NOTICE OF MEETING

ADULTS & HEALTH SCRUTINY PANEL

Tuesday, 16th December, 2025, 6.30 pm - George Meehan House, 294 High Road, N22 8JZ

(To watch the live meeting click here or watch the recording here)

Members: Councillors Pippa Connor (Chair), Cathy Brennan, Thayahlan Iyngkaran, Mary Mason, Sean O'Donovan, Felicia Opoku and Sheila Peacock

Co-optees/Non Voting Members: Helena Kania (Co-Optee)

Quorum: 3

1. FILMING AT MEETINGS

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2. APOLOGIES FOR ABSENCE

3. ITEMS OF URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business (late items will be considered under the agenda item where they appear. New items will be dealt with as noted below).

4. DECLARATIONS OF INTEREST

A Member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and

(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Members' Register of Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interest are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. DEPUTATIONS/PETITIONS/ PRESENTATIONS/ QUESTIONS

To consider any requests received in accordance with Part 4, Section B, Paragraph 29 of the Council's Constitution.

6. MINUTES (PAGES 1 - 14)

To approve the minutes of the previous meeting.

7. HARINGEY SAFEGUARDING ADULTS BOARD - ANNUAL REPORT 2024/25 (PAGES 15 - 88)

To consider the annual report of the Haringey Safeguarding Adults Board for 2024/25.

8. COMMUNITY EQUIPMENT - LEARNING FROM PROVIDER FAILURE

Report to follow.

9. LOCAL GOVERNMENT & SOCIAL CARE OMBUDSMAN - UPHELD COMPLAINTS (PAGES 89 - 126)

To consider details of Adult Social Care complaints upheld by the Local Government & Social Care Ombudsman (LGSCO).

PART A – To consider a public report by the LGSCO following an investigation into an Adult Social Care complaint.

PART B – To consider an overall overview of Adult Social Care complaints.

10. WORK PROGRAMME UPDATE (PAGES 127 - 130)

11. NEW ITEMS OF URGENT BUSINESS

To consider any items admitted at item 3 above.

12. DATES OF FUTURE MEETINGS

- 9th February 2026 (6.30pm)

Dominic O'Brien, Principal Scrutiny Officer, dominic.obrien@haringey.gov.uk
Tel – 020 8489 5896
Email: dominic.obrien@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Monday, 08 December 2025

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Agenda Item 6

MINUTES OF THE MEETING OF THE ADULTS & HEALTH SCRUTINY PANEL HELD ON THURSDAY 13TH NOVEMBER 2025, 6.30 - 10.00pm

PRESENT:

Councillors: Pippa Connor (Chair), Cathy Brennan, Thayahlan Iyngkaran, Sean O'Donovan and Felicia Opoku

25. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

26. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Sheila Peacock and Helena Kania.

Apologies for lateness were received from Cllr Felicia Opoku.

27. ITEMS OF URGENT BUSINESS

None.

28. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

29. DEPUTATIONS/PETITIONS/ PRESENTATIONS/ QUESTIONS

None.

30. MINUTES

The minutes of the previous meeting were approved as an accurate record.

RESOLVED – That the minutes of the meeting held on 22nd September 2025 be approved as an accurate record.

31. SCRUTINY OF THE 2026/27 DRAFT BUDGET / 5-YEAR MEDIUM-TERM FINANCIAL STRATEGY (2026/27 - 2030/31)

At the outset of this item, Cllr Connor noted that some additional information had been provided to the Panel as a printed spreadsheet which set out details of savings which had been agreed in previous years but would be implemented during the forthcoming Medium-Term Financial Strategy (MTFS) period.

Details on the Budget for 2026/27 and the MTFS for 2026/27-2030/31 were provided by Neil Sinclair, Head of Finance (People), Jo Baty, Service Director for Adult Social Services and Cllr Lucia das Neves, Cabinet Member for Health, Social Care & Wellbeing.

Neil Sinclair introduced the report commenting that the Council faced an extremely challenging financial situation driven by continuing trends of increased demand and increased costs of services. A range of future pressures had been considered and it was forecast that at least an additional £30m would be required in 2026/27, mainly in adult social care and also temporary accommodation. £7.0m of new savings proposals for 2026/27 were included in the report, adding to the £14.9m of previously agreed savings proposals, which meant that a total of £21.9m of savings were planned for implementation in 2026/27. Brought together with the corporate assumptions about likely inflation and interest rates, it was estimated that the Council would need to apply for £57m of Exceptional Financial Support (EFS) from the Government in 2026/27. It was also estimated that a total of £71m of EFS would be required in 2025/26 – this comprised of the £37m of EFS that was originally forecast plus £34m of in-year overspend. The EFS received in 2024/25 was £10m. Chart 2 on page 43 of the agenda pack showed the forecast cumulative increases in the EFS over the MTFS period which was clearly not sustainable. Table 6 on page 45 of the agenda pack illustrated the breakdown of the budget gap.

