solutions Panel (MASP)

The Multi-Agency Solutions Panel (MASP) was established in May 2021 after reviewing the Haringey High Risk Panel (HHRP). The review identified several areas for improvement, such as increasing the number of referrals and referrers, ensuring more consistent and senior panel membership, broadening the range of case types presented, and increasing the frequency of panel meetings.

Impact Over the Last 12 Months

- Decrease in Referrals: There was a 42% reduction in referrals. This was partly due to increased multi-agency case discussions, ensuring all cases undergo this process before reaching MASP. However, the demand, pressure, and complexity within the system suggest that the number of referrals should be higher.
- Engagement and Communication: Efforts to improve engagement and communication with partners, including information sharing programs, have helped boost referral numbers but require ongoing work.
- Referral Reasons: Slight reductions in self-neglect/hoarding and increases in housing/homelessness and substance misuse cases. The overall types of cases heard by MASP have not changed significantly despite fewer referrals.
- Referral Sources: Equal referrals from Adult Social Services, Health, and Housing/Homelessness Services indicate balanced engagement from

main partners. However, there is a need to engage other parts of the system less connected to health, housing, and social care.

- Gender and Ethnicity: Referrals were balanced between men and women. Ethnic diversity was well-represented, reflecting the borough's diverse nature. However, efforts are needed to support disadvantaged groups not adequately represented in the numbers.

The MASP has shown effectiveness in addressing complex cases and improving multi-agency collaboration. Despite the reduction in referrals, the efforts to engage partners and promote the panel are positive steps. The MASP will continue to focus on communication, engagement, and system-wide support for enhancing MASP's impact in the future.

4.1.9. ICB and the Cost of Living Impact

The ICB have worked collaboratively with Safeguarding Adult and Safeguarding Children Partnership Boards across NCL, working collaboratively with local community teams, including our borough voluntary and community sectors to provide support to those in greatest need. From a health perspective our designates work collaboratively with our safeguarding leads across our health providers, including Primary Care, supporting them to provide additional training and support to all staff to recognise and report concerns where they have a concern that an adult and/or child may be at risk of abuse, including malnutrition and neglect, as a consequence of the current cost of living issues.

4.2 Work of the HSAB Subgroups

The HSAB subgroups facilitate focused work in line with the objectives of the new five-year strategic work plan. Each subgroup is chaired by a member of the Board.

4.2.1 Safeguarding Adult Review Subgroup (SARs)

The purpose of the SAR Subgroup is to consider referrals for any case which may meet the criteria for a Safeguarding Adults Review (SAR) under Section 44 of the Care Act 2014[2]. 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

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

protect the adult, or if the same circumstances apply where an adult is still alive but has experienced serious abuse or neglect.

SABs 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.

4.2.1.1 Achievements in 2023/24:

The SAB has published two SARs in 2023/24 and the SAR Subgroup has continued to discuss other cases, making clear decisions about referrals meeting the SAR criteria and progressing cases for independent review where the SAR criteria are met. Terms of reference have been developed for a further two SARs to be undertaken in 2024/25.

4.2.1.2 SAR referrals

Five SAR referrals were received for consideration during 2023/24. One of these referrals has led to a joint SAR being commissioned, due to some overlap in issues raised in a previous SAR referral. One referral was found not to meet the SAR criteria and information continues to be collected for the remaining three referrals, which are still under consideration.

All of the SAR referrals made to the SAR Subgroup in 2023/24 involved either suspected neglect and acts of omission or self-neglect. Two of the five SAR referrals involved adults who had died at a relatively young age, a trend that was observed in the previous two years. However, three of the referrals related to people who had died in their 70s and 80s, suggesting that the Subgroup has been successful in communicating the SAR criteria and encouraging a wider range of appropriate referrals from partners. Ethnicity data continues to be collected on SAR referrals; three referrals were for people from White British backgrounds, one related to a person from a Black British background and one related to a person from an Eastern European background. The SAR Subgroup will continue to monitor trends in referrals through the collection of information about each person's protected characteristics within the SAR referral form.

4.2.1.3 Safeguarding Adults Reviews (SARs)

During 2023/24, the Steve and Paulette SARs have been published on the Haringey website: Safeguarding Adults Reviews | Haringey Council. The full SAR reports and 7-minute briefings have been shared with SAB partners to aid the dissemination of learning across partner agencies.

The SAB commissioned the independently led Steve SAR to identify learning from the events leading to the death of Steve, who sadly passed

away after injuring his leg falling through the rotten floor of his privately rented property. Agencies were trying to help Steve access alternative housing in the three months prior to his death. However, an offer of housing came too late, and Steve sadly passed away in hospital, aged 61. Changes and improvements were made by the agencies involved in this review, but the SAR recommended further improvements regarding:

- Reviewing the use, accessibility and promotion of multi-agency meetings;
- The processes available to escalate concerns about private sector housing;
- Provision of regular adult safeguarding training widely across agencies;
- Review and promotion of adult safeguarding pathways;
- Oversight and follow up of referrals to alcohol and mental health support services;
- The housing needs assessment of vulnerable people.

The Paulette SAR was published in January 2024. This review looked at the learning arising from the events leading to the death of Paulette, who sadly passed away, aged 56, from multiple organ failure and sepsis, almost two years after receiving health diagnoses, including early onset dementia, that led to her moving temporarily into a local care home. The SAR recommended improvements, including:

- Ensuring Deprivation of Liberty Standards (DoLs) procedures are working effectively;
- Reviewing gaps in commissioned services and alternatives to residential care;
- Seeking assurance about care home quality assurance and care planning;
- Ensuring specialist wheelchair services are available to local care homes;
- Seeking assurance about joint work on tenancy accounts;
- Reviewing assessment and recording of pressure damage and management of repetitive patterns;
- Embedding the use of multi-agency meetings.

In response to learning from SARs, the following improvements have been made:

- Review of Multi-Agency Solutions Panel (MASP), including signposting to other multi-agency forums.
- Raised awareness of MASP through promotion to SAB and the voluntary and community sector (VCS), with information and video on Council website.
- Assurance about the condition of landlord's properties in Steve case.

- Improved interagency communication between Environmental Health, Housing and MASP about any concerns in private sector housing.
- Information shared with SAB and VCS about tenants' legal rights.
- Changes to safeguarding concern referral process.
- Understanding of self-neglect reinforced through multi-agency safeguarding training, posters and self-neglect & hoarding procedure.

4.2.1.4 SAR Subgroup Priorities for 2024/25:

In addition to the consideration of new SAR referrals, the priority areas of work for the SAR Subgroup currently identified for 2024/25 are:

- Commissioning and undertaking two new SARs.
- Planning SAR publication and dissemination of learning.
- Reviewing referrals for SARs and commissioning any new SARs meeting the statutory criteria.
- Responding to the findings of the second National SAR Analysis.

4.2.2 Engagement and Prevention subgroup

The Engagement and Prevention Subgroup is a vital component of the HSAB, focusing on Priority 1: Prevention and Awareness within the HSAB Strategic Plan. The subgroup has initiated the process of establishing its terms of reference, membership, and planning for the upcoming year.

The subgroup is tasked with several crucial responsibilities aimed at promoting engagement, raising awareness of safeguarding, and leading on prevention efforts. These include:

- Overseeing the delivery of the Haringey Safeguarding Adults Prevention Strategy.
- Leading safeguarding awareness campaigns.
- Promoting effective communication and engagement with the community and stakeholders.
- Ensuring accessible information about HSAB's work and priorities.

4.2.2.1 Initial Progress

Given the recent establishment of the strategic plan, much of the subgroup's work has been foundational. Initial progress includes:

- Setting Up Terms of Reference and Memberships: The subgroup has been focused on defining its scope, roles, and membership structure to ensure effective functioning.
- Planning for the year ahead: Preparations are underway to develop a comprehensive plan for the upcoming year, aligning with the strategic priorities of HSAB.

4.2.2.2 Objectives and Planned Activities

The subgroup will focus on several key objectives and activities to fulfil its mandate:

- Engagement with Healthwatch Haringey and the voluntary sector: Regular engagement with these entities to ensure a collaborative approach to safeguarding.
- Collaboration across North Central London (NCL): Joint projects and resource-sharing with Enfield, Barnet, Camden, and Islington to address shared priorities.
- Utilising data to identify and engage with community groups needing targeted safeguarding initiatives.
- Developing and delivering a plan to increase community awareness and support for adult safeguarding issues.
- Collaborating with the Joint Partnership Board and the VCS to assess the impact of engagement activities.
- Creating and disseminating campaigns through various channels to encourage reporting and prevention of adult abuse.
- Updating and executing the Prevention Strategy (2022-25) in alignment with the new strategic plan.
- Working with residents, community groups, charities, and volunteers to address safeguarding concerns and share expertise.
- Developing targeted outreach activities to vulnerable groups to raise safeguarding awareness.
- Organising events to highlight safeguarding issues and promote awareness.