Neil Sinclair commented that getting the EFS figures right was a complex process with a number of moving parts and that the final figures would not be confirmed until the accounts were closed for that financial year. The Council was doing everything it could to reduce expenditure, implementing spending controls and improving income collection. The Council would also continue to lobby the Government on the current funding system as it was not currently sustainable to meet the Council's requirements.

Neil Sinclair, Jo Baty and Cllr das Neves then responded to questions from the Panel:

- Cllr Connor asked about the figures in Chart 3 on page 43 of the agenda pack which set out the forecast annual EFS interest charge. Neil Sinclair confirmed that the £6.1m of interest charges forecast for 2026/27 were already included in the overall budget forecast and EFS requirement for 2026/27 and also for future years. The EFS was repayable over a period of 20 years.
- Cllr Connor referred to the forecast in-year overspend of £34m for 2025/26, noting that £7.6m of this overspend related to adult social care. Asked whether the adult social care figure could be reduced, Neil Sinclair said that the direction of travel was currently positive and that spending controls were being maintained. Jo Baty added that, while demand was not reducing, there were a number of measures being used to maximise income, claim grants and improve

joint funding arrangements. Culturally, the organisation had worked hard to make finance everyone's business and the benefits of this were being seen. Other measures included the approach to commissioning with providers. Jo Baty acknowledged that this could be a particularly tricky area because of the Council's objectives to ensure that people were paid the London Living Wage and that residents were provided with stability and good quality of care. She also noted that the complexity of cases coming through was rising and that some providers felt able to charge inflated prices which made the managing of commissioning costs so important.

- Referring to Table 6 (Budget Gap) on page 45 of the agenda pack, Cllr Brennan queried why the new pressures were £30m in 2026/27 but were projected to be approximately half of this in subsequent years. Asked how reliable these projections were, Neil Sinclair clarified that he could only comment on the adult social care element of this which was £10.6m out of the £30m of new pressures in 2026/27. £7m of the £10.6m figure related to placement demand pressures but there was also a further £8.2m of service pressures approved in previous years. There was therefore a total of £15.2m of placement demand pressures which were added to the budget on a recurring basis. Regarding the forecasting process for this, Cllr das Neves explained that a range of projections were calculated including best and worst case scenarios. However, the figures in the report were in the middle of this range. Neil Sinclair added that a number of factors were built into the forecasting with inflation set at 4% but other factors included the London Living Wage which would rise by over 6%. However, negotiations with providers on uplifts were ongoing.
- Cllr Iyngkaran requested further details on the assumptions behind the halving of the new pressures in the three years after 2026/27. Neil Sinclair said that he could only comment on the adult social care element which accounted for the assumptions at the MTFS projections set the previous year plus the gap from the current year. This would reach a level that the Council believed was sustainable going forward and then subsequent years included further increases to account for the increased demand and complexity that was anticipated. Jo Baty added that managing the rising levels of demand required improvements to the digital response and to the availability of advice and guidance, including signposting to other sources of support where appropriate. She reported that at least half of the demand at the 'front door' of adult social care did not lead to a Care Act Assessment.
- Asked by Cllr Brennan how the figures on pressures were adjusted in-year as actual costs become clearer, Neil Sinclair explained that pressures had been applied in previous years but that this was now being updated through this budget setting process as further pressures on top of this were now anticipated. The MTFS was updated each year which included all moving parts including pressures, savings, inflation and other factors.
- Cllr O'Donovan referred to paragraph 12.26 of the report which explained that the new savings proposed were relatively low because the Council was already committed to deliver £33.9m of savings and the priority was to unblock any barriers to delivery. Asked about the blockages in adult social care, Jo Baty said that capacity and staffing was a priority issue. She explained that some of

the savings sat within commissioning which required recruitment to the team to deliver these. However, this had been delayed by liquidation of NRS Healthcare, which was the community equipment provider for residents. Other recruitment was also needed, for example to carry out reviews for residents who had been placed out of borough. This would enable the service to have the staffing capacity to be more responsive and work with partners to make the necessary savings and improvements that were required. However, there was always risk associated with organisational transformation. She added that the Mental Health Trust was also experiencing major change and so there could be difficulties in navigating their services to support some of Haringey's most complex and vulnerable residents. Continuing Healthcare funding arrangements was also a difficult and complex area where savings for the Council was needed. Cllr das Neves added that the Health Service Journal had recently reported potential cuts to the Better Care Fund which was an example of regular changes that could impact on the Council's finances and multiple systems that are under deep pressure.

- Cllr O'Donovan highlighted the importance of investing to save where possible and avoiding cuts that could lead to additional costs in future.
- Cllr Iyngkaran sought clarification on the forecast EFS charges in Chart 3 and whether this included the reduction of the capital amount. Neil Sinclair confirmed that this illustrated the interest charges only. The Panel requested further details on the scheduled repayment of the EFS as this was not included in the report. **(ACTION)**
- Cllr Iyngkaran asked about the impact of cost controls on the services received by residents. Cllr das Neves responded that the statutory duty to the Council did not change but there were other ways to control costs, including reform to the social care system which was fundamentally broken at a national level. She said that this was a necessary national ambition in the medium-term because the status quo was unsustainable with adult social care directors across the country unable to balance their budgets. Jo Baty added that demand could not be controlled but it could be managed better by the Council and services could be delivered more efficiently. This included the delivery of day services that were more relevant to the needs of residents for example.
- Cllr Connor referring to the huge scale of the budget gap over the MTFS period and to paragraph 13.6 of the report which stated that *"In the future, not everything may be affordable, and the Council's limited financial resources will need to continue to be prioritised to the most vulnerable".* Asked how this challenge could be addressed by adult social care services, Cllr das Neves reiterated the possible ways of driving efficiencies that Jo Baty mentioned earlier and the existing savings that were committed to, but emphasised that there wasn't a huge amount more that could be saved in this area. She added that it might be possible to be more ambitious with invest to save proposals when the national themes became clearer. Jo Baty said that staffing was critical in order to get up to pace in certain areas including with Continuing Healthcare negotiations, to have someone leading on transition in commissioning, investing in the Carers' Strategy and investing in digital. The 31Ten consultancy was also reviewing the effectiveness of the Council's panel arrangements on

financial decisions. There had therefore already been a significant amount of invest to save work.

- Asked by Cllr Brennan about savings on commissioning and procurement, Jo Baty explained that she chaired the Commissioning Board in adult social care with the work in this area being led by the Assistant Director for Commissioning & Programmes and that this area had been tightened following the procurement legislation to ensure that the service was in compliance. Going forward they would be looking for stronger representation in the corporate space. Cllr das Neves added that a lot of the spending in adult social care was led by a market management approach with others in the North Central London area and so the scope for further savings in this area was limited. Jo Baty added that there were also capacity issues because it was necessary to have enough operational commissioners to be able to provide assurance of the quality, safety and value for money of the provision on the ground.
- Following on from the previous point, Cllr Brennan noted that a report to the Audit Committee earlier in the week had made reference to the daycare placement out of Borough. Jo Baty explained that this type of placement was typically very expensive and there were now fewer providers in the market so the Council was making efforts to reduce spending in this area. Neil Sinclair added that the Director of Finance was leading a commissioning modernisation process across the Council to improve quality and standards. Cllr das Neves indicated that she would be happy to bring a more detailed report to the Panel in future on strategic commissioning as there were ongoing conversations about different ways of commissioning locally and with various partners. **(ACTION)**

Cllr Connor then summarised the areas discussed by the Panel and the recommendations to be put forward to the Overview & Scrutiny Committee as follows:

- The Panel noted with concern the risks associated with the cumulative projected budget gap of £192.5m between 2026/27 to 2030/31 as illustrated in Table 6 on page 45 of the agenda pack.
- The Panel referred to the significant annual levels of interest charges incurred by the Exceptional Financial Support (EFS) as illustrated in Chart 3 on page 43 of the agenda pack. The Panel requested that further details be provided on how the capital repayments were factored into future budgets in the MTFS period.
- The Panel also noted that, as stated in paragraph 13.6 of the Cabinet report, due to the Council's limited financial resources, this may mean spending more in some areas of greatest need and priority and more significant reductions in other areas. It would therefore be necessary to understand further what this would entail for the future of adult social care services.
- The Panel expressed concern about the cuts to the Better Care Fund and the risk of the knock-on impact on adult social care services. It was recommended that this be monitored further by the Panel going forward.
- The Panel welcomed the approach to invest to save through improvements to digital solutions but noted that similar proposals had been seen by Scrutiny in

previous years that had not fully come to fruition. The Panel therefore noted a potential risk in the delivery of these improvements.

- The Panel felt that there was a particular ongoing risk over the rising costs from service providers within the adult social care sector and the potential impact of this on the modelling of anticipated expenditure over the MTFS period. The Panel made reference to the risk highlighted in the recent KPMG Value for Money Risk Assessment to the Audit Committee which stated that
  - *"The Council does not have adequate procurement processes in place to enable it to achieve value for money in respect of contracts entered into for services received."*
  - *"The Council does not have adequate processes in place to ensure that Adult Social Care spend is sufficiently forecast and managed"* (page 43, agenda papers for Audit Committee, 10th Nov 2025).

  It was recommended that the strengthening of procurement processes be monitored further by the Panel going forward.