While the Engagement and Prevention Subgroup is in the early stages of establishment, it has laid a strong foundation for future activities. With a clear focus on prevention and awareness, the subgroup is poised to make significant contributions to safeguarding adults in Haringey through strategic planning, collaborative efforts, and targeted community engagement.

4.2.3 Quality Assurance Subgroup

The Quality Assurance (QA) Subgroup operates under the Haringey Safeguarding Adults Board (HSAB) with the primary aim of ensuring that safeguarding arrangements in Haringey are effective and that residents receive safe, high-quality care. Despite the recent approval of the HSAB strategic plan and the early stages of subgroup establishment (with new co-chairs), the QA Subgroup has made significant progress in monitoring care quality across the provider market.

4.2.3.1 Purpose of the Subgroup

The QA Subgroup is tasked with supporting the HSAB in fulfilling its mission to ensure local safeguarding measures are robust. The subgroup employs the Board's Quality Assurance Framework (QAF) to hold local agencies accountable for their safeguarding efforts, focusing on prevention and early intervention. This involves developing and executing an annual work plan aligned with the Board's strategic priorities and regularly producing reports and information for the Board.

4.2.3.2 Specific Responsibilities and Progress

Despite being in the initial stages of setting up terms of reference and memberships, the QA Subgroup has continued its crucial role in monitoring care quality. The following outlines their specific responsibilities and progress:

- The subgroup is committed to advancing relevant recommendations from Safeguarding Adults Reviews (SARs).
- Care Organisational Audits: Audits of care providers are conducted to identify key safeguarding issues.
- Efforts are underway to identify and engage community groups needing specific safeguarding attention.
- The subgroup coordinates the HSAB's Performance Framework and presents findings to the Board regularly, identifying trends and gaps to inform targeted improvements.
- The subgroup monitors key outcomes from national reviews, advising the HSAB on applicable learnings for Haringey.
- The subgroup liaises with other subgroups to ensure a cohesive approach to safeguarding activities.
- The subgroup considers the impact of the cost of living crisis on safeguarding, addressing issues like food and fuel poverty.
- Joint provider monitoring reports are produced quarterly, detailing Care Quality Commission (CQC) status and training activities within the provider market in Haringey.

4.2.3.3 Joint Provider Commissioning Reports

Adult Social Services and the North Central London Integrated Care Board (NCL ICB) continue to commission services from providers rated 'Good' or 'Outstanding'. This stringent quality assurance approach has increased the number of council-commissioned services rated 'Good' in Haringey, ensuring that residents receive high-quality care.

4.2.3.4 Multi-agency case file audits

The Quality Assurance subgroup identified self-neglect as the area of focus for the multi-agency case file audit. Given that most self-neglect

cases are managed under s.9 and not s.42 this did limit the number of cases which could be used for the audit.

The first of the cases was NB, a 73-year-old Black British male who was living at home with support being provided by his son. Reported diagnosis of dementia and Parkinson. He was admitted to North Middlesex Hospital after being found wandering from his home.

The second case was TJ, an 86-year-old White British male who was living at home with no support in place. TJ had no family and was being supported by the community palliative care team who raised concerns that he was unable to manage his personal hygiene and pressure care. Unfortunately, TJ died before the s.42 could be completed and as such there is only limited information that could be used as part of this audit.

Summary of findings

- **Making Safeguarding Personal -** In both cases there is no evidence that the hospital has sought the views of either of the individuals to whom the safeguarding concern relates to.
- **Mental Capacity and Consent -** In both safeguarding concerns raised by the hospital they have not sought the consent of the individual for whom the concern relates to, neither have they properly considered their mental capacity.
- **Timeframes -** There was a significant delay (7 weeks) from when the safeguarding concern was raised by the hospital to the time in which it is actually recorded on the system. The inability to respond presents significant risks to individuals who are referred onto the safeguarding pathway.

Actions following audit

- Safeguarding Adults concern form to be updated to clearly set out the criteria around outcomes and consent.
- Practice notes to be shared with Haringey Social Care practitioners on clearly defining outcomes with the person as to meaningful safeguarding interventions.
- Mental Capacity Assessment and consent responsibility to be raised with health and social care staff through safeguarding leads in each area.
- Audit of safeguarding mental capacity assessments to be undertaken by Principal Social Worker.
- Restructure of pathways for First Response, Safeguarding and Assessment teams
- SAB to request Performance team to provide update on timeframes of when concerns are raised to when they are recorded on the system.

4.2.4 Practice & Improvement Subgroup

The Practice & Improvement Subgroup is a newly established subgroup, formed in response to the feedback from the strategic plan consultation. As part of the recently approved HSAB strategic plan, the subgroup is in the early stages of development, focusing on setting up its terms of reference, membership, and plans for the upcoming year.

To develop mechanisms to support practice improvement in safeguarding across the partnership, the subgroup will focus on the following:

- Pressure Ulcers;
- Mental Capacity Assessments (MCA's); and
- The development of a training matrix

4.2.4.1 Key Activities and Plans

- The subgroup aims to explore opportunities for collaboration with NCL-wide initiatives. For instance, pressure ulcers will be used as an example to reflect on potential synergies between local and regional efforts. This approach underscores the need for comprehensive strategies to practice improvement.
- A Training Matrix will be developed to standardise training efforts across the partnership, ensuring consistent and effective practice improvement.
- Ensuring that reviews are completed in line with Care Act requirements and that collective lessons are learned.
- Collaboration with the Safeguarding Adult Review Subgroup: Highlighting areas for monitoring or enhancement based on review outcomes.
- Implementation and Refreshing of the Practice Improvement Strategy (2022-25): Aligning efforts with the new HSAB Strategic Plan and priorities.
- Collaboration with Other Agencies: Identifying areas of concern and sharing knowledge and expertise around practice improvement.
- Engagement with Other HSAB Subgroups and Partners: Fostering collaboration and sharing good practices to maximize collective impact.
- Focus on MCA/Mental Health & TVN: Addressing major areas identified by Safeguarding Adult Reviews that require focused attention.
- A dedicated working group will be established to ensure all activities, priorities, and plans are actioned efficiently and in a streamlined manner.

Although the Practice & Improvement Subgroup is still in its early stages following the strategic plan consultation feedback, it has made initial progress in laying a robust foundation for achieving its objectives. By focusing on key themes like pressure ulcers and mental capacity assessments, exploring collaborative opportunities, and establishing a

clear framework for practice improvement, the subgroup is poised to make significant contributions to safeguarding practices across the partnership. The upcoming year will be crucial for implementing these plans and realizing the strategic goals set forth by the HSAB.

5. Joint HSAB/Haringey Safeguarding Childrens Partnership (HSCP)

The HSAB and the Haringey Safeguarding Children Partnership (HSCP) hold biannual meetings to ensure joint collaborative efforts. Their primary goal is to improve local safeguarding and promote the welfare of children and adults with care and support needs in Haringey. While both boards maintain their own lines of accountability for safeguarding and welfare promotion, they work together to enhance coordination and effectiveness.

The HSCP oversees safeguarding arrangements, ensuring that partners and relevant agencies collaborate effectively. This includes identifying and addressing the needs of children, commissioning and publishing local child safeguarding practice reviews, and providing scrutiny to ensure robust safeguarding practices.

Some of the key issues discussed during the year:

- Gambling Harms in Haringey
- Transitional Safeguarding
- Damp and Mould in Council and Housing Stock
- Right Care, Right Person; and
- Safe and well-being reviews

4.3 Addressing Gambling Harm in Haringey

Gambling harm encompasses the broad range of adverse impacts resulting from gambling activities, affecting not only the individual gambler but also their families, friends, and broader community. These harms can include financial difficulties, mental health issues, relationship breakdowns, and social isolation. In Haringey, addressing these harms is crucial due to the significant number of residents potentially affected.

4.3.1 Problem Gambling in Haringey

Nationally, an estimated 0.5% of the population are problem gamblers, a figure that rises to 1.8% in London. Applying this London rate to Haringey suggests approximately 4,070 residents might be problem gamblers. Each problem gambler typically affects six others, leading to broader social, economic, and emotional costs.

Certain groups are disproportionately affected. For example, 11.6% of the rough sleeping population in London report pathological gambling. Problem gambling is often linked with poor mental health and increased risk of suicide, with 24% of individuals with mental health issues who gamble online reporting a negative impact on their mental health. Additionally, the hidden nature of problem gambling in some communities can make it difficult to address.

4.3.2 Gambling Premises in Haringey

Haringey has an average of 24 gambling premises per 100,000 residents, significantly above the national average of 16 and the third highest in London. This high density of gambling venues contributes to the accessibility and prevalence of gambling activities in the borough.

4.3.3 Impact on Children and Young People

In Haringey, 5% of secondary school students have gambled in the past year, with boys (7%) more likely to gamble than girls (1%). While lower than the national average of 11% for 11-16-year-olds, exposure to gambling marketing is widespread, with 96% of surveyed 11-24-year-olds encountering gambling advertisements monthly. Despite this exposure, only 53% reported seeing age restriction messages, and 38% noticed safer gambling warnings. Additionally, 6% of young people follow gambling accounts on Snapchat, where some betting premises use QR codes to promote gambling.