The Panel then focused on the pressures and savings that had previously been agreed:

- Asked by Cllr Connor whether the previously agreed savings were on track to be delivered, Jo Baty confirmed that she was confident that they could be delivered but that any areas that became a concern would be reprofiled. She added that the extra staffing capacity would be very helpful in every area of improvement and saving.
- With regard to deliverability, Cllr das Neves referred to the liquidation of the community equipment provider, NRS Healthcare, which was an unexpected event that had a significant impact on the Department. Provider failure was a challenging issue because of the need to obtain alternative provision while maintaining control over costs.
- Asked about the £300k cost under 'Resettlement' for 2026/27, Neil Sinclair explained that these were budget support adjustments which corresponded to -£150k figures in both 2024/25 and 2025/26.
- Cllr Opoku queried the adjustment on resettlement funding (partnership and communities). Cllr das Neves said that some resettlement work was funded by grant programmes and that the Council would be renewing its Welcome Strategy to continue supporting voluntary sector organisations skilled in resettlement and working with communities in an innovative way. She also welcomed the Government's commitment to move away from one-year contracts towards longer-term funding as this improved the scope for effective planning. Jo Baty emphasised the importance of maintaining strong links with the voluntary and community sector and not relying on one organisation. This would help to make the system work for residents and ensure that they were directed to reach information, advice and guidance more quickly without the need to contact many different organisations.
- Cllr Connor noted that the saving on transitions resulted from fewer young people coming through the service but queried why this was the case when there was increased pressure on adult social services in the younger adults

cohort. Neil Sinclair explained that assumptions around transitions savings and cost had been built into the budget two years previously. However, following a further piece of work in summer 2025, based on newer data about expecting numbers and the anticipated support needs, further savings had been identified. Cllr das Neves added that the younger adults bracket for adult social services was a very broad age bracket of 18-65 so demand in this area did not necessarily decline when there were lower numbers in transitions.

- Asked by Cllr Iyngkaran about transport costs associated with transitions, Jo Baty explained that entitlements could be different for the 18-25 age group compared to under-18s which she acknowledged could be a major issue for parents due to the changes in arrangements that could be required.
- With regard to Supported Living Contracts, Cllr Connor queried the joined-up approach between the Adult Social Services and Housing teams. Jo Baty confirmed that they were working with Housing and that this item involved moving from spot purchasing arrangements to block purchasing arrangements which tended to be less expensive. This was a complex area as different residents required different levels of support needs but there were also opportunities for collaboration locally.
- Cllr O'Donovan expressed concern about the reduction of the capital item for the in-Borough children's respite facility on page 60 of the agenda pack. It was noted that this item would be scrutinised by the Children & Young People's Scrutiny Panel on Tuesday 18th November.

Cllr Connor then summarised the areas discussed by the Panel and the recommendations to be put forward to the Overview & Scrutiny Committee as follows:

- On the Supported Living Contracts item, the Panel emphasised the importance of ensuring that the housing capital projects would align with social care commissioning needs and anticipated levels of demand.
- The Panel recommended that further scrutiny was required on transitions, in partnership with the Children and Young People's Scrutiny Panel, in order to understand the reasons for the reduced numbers despite the national trends appearing to indicate greater demand.
- The Panel noted that, of the previously agreed savings, there were no current concerns about these becoming undeliverable.

The Panel then focused on the new pressures detailed in Appendix 2 starting from page 61 of the agenda pack:

- Referring to paragraph 1.5 of Appendix 2, Cllr O'Donovan queried why the number of Younger Adults with a Physical Disability primary need was projected to rise by 28% (from 615 to 787) by March 2027. Neil Sinclair explained that this was part of an ongoing trend which was expected to continue. However, the size and cost of the care packages tended to be smaller than other cohorts. Cllr das Neves said that a significant part of the additional demand being seen tended to involved people in their 50s and early 60s with greater complexity of health conditions.

- Cllr Iyngkaran requested further detail on how the £3.6m figure for the Adult Social Care staffing cost pressure had been reached. Jo Baty said that the additional £3.6m provided the security that the service would have enough staff to meet demand, to fulfil statutory duties and to deliver required savings over the next three-year period. The business case and specific figures for this had been developed in conjunction with the HR and Finance teams. There would also be some reconfiguration of the team to meet needs in the areas of highest demand in the east of the Borough and also strengthening the safeguarding team. There would also be improvements in the delivery of the Carers Strategy including more staff undertaking care reviews. The additional funds would also help to ensure greater stability of staffing which had been an issue of concern in recent years. She added that there was a slide deck detailing the high-level posts that were being added which could be shared with the Panel **(ACTION)**
- Asked by Cllr Iyngkaran why there were no further new savings proposed beyond 2026/27, Jo Baty explained that it had been agreed with the Director of Finance that the focus needed to be on delivering the savings that had already been committed to, including the current in-year savings. However, further proposals were possible in future years.
- Cllr Connor observed that there had historically been challenges with the retention of social workers and asked how confident the service was about doing so with the new staff being brought in. Jo Baty responded that visible leadership and strong communications with staff were important elements of this, including being upfront about the improvements required and the challenges involved with delivery and the existing systems. A workforce race equality scheme was being implemented to help with career progression at all levels. Getting a solid workforce development programme in place would also help with this. However, she acknowledged the challenges involved with retention, particularly because staff in London did often change jobs on a regular basis.
- Asked by Cllr Connor about the pressures on staff to deliver the 10 areas of improvement specified by the recent CQC inspection. Jo Baty responded that the improvement plan had recently been delivered to an expanded leadership team. Further work on KPIs was required and a new performance framework for staff would be piloted which would help people to know where they fit in the improvement agenda and how they could contribute.
- Cllr Connor requested further details about the management actions set out in the table on page 61 of the agenda pack, Cllr das Neves said that this included using the public health grant effectively, maximising income in areas where the NHS contributed to services, the continued negotiations of Continuing Healthcare and the evidence base for Section 117 (Mental Health Act) work. It also included improved monitoring of providers so that charges were only made for actions that had been completed, such as visits for example. Asked to clarify why the projected savings were significantly higher in 2027/28, Neil Sinclair explained that this was due to the scaling up of work in 2026/27, the benefits of which would then be realised the following year.
- Cllr Brennan highlighted the importance of appropriate support and training for social workers given the public facing nature of their role. Jo Baty replied that a

layered approach was required as different issues could arise at different levels. It was therefore important to ensure that staff had professional supervision and proper training as part of an efficient business-like approach. She added that the tone of the notes written by social workers could be a good indicator of training as these should be written in a respectful and non-judgmental way. Cllr das Neves spoke about members of staff that she had met who modelled all the right behaviours and that this type of staff would help others to develop.

Cllr Connor then summarised the areas discussed by the Panel and the recommendations to be put forward to the Overview & Scrutiny Committee as follows:

- The Panel welcomed the additional investment in staffing and highlighted staff retention as a potential risk as this could impact on the Council's ability to fulfil its statutory duties. It was recommended that workforce issues be monitored further by the Panel going forward, particularly in relation to improvements to Care Act assessments.

The Panel then focused on the new saving on adult social care charging policy detailed on page 81 of the agenda pack:

- Asked by Cllr Connor for further explanation about the charging policy, Cllr das Neves clarified that this was not about failing to collect money but instead was about putting in more resource in order to carry out assessments earlier and managing the process better. This meant that people would be charged when they started to receive care rather than when they first had a financial assessment. The implementation of this involved an invest to save approach. Jo Baty added that Disability Action Haringey had recently won a contract (not from the Council) on information, advice and guidance and they would work with the Aged Debt Board on concerns about disabled residents who found out about the scale of their contributions at too late a stage. Support was also being provided to the Council by Safeguarding Circle to assist with managing safeguarding risks. Neil Sinclair added that the Council had not historically been good at managing debt and joining up different parts of the Council to support effective processes in this area. This change would establish better processes, including by ensuring that residents were kept up to date about their case and that debts were recovered before the accumulation of large sums. He added that there was a programme board looking at the collection of debt and the removal of unrecoverable debt from the books.
- Asked by Cllr Connor about the total amount of income generation expected from the proposal, Neil Sinclair clarified that this would be over £1m in total, but after accounting for extra staff costs this would be reduced to £909k.
- Cllr Connor said that this was a good initiative but queried why this money had not been collected in the past. Cllr das Neves acknowledged that some money may not have been recovered previously but the resource to reform this process had not previously been put in.

- Asked by Cllr Brennan about the assessment for people who could not afford care, Jo Baty explained that residents needed the right information, advice and guidance right at the beginning of the process so that they could make informed decisions. The proposal was about working in a person-centred way and to avoid circumstances where residents were building up debt to the Council. Cllr das Neves commented that some people were still unaware that financial contributions and financial assessments were required in order to access adult social care services. She added that she considered the proposal to be the right level of policy change and brought Haringey more in line with other Boroughs, although some local authorities were charging more to their residents.

On the new savings proposal, the Panel concluded that:

- This was a necessary piece of work and the income generation was welcomed by the Panel.
- The Panel had sought assurances that residents on low incomes would not be put in circumstances where they did not have access to care services and the Panel felt that this point had been answered to their satisfaction.
- The Panel expressed concerns that this policy change had not been carried out in the past as this could have achieved savings at an earlier stage. The Panel queried whether there were any other similar areas where practice was out of step with other Boroughs and opportunities for income generation may be being missed.

The Panel briefly spoke about the savings proposal on page 82 of the agenda pack (reduction of floating support contracts) which related to the housing-related support available to vulnerable residents. While this proposal was from the Adult, Health and Communities service, it was within the remit of the Housing, Planning & Development Scrutiny Panel and not the Adults & Health Scrutiny Panel. Cllr O'Donovan commented that:

- The proposal was to deliver a 35% reduction in contract value, and the floating support services would then prioritise those with the most complex needs and highest risk of tenancy breakdown with a focus on crisis intervention and short term intensive care.
- That other residents with needs that don't fall into those categories, may therefore seek support, advice and guidance through other welfare and financial inclusion services. It was also probable that some residents would not seek support and advice until a crisis was reached.