4.3.4 Haringey Gambling Harms Programme Design

To tackle gambling harm, Haringey has implemented a comprehensive Health in All Policies approach, focusing on six main elements:

- Adult Co-produced Work: Conducting literature reviews and focus groups with local residents to identify needs and solutions.
- Youth Engagement: Offering educational workshops and training for teachers and parents and working with the youth council.
- Raising Awareness: Running a borough-wide campaign with materials from national organizations like GamCare.
- Delivering a Gambling Summit: Hosting a professional conference on gambling-related harms, resulting in the formation of the Gambling Network.
- Training Programme: Providing training to statutory and voluntary sector staff, including council members and volunteers.
- Sustainable Pathways Development: Establishing a referral service and refining service pathways to ensure sustainability.
- Achievements to Date
- Awareness Materials: Development and distribution of leaflets with GamCare, and inclusion of information on Haringey’s webpages and in the Cost-of-Living Crisis Booklet.
- Referral Pathways: Establishing clinics in Wood Green and Northumberland Park and embedding pathways within Children's and Adult Social Care systems.
- Collaboration with MIND: Developing joint initiatives to support affected individuals.
- Workshops and Training: Conducting sessions in secondary schools and youth clubs, including questions in the SHUE Survey (January 2024). Training has been provided to 68 staff members, council leaders, and volunteers, with bespoke training offers for specific services.

- Haringey's efforts in addressing gambling harm are a testament to the borough's commitment to mitigating the adverse effects of gambling on its residents and fostering a healthier, more aware community.

4.4 Transitional Safeguarding: Collaborative Efforts between Haringey Safeguarding Children's Partnership and Haringey Safeguarding Adults Board

The Haringey Safeguarding Children's Partnership (HSCP) and HSAB have been collaboratively developing an approach to Transitional Safeguarding. This initiative focuses on supporting the most vulnerable young people and adults in Haringey who are at risk of exploitation as they transition from adolescence to adulthood. It distinguishes between 'transitions' the process of changing from one state to another and 'Transitional Safeguarding,' which involves a needs-led, personalised approach that goes beyond traditional notions of both transitions and safeguarding.

The collaboration aims to create a more effective partnership plan for young people transitioning to adulthood. This approach will enable earlier identification of safeguarding risks and embed Transitional Safeguarding as an integral part of the Preparing for Adulthood Strategic Development.

4.4.1 Work to Date

- Transitional Safeguarding Protocol Launch: Signed off in December 2022, this protocol outlines four key priorities and ensures active engagement with young people from the Young Adults Service (YAS). It includes consultations with Care Leavers to consider their impact.
- Involvement of the Parenting Advisory Committee and a Lead Member linked to colleges and housing to address the impact on parenting and Care Leavers.
- Transitional Safeguarding Action Plan: this plan outlines priorities and progress, emphasising continuity of support for young people moving from care to adulthood.

4.4.2 Champions Model Workstream

- Involvement of Experts: Individuals with lived experience shape the Champions Model Workstream, ensuring young people's voices are included in policy development and decision-making.
- Vulnerable Young People: Prioritising support for those with complex safeguarding needs, such as substance misuse or exploitation.

The collaborative efforts of HSCP and HSAB in Transitional Safeguarding highlight the importance of continued collaboration, active engagement with young people, and the integration of Transitional Safeguarding approaches into broader strategic development. The ongoing work and planned initiatives aim to ensure that vulnerable young people in Haringey receive the support they need as they transition into adulthood.

4.5 Damp and mould in council and Housing Stock

Haringey Council took significant steps to address the issue of damp and mould in its housing stock. A dedicated operational team was established within the Housing Repairs Service to prioritise and remediate these cases, with a tracker system implemented for monitoring purposes. To streamline reporting and response, a dedicated hotline and email address were introduced.

A comprehensive Damp and Mould policy, approved by Cabinet, was implemented alongside a new Decant policy to relocate residents temporarily while severe damp and mould issues are addressed. Housing staff were trained on the new policy and provided with specialised training to identify and assess hazards. A concerted effort was made to engage and communicate with residents, including updates to the website, information leaflets, and consultations during the policy development phase.

The council's efforts included improved information sharing with Adult and Children services to ensure prioritised responses to flagged cases. The volume of identified cases increased as the stock condition survey progressed, and efforts were made to ensure 100% stock survey completion. The council reported a reduction in Category 1 and 2 cases over the year and continued to validate and provide remedial works.

To further enhance case management, a new digital case management system is being implemented, and a pilot program for installing damp and mould sensors in tenants' homes was initiated. Collaboration with public health entities and the procurement of additional specialist contractors are ongoing to support these initiatives.

The HSCP and HSAB can play a pivotal role in tackling damp and mould issues. By working closely with the operational team, these boards can help ensure that vulnerable residents are identified promptly and referred for necessary interventions. Health professionals, including district nurses and health visitors, can serve as frontline identifiers of damp and mould conditions during their visits to residents' homes. This collaborative approach will enhance the council's ability to respond swiftly and effectively, improving the living conditions and overall health of vulnerable populations in Haringey.

6. Safeguarding Performance - Adults Activity 2023/24

Introduction

We collect information on safeguarding adults to assess the effectiveness of protection measures. This data guides the HSAB in setting its priorities. Both local and national data on all safeguarding issues are monitored, this includes recording and coordinating all safeguarding concerns and inquiries. The council tracks the progress of each case from initial concern to resolution, evaluating factors such as the nature of harm, demographics, and outcomes. The Quality Assurance Subgroup scrutinises this information and reports key findings and trends to the HSAB.

The Care Act 2014 outlines legal duties for safeguarding, including conducting inquiries (Section 42) to protect individuals. The following pages summarise safeguarding activities recorded during 2023/24, detailing both reported concerns and Section 42 inquiries conducted.

Understanding Safeguarding Concerns

When someone reports potential abuse or neglect of an adult requiring care and support, it's referred to as a safeguarding concern. If investigated further, it becomes an inquiry.

Section 42 Inquiries

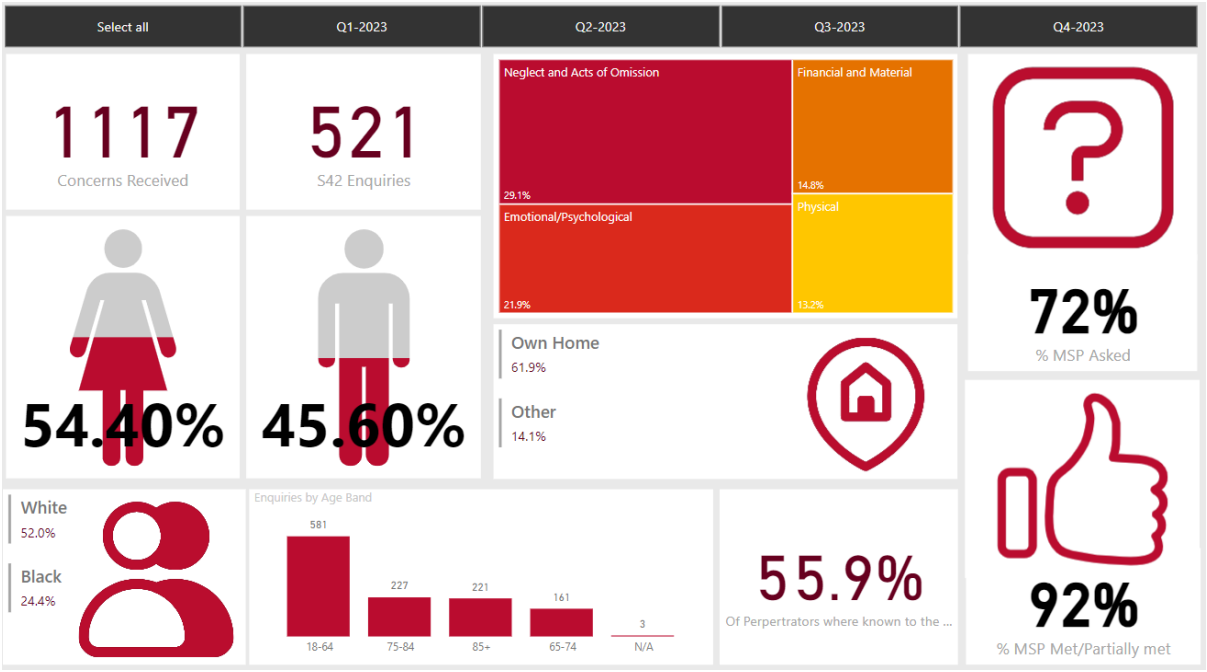
There are two types of safeguarding inquiries: Statutory Safeguarding Enquiries, which are required by law under Section 42 of the Care Act 2014 for adults meeting specific criteria, and Non-Statutory Enquiries, which are discretionary investigations undertaken for other cases.