Cllr O'Donovan recommended that if the proposal was agreed, the Adult & Health Scrutiny Panel should work with the Housing, Planning & Development Scrutiny Panel during 2026/27 in order to monitor this proposal and evaluate the impact on vulnerable residents. It was agreed that these comments be passed to the Chair of the Housing, Planning & Development Scrutiny Panel in advance of the Panel's meeting on Monday 20th November where this proposal was due to be discussed. **(ACTION)**

The Panel then focused on the reduction to the Locality Hub item on the capital programme as detailed on page 66 of the agenda pack:

- Cllr das Neves noted that the localities model was operational in the West, Central and East areas of the Borough. Her understanding was that, as the first Locality Hub in the East was based in a Council building, this could be part-funded through the Housing Revenue Account (HRA). In the Central area there were plans for a new health hub in the Wood Green area which would also accommodate some GP space, but there were some challenges with funding from the health sector on this. Further details on this would therefore be available at a later date.
- Asked why there were no further changes to the capital programme, Cllr das Neves said that the approach was not to overstretch and much of the current focus was on delivering revenue savings. Jo Baty acknowledged that there could be further proposals developed going forward and the Panel requested to be kept informed of developments. **(ACTION)**

32. ACTION TRACKER

Dominic O'Brien, Scrutiny Officer, provided an update on the Panel's action tracker:

- Action Point 3a related to a request for details on the number of adult social care packages in the 50-64 age group. The Department had explained that the current reporting systems only tracked the number of younger adults by using a 18-64 age bracket and so this data was not available. However, the Panel could consider carrying out a more detailed financial deep dive in this area at a later date.
- Action Point 7 related to a request for details on the future model for reablement services. Jo Baty had replied to explain that the external consultancy 31Ten had recently carried out a review in this area and that she had suggested bringing a full update on this to the Panel's meeting in February 2026. **(ACTION)**
- Action Point 8 concerned the Q1 finance update. The Panel had noted that the graphs on service users and costs did not cover all age cohorts. It had been explained that the report only covered the most relevant areas but that the Panel could request additional data if required. Cllr Opoku said that a particular concern was that details of different age cohorts were included for different areas which made it difficult to make direct comparisons. She requested that clearer information be provided in the finance updates in future. **(ACTION)**
- Action Point 9 concerned the request from the Panel for information about the progress of savings proposals that had been agreed in previous years but were still in the process of being implemented to be included in future finance updates. This request had been passed to the Finance team.
- Action Points 10 and 11 were requests for information to be passed on following the discussion with the Joint Partnership Board (specifically on the Tottenham Pensioners Group and the Transport Inclusion Group). These actions had been carried out.

Cllr O'Donovan requested that Attachment A (the procedure for the appointment of co-optees to vacant positions on the Scrutiny Panels) be recirculated. **(ACTION)** Dominic O'Brien explained that the intention was for the co-optee recruitment process to take place once per year at the beginning of the municipal year. Cllr O'Donovan requested that information about this should be provided to local stakeholders at an early stage so that new co-opted members were ready to start at the first meeting of the new Scrutiny Panels in 2026/27. **(ACTION)**

33. WORK PROGRAMME UPDATE

Asked about the progress of the Scrutiny Review on Hospital Discharge, Dominic O'Brien reported that further evidence had been collected from the Council, the Mental Health Trust and the Integrated Care Board. This would be written up and circulated with a draft report expected to be provided to the Panel at its next meeting on 16th December.

Cllr Connor noted that there were currently too many items pencilled in for the Panel's meeting in February 2026 and so this would need to be reduced. Councillors were reminded to contact the Chair or Scrutiny Officer if they had any preferences on items to be prioritised. Dominic O'Brien also noted that another item on reablement services had also been suggested by Jo Baty.

Cllr Opoku asked whether an update could be provided to the Panel on the proposed merger of the North Central London Integrated Care Board and the North West London Integrated Care Board as this could be implemented by April 2026. Cllr Connor reported that this was due to be discussed at the next meeting of the Joint Health Overview and Scrutiny Committee (JHOSC) and so she could provide an update to the Panel at the next meeting after this. **(ACTION)**

34. SCRUTINY REVIEW - SCOPING DOCUMENT

The scoping document and terms of reference for the proposed Scrutiny Review on Communications with Residents (Adult Social Care) was considered by the Panel. Dominic O'Brien reported that the draft version of this document had previously been circulated to the Panel and that two suggested amendments had been included in the version in the agenda papers.

Dominic O'Brien explained that the final version of the document would be included in the agenda papers for the Overview and Scrutiny Committee meeting on 27th November 2025. Evidence sessions would then be set with the stakeholders referred to in the document to take place in December 2025 and January 2026 with a view to the completed report being provided to the meeting of the Overview and Scrutiny Committee on 11th March 2026.

RESOLVED – That the scoping document for the proposed Scrutiny Review on Communications with Residents (Adult Social Care) be approved by the Panel for submission to the Overview and Scrutiny Committee.