Other Safeguarding Concerns

A significant number of referrals do not meet the criteria for Section 42 inquiries but are still important ('Other' safeguarding concerns). These cases are managed to ensure appropriate actions are taken, which may include preventive measures or referrals to other services or support. This proactive approach helps manage safeguarding concerns effectively, even when a Section 42 inquiry is not required.

Definition of 'Other Safeguarding Enquiries'

These are non-statutory inquiries deemed necessary and proportionate by the local authority, even though they do not meet all Section 42 criteria. Such inquiries focus on promoting well-being under the Care Act, including cases involving carers who do not qualify for Section 42 inquiries. The increase in 'Other' safeguarding activities indicates ongoing efforts to ensure resident safety and well-being beyond statutory requirements.



The number of safeguarding concerns has decreased by 38% in 2023-24 compared to the previous year. The number of Section 42s (S42 Enquiries) increased by 29% from last year. The proportion of concerns leading to S42s has also increased from 22% in 2022-23 to 47% in 2023-24

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.

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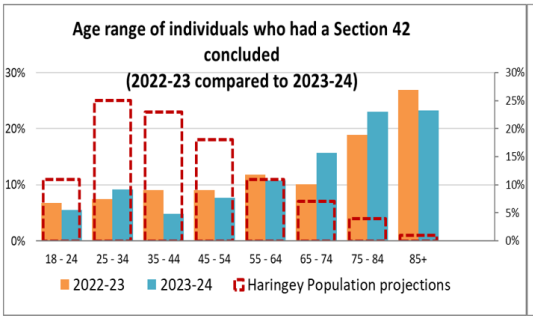
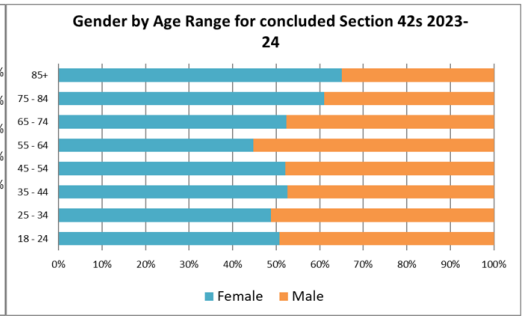
Section 42's Age and Gender

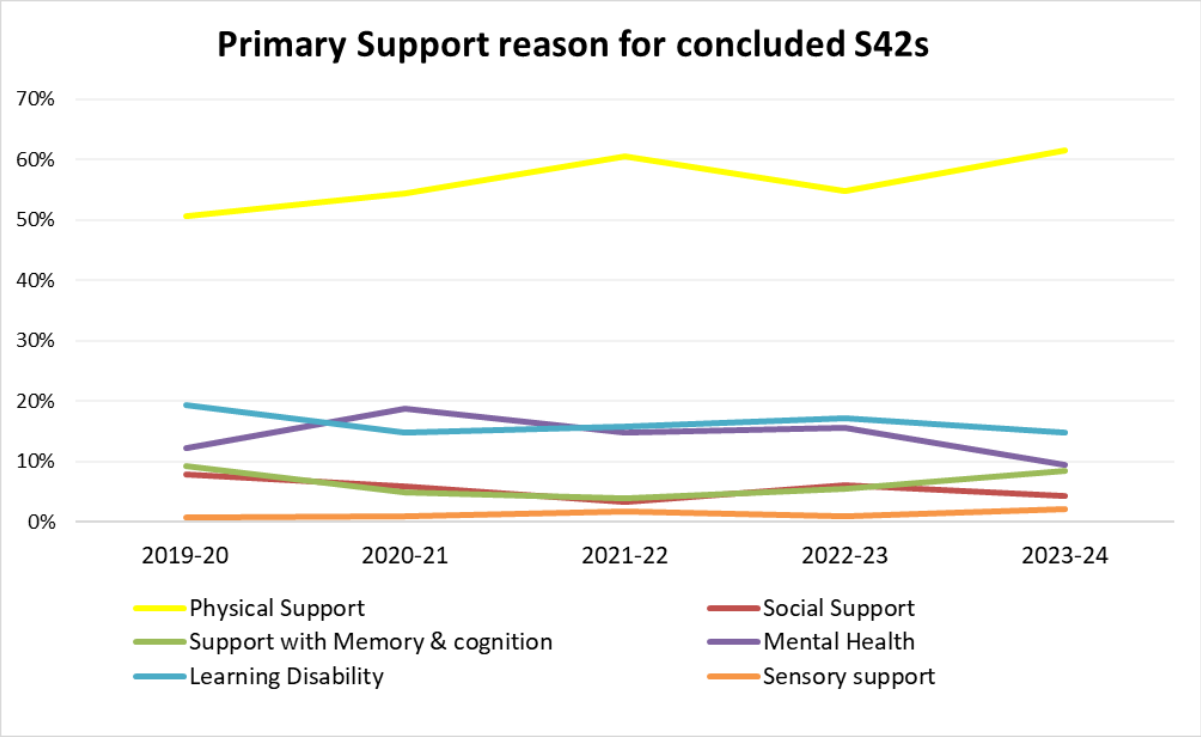


73% of individuals with a Section 42 enquiry are aged 55 and over, overrepresented when comparing to Haringey's adult population.



56% of individuals with a Section 42 enquiry are Female, a 2% decrease compared to 2022-23.

In males, 44% of individuals had a section 42 and increase of 4% compared to 2022-23.



Physical support remains to be most common type of Primary support reason, followed by Learning Disability and then Mental Health.

Physical has seen the biggest increase in % (7%)

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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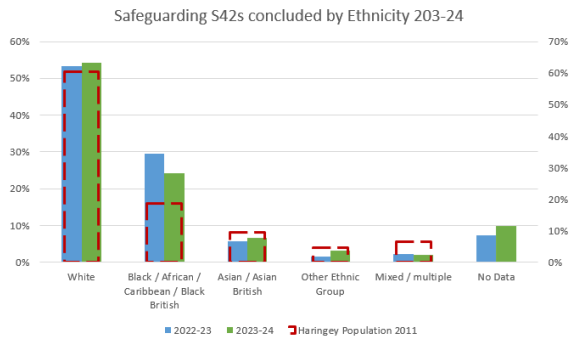
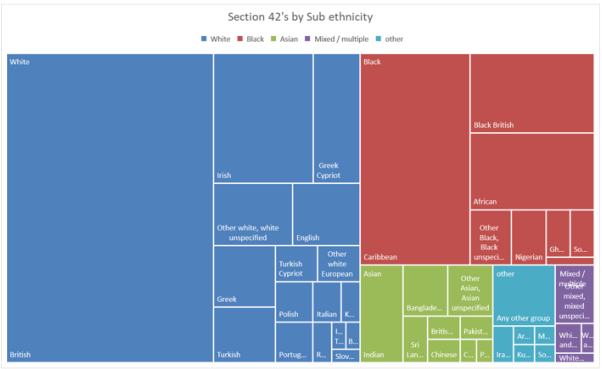
Ethnicity



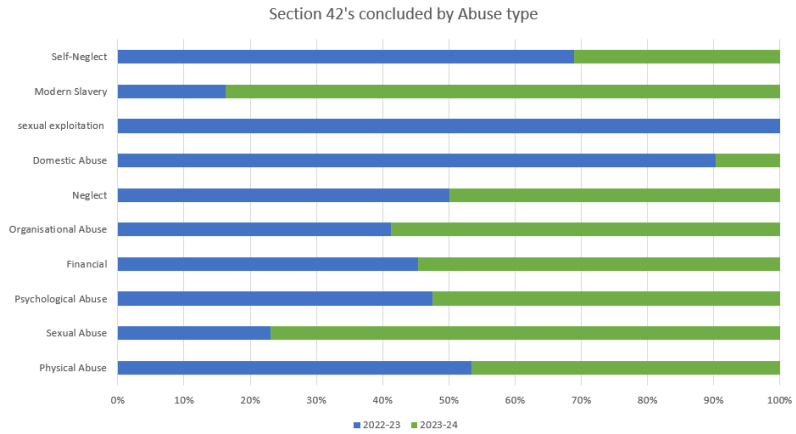
54% of individuals who had Section 42 concluded are White, a 1% increase compared to previous year almost in line when compared to Haringey's population. 24% are Black, a decline of 6% from previous year but over-represented when compared to the Haringey population (19%)



Most white individuals were British (59%), followed by Irish (12%) and Greek Cypriot (6%)
Most black individuals were Caribbean (47%), followed by Black British (20%) and African (19%)

Most Asian individuals were Indian (32%), followed by Bangladeshi (18%) and Other Asian (18%)

Abuse Type



Proportionately Neglect and Acts of Omission account for the majority of risk types, accounting for 39% of all risk types in 2023-24, no change from the previous year.