35. DATES OF FUTURE MEETINGS

- 16th December 2025 (6.30pm)
- 9th February 2026 (6.30pm)

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

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Report for: Adults and Health Scrutiny Panel, 16th December 2025

Title: Safeguarding Adults Board Annual Report 2024-2025

Report authorised by: Natalie Cowland (Independent Chair of Haringey Safeguarding Adults Board).

Lead Officer: Farzad Fazilat, HSAB Board Manager.

Ward(s) affected: ALL

Report for Key/ Non-Key Decision: Non key decision

1. Describe the issue under consideration

1.1 The annual report is for the period 1st April 2024 to 31st March 2025 and is produced as part of the Haringey Safeguarding Adults Board's (HSAB) statutory duty under The Care Act 2014 and Chapter 14 of the Care & Support Guidance. We are required to publish an annual report in relation to the preceding financial year, on the effectiveness of safeguarding in the local area.

1.2 The HSAB Annual Report 2024/25 outlines the work of the Board over the last twelve months and how partner agencies have worked together to improve the safety of adults at risk of or experiencing abuse and neglect. The report contains details of how safeguarding has been promoted and developed over the last year through the Board and its subgroups.

1.3 **Safeguarding Adult Reviews (SAR)**

The HSAB has published three SARs in 2024/25. During 2024/25, the Victoria, Eleanor and Adult Safeguarding and Provider Concerns Thematic SARs were published on the Haringey website: https://www.haringey.gov.uk/adult-social-care/safeguarding-adults/haringey-safeguarding-adults-board/safeguarding-adults-reviews. The full SAR reports and 7-minute briefings have been shared with HSAB partners to aid the dissemination of learning across partner agencies.

The HSAB commissioned the independently led Victoria SAR to identify learning from the events leading to the death of Victoria, who sadly passed away, aged 38, from sepsis of unknown aetiology. The SAR recommended improvements, including:

- Reviewing the SAB's Self-Neglect and Hoarding Procedure to ensure that the level of risk an individual exposes themselves to is fully assessed in cases of self-neglect.
- Reviewing SAB policy, guidance and training content relating to mental capacity assessment.

- Ensuring feedback is given when safeguarding concerns are referred.
- Ensuring concerns raised about a care provider are shared with the relevant commissioning team.
- Considering the benefits of wider roll out of the London Urgent Care Plan to share information across the healthcare system.

The Eleanor SAR looked at learning arising from the events leading to the death of Eleanor, who sadly passed away, aged 74, from heart failure, heart disease and obesity. The SAR recommended improvements, including:

- Raising awareness of the Multi-Agency Solutions Panel (MASP).
- Improving understanding of how medical needs are considered in housing allocations.
- Reviewing arrangements for authorising urgent packages of social care.
- Seeking assurance from housing providers that safeguarding risks are considered in the context of housing repairs.

The Adult Safeguarding and Provider Concerns Thematic SAR identified learning from the events leading to the deaths of Rosemarie and Mearl, who were living at a local care home. Rosemarie sadly passed away, aged 53, of multi-organ failure and disseminated breast carcinoma. Mearl sadly died, aged 83, with cause of death recorded as pneumonia alongside infected pressure sore, bed bound secondary to degenerative lumbar/cervical spine, and type two diabetes and hypertension. The SAR recommended improvements, including:

- Reviewing resource allocation for quality assurance of care providers.
- Mental health support for residents in care settings.
- Health/Local authority monitoring of pressure ulcer care.
- Care provider management of complaints.
- Audits of hospital discharge.
- Collaboration between agencies in preventing and responding to abuse/neglect.

2. Recommendation

2.1 To note the contents of the annual report.

3. Background information

3.1 The HSAB is a statutory body that works to make sure that all agencies are working together to help keep adults in Haringey safe from harm and to protect the rights of citizens to be safeguarded under the Care Act 2014, Mental Capacity Act (MCA) 2005 and the Human Rights Act (HRA) 1998. Under the Care Act 2014 HSAB has three core duties:

- developing and publishing an annual strategic plan setting out how we will meet our objectives.
- publishing an annual report which sets out what we have achieved; and
- commissioning SAR where serious abuse or death has occurred, and learning can take place.

3.2 The work of the Board is driven by its vision is that Haringey residents are able to live a life free from harm, where communities have a culture that does not tolerate abuse; work together to prevent abuse; and know what to do when abuse happens. The overarching purpose of the HSAB is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- assuring itself that safeguarding practice is person-centred and outcome focused.
- working collaboratively to prevent abuse and neglect where possible.
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred; and
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

4. The HSAB Strategic Plan

The HSAB Strategic Plan 2023-2028 describes our strategic priorities and objectives which will help us to achieve our vision. It provides direction and continuity to our annual delivery work plan and embraces the six key principles of safeguarding (empowerment, prevention, proportionality, protection, partnership, and accountability) which are set out in the Care Act 2014. The six principles hold equal importance and are the foundation of good and effective safeguarding.