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

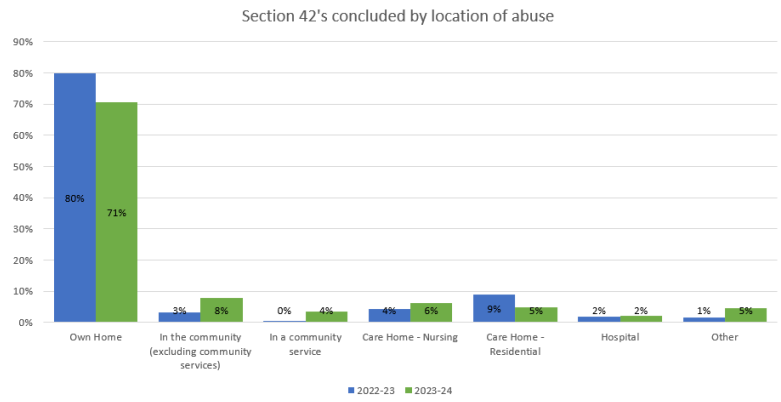
There were 13 cases of sexual abuse compared to 5 recorded the previous year.

We have seen a decrease in the following abuse types: Physical Abuse (2%), Domestic Abuse(3%), Self-Neglect (3%)

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.

Abuse Location



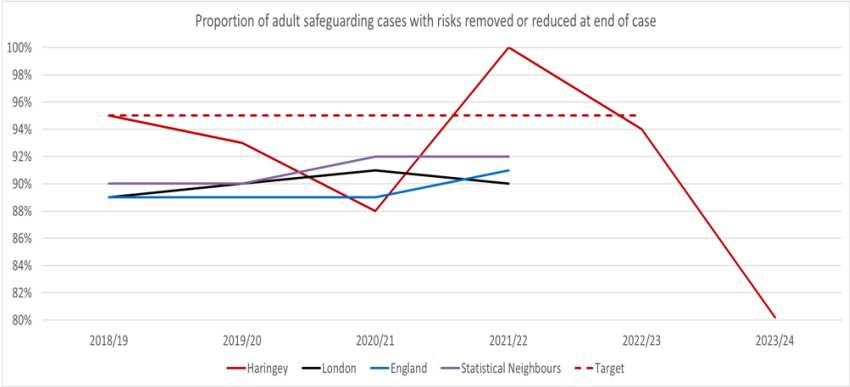
The home of the adult at risk accounted for **71%** of the risk locations in 2023-24, a decline of 9% from previous year.

'In the community (excluding community services)' increased by **5%** this year.

Care home residential decreased by 4% in 2023-24

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.



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

In Haringey **80%** of the safeguarding cases concluded had their risks either removed or reduced in 2023/24, 15% below the end of year target and the lowest it's been in 4 years

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.

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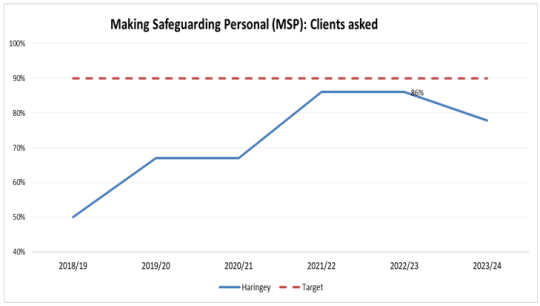
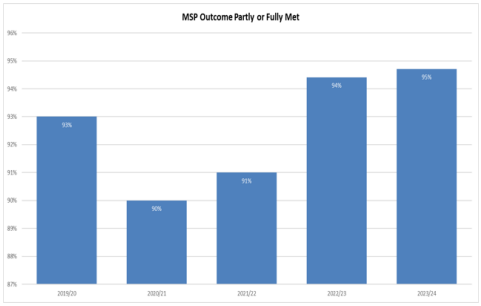
Making Safeguarding Personal





The proportion of people asked about their making safeguarding personal desired outcome is 78% in 2023-24, this is 12% behind the target of 90%.

In 2023-24, 95% individuals had their desired outcomes met or partly met, 1% increase from last year.

7. 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.

7.1. Adult Safeguarding Adults Team

7.1.2. In the past year what have been the key achievements within your organisation/subgroup in terms of safeguarding adults? And how did these achievements contribute to the overall objectives of the Safeguarding Adult Board?

- Embedding 'Making Safeguarding Personal (MSP)' our approach to ensure that the Person (adult at risk) and/or their advocate in relation to the safeguarding enquiry, are fully engaged and consulted throughout and that their wishes and views are central to the final outcomes as far as practicably possible.
- The Safeguarding Team ensure more proactive planning and or professional meetings are convened so that clear action / activity are agreed with timeframes for activity / actions / preventive measures and to agree who would lead on these. This could involve providers / organisations / other teams / other directorates e.g. housing. This involves convening a MS Team planning / professionals meeting to go through tasks requested of other parties.
- A safeguarding enquiry is now not be closed when enquiries are being conducted by the police or other parties until the outcome of the enquiries are recorded by the local authority.
- Ensuring staff use the Haringey Multi-Agency Solutions Panel (MASP) to discuss the more complex cases, particularly for those with clutter and hoarding issues and self-neglect.

7.1.3 Case Studies

Case Study 1 involved a 32-year-old lady

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.

Activity involved working in partnership with:

- Vulnerable Adult
- Advocacy
- Her mother
- GP (Primary Care) and Secondary Health Partners (Continuing Health Care Team)
- Domiciliary Carer provider
- Respite Care Provider
- Rapid Response Team
- Adult Assessment Team
- Safeguarding Team

Outcome: 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.

Case Study 2 - involved an 82-year-old lady

Coercive control and financial exploitation by an informal carer (live in daughter) leading to **Neglect and Acts of Omission** included ignoring medical or physical care needs, failure to provide access to appropriate health and social services, the withholding of the necessities of life such as medication, adequate nutrition and/or heating.

Activity involved working in partnership with:

- Independent Advocacy (because vulnerable adult lacked capacity)
- Legal Team in Council
- Police
- Court of Protection
- GP (Primary Care)
- Family (Her other children x 4)
- Adult Assessment Team
- Safeguarding Team
- Independent Legal Representation - to facilitate Deputyship of finances.

Outcome: 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.

7.1.4 Looking ahead, what are your organisation's/subgroups plans and priorities for the coming year in terms of safeguarding adults at risk? How do these align with the priorities and objectives of the Safeguarding Adult Board?

- Giving information and advice as and when appropriate

- 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.

7.1.5 In the past year, what changes have taken place in your organisation/ in response to learning from local or national SARs?

- The Safeguarding Team ensure more proactive planning and or professional meetings are convened so that clear action / activity are agreed with timeframes for activity / actions / preventive measures and to agree who would lead on these. This could involve providers / organisations / other teams / other directorates e.g. housing. This involves convening a MS Team planning / professionals meeting to go through tasks requested of other parties.
- A safeguarding enquiry is now not be closed when enquiries are being conducted by the police or other parties until the outcome of the enquiries are recorded by the local authority.
- Ensuring staff use the Haringey Multi-Agency Solutions Panel (MASP) to discuss the more complex cases, particularly for those with clutter and hoarding issues and self-neglect

7.2. North Central London Integrated Care Board

7.2.2 In the past year what have been the key achievements within your organisation/subgroup in terms of safeguarding adults? And how did these achievements contribute to the overall objectives of the Safeguarding Adult Board?

NCL ICB, in partnership with health partners, embedded a robust safeguarding assurance and governance process across the system and established a NCL safeguarding strategic oversight group, and a NCL safeguarding assurance group.

NCL ICB has facilitated system wide learning from local & national SARS which was presented via: online and in person training; local, regional & national safeguarding forums and webinars; information on the ICB intranet and internet; conferences facilitated by the ICS safeguarding training and system learning group.

We have a well-established 'Quality oversight' forum, chaired by the Director of Safeguarding and Deputy Directors of Quality and, and attended by the Complex Individualised Commissioning teams, along with our safeguarding colleagues. The purpose of the forum is to share local intelligence on providers where the ICB commission 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 is a subcommittee of the ICB Board. Since its inception the QSC have reviewed the following:

- Approval of NCL Safeguarding Adults and Safeguarding Children Policies.
- Overview of Maternity Services across NCL.
- Update on the Patient Safety Incident Response Framework.

Highlights on other achievements in safeguarding commissioning a restorative safeguarding supervision over 60 staff across NCL health providers.

In February and March 2023, ICB also commissioned a Mock Inquest training delivered for 50 staff.

7.2.3 In the past year, what were the key challenges or obstacles your organisation/subgroup faced, and how did you address or overcome them?

We identified Domestic abuse as an area for further development across the ICB. To address this, the designated professionals for safeguarding are a key strategic partner across the five boroughs representing the ICB at Borough strategic Violence Against Women and Girls (VAWG) Boards. The ICB presented our pledges underpinning the pan-London framework to implement a public health approach in tackling violence against women and girls at the "VAWG is everyone's business" summit in September 2023 facilitated by the Mayor's Office of Policing and Crime (MOPAC). We continue to support our commissioning and contracting colleagues to monitor health commissioned domestic abuse services including Independent Domestic Violence Advocate (IDVA) service, who are co-located in acute and mental health NHS Trusts across NCL. Specific perpetrator awareness programmes and IRIS (Identification and Referral to Improve Safety), a programme for General

Practice, provide specialist in-house domestic abuse training for general practice functions and a named Advocate Educator to whom patients can be referred for support.

NCL ICB is currently working across the system with the police, local authority, the Royal Free hospital and CNWL NHS Trust to develop new pathways for victims of non-fatal strangulation. This is new and innovative work, where victims are being identified who may not have otherwise disclosed their experience and offered medical support and treatment to avoid serious harm.

Embedding learnings from SAR (Serious Care Review) remains a priority across NCL. The ICB is in the process of undertaking a scoping exercise to identify opportunities to implement systems and processes to ensure that learning from SARs is implemented and actions are followed.

7.2.4 What specific initiatives, training, or activities did your organisation/subgroup undertake in the year 2023/24 to promote safeguarding of adults at risk? Please give as much detail as possible.

Promotion of online & in person learning events, seminars, webinars across the NCL health system; hosting bi-monthly safeguarding system learning events across the five Boroughs where partners discuss current key safeguarding issues such as self neglect and cuckooing and influence change; training to GPs; participation in multi-agency Haringey high risk panel and frailty hub.

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.

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 intranet and in newsletters including, Mental Health and Suicide Prevention, Trafficking of people and Modern Slavery; Learning Disabilities; Domestic Abuse; Sexual Violence and Abuse; FGM Awareness and Online Safety.

7.2.5 Looking ahead, what are your organisation's/subgroups plans and priorities for the coming year in terms of safeguarding adults at risk? How do these align with the priorities and objectives of the Safeguarding Adult Board?

NCL Integrated Care System (ICS) will hold the first ICS in person safeguarding conference on the 19th of April 2024 for 130 delegates from across health and care. The theme will be Promoting Curiosity. Presentations will feature cutting edge research, the voices of service users, and new information to support health and social care practitioners to spot signs of abuse earlier, to ask the right questions and understand the context of people's lives. The topics covered will include A new pathway for victims of non-fatal strangulation; Hearing from women affected by FGM; The Insidious Nature of Coercive Control; Gaming and Extremism; and developing resilience as a practitioner.

7.2.6 In the past year, what changes have taken place in your organisation/ in response to learning from local or national SARs?

Over the last year, NCL ICB has been working with NHSE to develop a Safeguarding Case Review Tracker (S-CRT).

Whilst acknowledging that safeguarding statutory reviews and any associated learning and actions are generally managed on a borough basis, the ICB believes that there is also high value in monitoring and analysing data from safeguarding reviews at a NCL wide level. To achieve these aims the ICB will:

- Through its ICB borough safeguarding professionals, engage with and support all stages of local statutory review processes.
- With permission from the relevant Board/ Partnership Independent Chair, share internally, appropriate information related to the local reviews with the ICB Director of Safeguarding and any delegated officer, for the purposes of ongoing analysis, monitoring, and thematic learning at NCL wide level.
- Assimilate information from relevant national or regional thematic safeguarding statutory review publications, and benchmark against our own NCL wide themes and data.

7.3. Whittington

7.3.2 In the past year what have been the key achievements within your organisation/subgroup in terms of safeguarding adults? And how did these achievements contribute to the overall objectives of the Safeguarding Adult Board?

- Drop in established for community staff to discuss MCA and safeguarding adults concerns.
- The new Safeguarding Allegations policy has been embedded across the Trust.

- There has been an increase in resources/staffing for the Trust safeguarding adults team to reflect the increased activity for safeguarding adults, the MCA and DoLS.
- Face to face training for safeguarding adults level 2 has been maintained. This now includes our new, co-produced learning disability awareness training video, and information about autism.
- New training has been developed for both the preceptorship and Health Care Support Workers training programmes.
- We have co-produced information videos for our learning disability patients, and also leaflets. We have also co-produced a training video for learning disability and purchased 'Learning Disability care bags' which aim to reduce anxiety and distress experienced by our LD patients.
- We have created a system in which a daily list of all current inpatients with a safeguarding adult concern for this admission is circulated internally, to ensure any safeguarding adult concerns form part of discharge planning.

These achievements have contributed to the overall objectives of the SAB in several ways. By delivering face to face training for level 2 safeguarding adults, we can ensure dissemination of learning from local Safeguarding Adult Reviews (SARs).

Devising and embedding the new 'Staff Allegations Safeguarding Policy' ensures we are contributing to the PiPoT processes.

Introducing new resources for our learning disability patients and families recognise the additional needs experienced by these patients, and the importance of reducing barriers to accessing appropriate care.

7.3.3 What specific initiatives, training, or activities did your organisation/subgroup undertake in the year 2023/24 to promote safeguarding of adults at risk? Please give as much detail as possible.

The safeguarding adult team provides additional internal training to Health Care Support Workers, and the Preceptorship programme around safeguarding adults. We have co-produced a training video for staff around learning disability awareness.

7.3.4 In the past year, what were the key challenges or obstacles your organisation/subgroup faced, and how did you address or overcome them?

The volume and complexity of concerns continues to increase and has necessitated new ways for staff to contact the safeguarding adult team, i.e. via the new weekly drop-in sessions. We continue to be a visible, accessible team working closely across the Trust in both community and inpatient settings.

7.3.5 Please provide a case study illustrating good partnership and safeguarding practice within your organisation and partnership across agencies.

A care home resident was admitted to hospital following concerns arising from a seven-inch hematoma. Given the resident was unable to move independently, non-responsive and was completely reliant on others for all aspects of care, the patient was admitted to hospital whilst enquiries could be made as to how the resident had sustained this injury. Subsequent discussions with a range of different agencies including the local authority and police ensured the discharge from hospital could only take place once the safeguarding concerns around the origin of the injury were established, and a robust mitigating plan for a new placement put in place.

7.3.6 In the past year, what changes have taken place in your organisation/ in response to learning from local or national SARs?

London Fire Brigade fire home safety checks highlighted following an Islington SAR, and development of guidance for staff around the importance of nutrition for patients following the Steve SAR.

7.3.7 Looking ahead, what are your organisation's/subgroups plans and priorities for the coming year in terms of safeguarding adults at risk? How do these align with the priorities and objectives of the Safeguarding Adult Board?

- Continue face to face teaching which builds on knowledge of safeguarding adults.
- Develop domestic abuse pathway.
- Develop clear mental health pathway which will initially focus on training staff in Accident and Emergency in de-escalation techniques. There has been an increase in mental health presentations to Accident and Emergency which necessitates this additional training.

7.4. North Middlesex University Hospital (NMUH)

7.3.3 In the past year what have been the key achievements within your organisation/subgroup in terms of safeguarding adults? And how did these achievements contribute to the overall objectives of the Safeguarding Adult Board?

- The re-establishment of subgroups for mental health, dementia and learning disability which feed into the Safeguarding adults board and identify areas of improvement required in each of these areas that relate to adult safeguarding.
- A focus on domestic and sexual abuse includes embedding an IDSVA within the hospital and working on a stand-alone domestic abuse training and resource pack for all staff.

- Positive collaborative working with the Haringey Hospital Social workers. Developing a strong professional relationship to ensure our patients are well supported and safely discharged.

7.3.4 In the past year, what were the key challenges or obstacles your organisation/subgroup faced, and how did you address or overcome them?

- Barriers to Woking in collaboration with Haringey safeguarding team. This included delays in response times. Meetings between management have been put in place to resolve the issue and ensure safeguarding case prioritisation.
- Multiple disadvantage including those presenting with many overlapping problems of poverty, drug misuse, domestic abuse and mental health/physical health. Strong multi agency working has been required for complex cases. Some service users can have delayed discharges due to multiple problems in the community and staff need to be expert at navigating organisations and coordinating care.
- Hidden harm including online exploitation which staff need continued

7.3.5 What specific initiatives, training, or activities did your organisation/subgroup undertake in the year 2023/24 to promote safeguarding of adults at risk? Please give as much detail as possible.

- Safeguarding week- online access to teaching/resources.
- Walk and talk initiative with the local police, staff and community.
- Induction training twice monthly.
- Simulation training- role plays for think family approach.
- Team briefs to show case positive collaborative working cases.
- ADHOC supervision/training to individual departments depending on recommendations from DHRs/SARS/s42's enquiries.
- Robust partnership working with a integrated safeguarding committee. Including support for Mental health, dementia, Learning disability, maternity, adults and Childrens.
- New national Pressure ulcer protocol is being implemented in NMUH.

7.3.6 Case study

A woman, SA, was being treated in the community by carers from the local authority and district nursing. It was noted by the local authority that the husband was blocking care and carers noted that they had been treated poorly by the husband. It wasn't clear whether SA was medically well due to the inability of district nurses to provide care. Therefore, a collaborative decision was made for SA to come into hospital for.

The NMUH safeguarding team were made aware and were able to complete safeguarding interviews and meet with the local authority to provide a collaborative response to address the blocking of care and ensure robust plans were in place for discharge.

7.3.7 Looking ahead, what are your organisation's/subgroups plans and priorities for the coming year in terms of safeguarding adults at risk? How do these align with the priorities and objectives of the Safeguarding Adult Board?

The safeguarding plan is written to encapsulate the changes required to drive the continued improvement in our standards of care for patients of all ages at risk of or experiencing abuse, neglect, or self-neglect. Incorporated is learning from Child Safeguarding Practice Reviews, Rapid Reviews,

This delivery plan is written to encapsulate the changes needed to drive forward improvement in our standards of care for those at risk of and/or experiencing abuse, neglect, or self-neglect, using as evidence the results of local safeguarding audits, Domestic Homicide Reviews and Safeguarding Adult Reviews.

On an operational level the team aims to prioritising communication, MDT collaboration between the NMUH safeguarding team/NMUH integrated discharge team and Haringey social care to reduce delayed discharge times and ensure the safety to our most vulnerable patients.

7.3.8 In the past year, what changes have taken place in your organisation/ in response to learning from local or national SARs?

- NMUH trusts are committed to collaborating with our local authorities and external agencies and chair MDT/professionals meetings for those cases that are high risk.
- We currently have an onsite ISVA (solace/Enfield) who is available to assist with sexual violence cases).
- We are committed to developing our serves for those with self-neglect as this is our second highest category of referrals, ensuring that we work closely with agencies such as Hoarding UK/red cross.
- We have resources available to provide patients with clothes/towels/hygiene products when they attend NMUH.
- Training to individual departments for ADSHOC supervision or training in areas such DHRs/SARS to support with learning and implementing recommendations with their service.

7.5. Barnet, Enfield, Haringey Mental Health Trust (BEHMHT)

7.5.2 In the past year what have been the key achievements within your organisation/subgroup in terms of safeguarding adults? And how did these achievements contribute to the overall objectives of the Safeguarding Adult Board?

In the past year there have been a number of measures put in place which have improved adult safeguarding practice across the Trust for example:

- The introduction of safeguarding surgeries (once a week for an hour) provides the opportunity for practitioners to seek advice/support on difficult cases.
- There has been an improvement in the identification of, and response to domestic abuse. Regular training is now offered on Domestic abuse, a Drop-in surgery operates on a weekly basis.
- The amalgamation of various policies (for example Domestic abuse, Adult and children safeguarding) has resulted in streamlined documents which practitioners have found easier to use.

7.5.3 In the past year, what were the key challenges or obstacles your organisation/subgroup faced, and how did you address or overcome them?

As with many organisations the partnership has problem with staff turnover. As such there is a constant need to train new staff around safeguarding.

7.5.4 What specific initiatives, training, or activities did your organisation/subgroup undertake in the year 2023/24 to promote safeguarding of adults at risk? Please give as much detail as possible.

- A Domestic Abuse and Harmful Practises Drop-in surgery runs on a weekly basis across the North London Mental Health Partnership which provides a space for staff to drop in and get advice on complex and high-risk cases.
- Bi-monthly Domestic Abuse Training is offered across the NLMHP and is available for all staff to attend, the training is also delivered to individual teams by request and aims to improve routine enquiry, understanding the risk and working to mitigate the risk of harm effectively.
- Leads within the Safeguarding Team provide case consultation for front line staff and teams who are working directly with high-risk/complex cases. This includes support at MDT's and Professionals Meetings.

7.5.5 In the past year, what changes have taken place in your organisation/ in response to learning from local or national SARs?

- 7-minute briefings continue to be produced in response to SAR's and any learning cascaded to staff.
- In terms of SARs a new protocol has been put in place where the onus is now on the Community Team to whom the Adult was known to complete the chronology. This has practice has resulted in the Teams taking ownership of the process and therefore better able to act upon any recommendations made.
- A new formulation checklist is being devised**.** When a service user is admitted to hospital a meeting is arranged to look at what contributed to their admission. It is being proposed that the process is formalised, so all aspects of the patient's life are considered in a more holistic fashion.

7.6 Haringey Met Police

7.6.2 In the past year what have been the key achievements within your organisation/subgroup in terms of safeguarding adults? And how did these achievements contribute to the overall objectives of the Safeguarding Adult Board?

Mental Health – reduction in amount of individuals detained under S136 of Mental Health Act. S136 allows officers to remove an individual to a place of safety if it appears to the officers that the individual is suffering with a mental disorder. The detention period can last for up to 24 hours (can be extended on clinical grounds by another 12 hours). On the previous year this is down by 39%.*

In the year shown we also continued to see a slight reduction in the use of S135 Mental Act Warrants conducted on the borough of Haringey, down by 7%. S135 MHA warrant is applied for by MH professionals and requires police to attend with MH services to assist with removing the individual for the purposes of them having MH assessment.

The significant drop in the use of S136 shows that officers used least restrictive option when an individual was in MH crisis and ensured that they received the right care appropriate to their needs.

*This figure represents those individuals sectioned in a public place only. It does represent any S136 conducted in any of the police custody suites.

RCRP was launched on the 1st November 2023, Met Police deployment to RCRP related calls has reduced from c. 41% to 29% (a decrease of 12%) compared to the same period in 2022. This ensure individuals in mental crisis are seen by the right professional, thus freeing up capacity to assist other areas of policing.

7.6.3 In the past year, what were the key challenges or obstacles your organisation/subgroup faced, and how did you address or overcome them?

Delivering local policy which highlighted alternatives to use of S136. This involved a change in mind set for police asking them to question if S136 is best to safeguard the needs of individual. We have lost our Vulnerable Coordinator in December 2023 which has some impact on service delivery.

7.6.4 What specific initiatives, training, or activities did your organisation/subgroup undertake in the year 2023/24 to promote safeguarding of adults at risk?

In March 2023 Haringey police MH unit undertook to train all response officers and neighbourhood officers in a local policy with the aim to reduce the S136.

This policy introduced the need to consult with the Duty Officer prior to the use of S136 and ensure that the requirement to consult with MH professional, in line with legislation, was adhered to.

The policy highlighted possible alternatives to S136, e.g., attending Crisis Café, voluntary attendance to hospital, consulting family and friends, taking the individuals wishes into consideration. The policy was fully supported by the Senior Leadership Team.

Once implemented it required close monitoring by the MH unit. Each S136 conducted by officer in Haringey was reviewed and where necessary any issues addressed with the officer concerned.

Consultation with the Uniform Officers has since been rolled out pan London and has now become service policy.

Later in the year the Met police implemented Right Care, Right person policy changing the way the emergency services respond to calls specifically related to MH mental health. The policy was introduced to ensure that the right agency is primary to deal with the needs / safeguarding of an individual.

With the local policy and RCRP it was imperative that officers were aware of the key elements of both so they were better equipped to deal with a MH incident.

MH Input to all new officers on the BCU commenced ensuring that these officers, new to policing and the BCU are given the confidence to assist a person in MH crisis and be mindful of all options available rather than the default of using S136.

7.6.5 Please provide a case study illustrating good partnership and safeguarding practice within your organisation and partnership across agencies.

Within the last year the BCU MH Unit, in line with direction from Central MH, introduced a procedure for applications of S135 MHA Warrants. Having established good, open relationship with the AMHP Service it was agreed that prior to applying for a warrant the AMHP Service will notify the police MH Unit of their intention to do same.

The MH Unit will examine the information supplied and integrate police intelligence systems, which can often contain information that the MH services are not privy to, to ascertain if there is a possibility of an assessment taking place without the need for a warrant.

Although the decision to apply for warrant will always remain with the MH service, by introducing this process, partner agencies have stated that they have done more community based assessments.

As part of the process, with the support of our SLT the decision was also taken to only use the neighbourhood officers to assist the services with S135 warrants. In doing this is allows the MH unit to warn officers in advance to attend the warrant and reduces the chances of non-attendance by police cancelled on the day due to the operational needs.

This has resulted in a shorter lead time from point of application to execution of a warrant.

Because of these changes and the close partnership working in place with the AMHP service we have continued to see a reduction in the number of S135 application for the year 2023 – 2024 and an improvement in the quality of the information provided by the MH Services to justify the necessity for the warrant.

7.6.6 Looking ahead, what are your organisation's/subgroups plans and priorities for the coming year in terms of safeguarding adults at risk? How do these align with the priorities and objectives of the Safeguarding Adult Board?

Met Police has undertaken Multi Agency Safeguarding Hub (MASH) Review. For the Adult strand, work is underway to develop guidance to recognise wider vulnerability in adults; to develop a Met Police and Adult Social Care terms of reference and joint response protocol. This would assist defining role and responsibilities clearly.

7.6.7 In the past year, what changes have taken place in your organisation/ in response to learning from local or national SARs?

Haringey officers have been given additional teaching around Mental Health and Safeguarding adults. They have been provided with a presentation and these teachings have come from SAR reports. Officers have also been provided with up to date contacts of who to liaise with concerns around vulnerable adults. Haringey Partnership Officers attend SAR learning events and disseminate learning across borough.

8. HSAB Priorities and Objectives 2024/2025

The plan is informed by our vision, partnership values, findings from Safeguarding Adult Reviews, performance information and consultation with partner agencies, the public and practitioners. The core objectives for our plan are grouped under the 3 priorities and aligned against the six safeguarding principles.

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

PRIORITY 1: PREVENTION AND AWARENESS			
Aligned Principle: Prevention			
Objectives	**Lead Subgroup(s)**	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
Objective 1 .1 The Board and Voluntary Community Sector, including the Joint Partnership Board to set up and maintain regular engagement.	**HSAB Management**	Attend quarterly meetings with the Joint Partnership Board to maintain clear actions and activities for the year. Regular communication with the VCS and annual meetings with the HSAB Chair	The Board has effectively connected with the JPB and the VCS to share messages on adult safeguarding and the roles and responsibilities of the board and the delivery of the board's plan.
Objective 1.2 Identify community groups that require targeted engagement activity.	**Engagement and Prevention**	Continue to use data available to target engagement activity and monitor short and long term impact jointly planned with the VCS and Haringey Healthwatch.	An increase in relevant knowledge and awareness within the targeted group(s).
	HSAB Management	Participate in planning and delivering of prevention activities across the North Central London region.	
Objective 1.3 Delivering a communication and engagement plan for 2024/25 to raise awareness of safeguarding in Haringey.	**Engagement and Prevention**	Review and refresh the **Haringey Safeguarding Prevention Delivery Plan** in line with the new HSAB priorities and objectives. Establishment of a robust framework for ongoing monitoring and	Effective alignment of the plan's goals, strategies, and actions with the updated HSAB priorities and objectives.

PRIORITY 1: PREVENTION AND AWARENESS			
Aligned Principle: Prevention			
Objectives	**Lead Subgroup(s)**	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
		evaluation of the delivery plan's impact.	
		Deliver a communication engagement plan for **2024/25.** Defining and prioritising communication and engagement based on national priorities and the Board Strategic Plan.	The development and execution of a comprehensive Communication Engagement Plan that reaches key stakeholders and generates measurable outcomes. Success indicators will include the breadth and depth of stakeholder engagement, heightened awareness and understanding of safeguarding issues, and also positive feedback from stakeholders.
		Establish a programme of events for Safeguarding Adults Week in November 2024 (Internal/North Central London events etc)	The level of engagement and participation demonstrating both awareness and active involvement in safeguarding activities (training, seminars, workshops etc) Improved engagement with the initiatives that the Board are running during safeguarding adults week.
Objective 1.4 To consider the safeguarding impact of the cost of living crisis (including food and fuel poverty).	**HSAB Management**	Ensure that residents have information on what is available to help them.	Increased awareness and understanding of the cost of living crisis and its impact on vulnerable adults among local communities, service providers, and other stakeholders.
	Quality Assurance	Monitor safeguarding impact and develop relevant actions where necessary.	Positive feedback from service users, carers, and families about the quality of services and support provided in response to the cost of living crisis.

PRIORITY 2: LEARNING, REFLECTION AND PRACTICE IMPROVEMENT			
Aligned Principle: Empowerment, Protection, Proportionality			
Objectives	**Lead Subgroup(s)**	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
Objective 2.1 Develop mechanisms to support practice improvement in safeguarding across the partnership	**Practice and Improvement**	The subgroup to focus on two prominent themes: Pressure Ulcers and Mental Capacity Assessments (MCA's). Explore opportunities for collaboration with NCL-wide initiatives, with pressure-ulcers as an example, and to reflect on potential	Measurable improvements in knowledge, practice, and outcomes related to these themes. The improvement in the quality and consistency of Mental Capacity Assessments.
	SAR Implementation	Ensure that learning from Safeguarding Adult Reviews is embedded in practice across the partnership and quarterly reporting to the Board.	Partners can provide the Board with assurance that key findings and recommendations from SARs have been effectively incorporated into organisations practice and culture.
	HSAB Management (PSW)	Continue to promote and improve use of the Multi-Agency Solutions Panel and improve responses to self-neglect. Annual report to be presented to the HSAB	Measurable improvements in multi-agency collaboration, case resolutions, and outcomes for individuals experiencing self-neglect.
	Practice & Improvement (PSW)	To undertake and oversee the delivery of multi-agency case file audits on two different themes in the year to identify areas for improvement. The Audit will always include Making Safeguarding Personal and Mental Capacity Act Assessment.	Actions and recommendations from multi-agency audits have been implemented across the partnership where relevant. Quality assurance measures evidence that consent is sought from the individual where it is appropriate to do so before referral and informed of their outcomes. Any decisions on consent are well documented.

PRIORITY 2: LEARNING, REFLECTION AND PRACTICE IMPROVEMENT			
Aligned Principle: Empowerment, Protection, Proportionality			
Objectives	**Lead Subgroup(s)**	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
			The Board is assured that practice has improved through auditing of the quality of Mental Capacity Act assessments and that practice is continuing to be audited and issues addressed.
Objective 2.2 Deliver a consistent approach to conducting and sharing learning effectively.	**SAR**	Continue the dissemination of SAR's learning through SAR reports, Domestic Homicide Reviews, Coroners inquests, 7-minute briefings and learning events. Partners to assure the Board of improvements made as a result of SAR's and impact of change though reports to the Board, and SAR learning workshops. Annual Safeguarding Adult Reviews learning event. Consider joint dissemination work with NCL SABs Ensure that there is ongoing monitoring of Safeguarding Adult Reviews learning (e.g., Housing issues).	Staff across partner agencies are aware of the key learning from SARs and can evidence impact of improvements made as a result of SARs learning. The Board is assured that all deaths and other incidents involving serious abuse or neglect are assessed within the Safeguarding Adult Reviews protocol and the process managed well with the focus from a range of experiences.
Objective 2.3 Incorporate national and regional learning and	**HSAB Management**	Contribute to national policy and practise through our active participation in	There is evidence of two way information sharing between regional and national networks.

PRIORITY 2: LEARNING, REFLECTION AND PRACTICE IMPROVEMENT			
Aligned Principle: Empowerment, Protection, Proportionality			
Objectives	**Lead Subgroup(s)**	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
innovations into practice improvement.		regional and national networks and forums.	
	HSAB Management	LeDeR reviews annual report 2023/2024. To focus on Haringey Adult Services actions, recommendations and impact.	The Board is assured that learning from LeDeR reviews is embedded and leads to improved safeguarding practice.

PRIORITY 3 SAFEGUARDING AND QUALITY OF SERVICES			
Aligned Principle: Accountability, Partnership			
Objectives	**Lead Subgroup(s)**	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
Objective 3.1 Seek assurance from providers to improve service quality and reduce safeguarding risk	**Quality Assurance**	Produce quarterly Joint Provider monitoring report in the provider market in Haringey to include Care Quality Commission status and the monitoring of training.	The Board is assured that the commissioning activities in the provider market focus is on quality and service improvement to support users and carers and to deliver better value for money.
	Quality Assurance	Quality Assurance subgroup to undertake care organisational audits (care related commissioned organisations) to identify key safeguarding issues that will improve the quality of services delivered to residents.	Evidence shows that actions and recommendations from the audits are implemented and monitored through the reporting to the Quality Assurance subgroup. Improving Care Quality Commission ratings across the market.
Objective 3.2 Working with other partnerships to address safeguarding issues.	**HSAB Management and Partners**	The Board will continue to support with on-going work in the following areas: • Homelessness and Safeguarding	Evidence and assurance to demonstrate that partner organisations understand each other's roles, responsibilities and legal duties to ensure they provide a collaborative safeguarding response.

PRIORITY 3 SAFEGUARDING AND QUALITY OF SERVICES			
Aligned Principle: Accountability, Partnership			
Objectives	**Lead Subgroup(s)**	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
		• Modern Day Slavery • Transitional Safeguarding and Think Family jointly with the Childrens Partnership • Violence Against Women and Girls • Serious Youth Violence	
Objective 3.3 The Board meets its statutory responsibilities.	**HSAB Management and Partners**	• Annual Safeguarding Adults Partnership Audit Tool. • Produce and disseminate the 2024/25 HSAB Annual report • Care Quality Commission inspection preparation for the Local Authority and Integrated Care Board to present preparation plans to the Board. • Review Board policies and procedures to ensure they are up to date and relevant. • Prisons and secured accommodation • Rough sleeping and homelessness	The Board is assured of improvements made as a result of findings from the Safeguarding Adults Partnership Audit Tool audits. The Board is assured that Care Quality Commission preparations from the Local Authority and Integrated Care Board are in place. The HSAB can effectively enhance monitoring, accountability, and responsiveness to homelessness and rough sleeping issues; and data on homelessness and rough sleeping is integrated into the quarterly performance reports within the agreed reporting periods.