5. Delivery 2025/26 Priorities and Objectives

The delivery of the Board's priorities and objectives is overseen by its sub-groups, task and finish groups, and partners:

- **Chairs Executive Subgroup**: Provides leadership and direction to ensure the Board operates efficiently and delivers high-quality safeguarding services to vulnerable adults in Haringey.
- **Quality Assurance Subgroup**: Supports the Board in ensuring local safeguarding arrangements are effective by monitoring and evaluating the quality and effectiveness of safeguarding policies, procedures, practices, and performance.
- **Engagement & Prevention Subgroup**: Oversees the Haringey Safeguarding Adults Prevention Strategy, coordinates multi-agency safeguarding training, delivers awareness campaigns, and promotes effective communication and engagement with the community and stakeholders.
- **Safeguarding Adults Review (SAR) Subgroup**: Reviews cases that may meet the statutory criteria for a SAR under the Care Act 2014, oversees the SAR process, and ensures that recommendations are implemented and lessons are shared with all partners.
- **Practice & Improvement Subgroup**: Ensures that SAR recommendations are acted upon and works to improve the quality of

safeguarding practices, ensuring vulnerable adults receive the necessary support and protection.

6. Contribution to Corporate Strategic outcomes

6.1 Links with the Haringey Corporate Delivery Plan 2024-2026

Cross cutting priorities across 'Children and young people', and 'Adults, Health, and Welfare'.

7. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

N/A

8. Use of Appendices

N/A

9. Local Government (Access to Information) Act 1985

- The Care Act 2014 (http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)
- Care & Support Statutory Guidance Care and support statutory guidance - GOV.UK (www.gov.uk)
- London Multi-agency Adult Safeguarding Policy and Procedures https://haringey.gov.uk/sites/default/files/2024-10/multi-agency-adult-safeguarding-policy-and-procedures-final-.pdf

Haringey Safeguarding Adults Board Annual Report

2024/2025

Foreword

Departing Message from Dr. Adi Cooper, Outgoing Independent Chair of HSAB

As I step down from my role as Independent Chair of the Haringey Safeguarding Adults Board, I want to express my deep gratitude to all those who have contributed to the Board's work over the past year and indeed, throughout my tenure. It has been a privilege to work alongside dedicated professionals, partners, and community members who share a commitment to safeguarding adults at risk and promoting their rights, dignity, and wellbeing.

The 2024/25 year has seen continued progress in strengthening our safeguarding arrangements, improving multi-agency collaboration, and embedding learning from safeguarding adult reviews. We have also faced complex challenges, including the ongoing impact of cost-of-living pressures and increasing demand on health and social care services. Despite these, the Board has remained focused on its core mission: to ensure that adults in Haringey are safe and supported.

I am proud of the strides we have made together and confident that the Board is in excellent hands as Natalie Cowland takes on the role of Independent Chair. Natalie comes to the HSAB from the Nursing and Midwifery Council (NMC) where she was Head of Organisational Learning, Quality and Improvement. Before this she had a 30-year career with the Metropolitan Police Service (MPS) which includes a significant background in multi-agency collaboration with 15 years' strategic experience across policing and regulatory health settings. She has worked in safeguarding settings at every level, leading teams dealing with complex adult protection investigations, leading MPS's response to all statutory safeguarding reviews including Safeguarding Adult Reviews (SARs), work with the Continuous Policing Improvement Command and with National Counter Terrorism.

The work of safeguarding adults is never done in isolation, and I am confident that under Natalie's experienced and leadership, the Board will continue to grow, innovate, and make a meaningful difference in the lives of those we serve. I wish her and all HSAB partners every success in continuing this vital work**.**

Thank you to all our partners, professionals, and community members for your unwavering support and collaboration. It has been a privilege to serve alongside you.

Dr. Adi Cooper
Outgoing Independent Chair, Haringey Safeguarding Adults Board

Introduction from Natalie Cowland, Incoming Independent Chair of HSAB

I am honoured to introduce the Haringey Safeguarding Adults Board Annual Report for 2024/25 as the new Independent Chair. I would like to begin by thanking Dr. Adi Cooper for her outstanding leadership and unwavering dedication to adult safeguarding in Haringey. Her legacy provides a strong foundation on which we will continue to build.

This report highlights the Board's achievements over the past year, including strengthened partnership working, improved data sharing and analysis, and a continued focus on learning from Safeguarding Adult Reviews to drive systemic change.

However, challenges remain. The pressures on public services, the complexity of safeguarding concerns, and the need to address inequalities in access and outcomes all require sustained attention. As we look ahead, our priorities will include enhancing preventative approaches, support workforce development, and ensuring that safeguarding is everyone's business across Haringey.

I am committed to working collaboratively with all HSAB partners, stakeholders, and residents to ensure that adults in Haringey are not only protected but empowered to live safe, independent, and fulfilling lives. Together, we will continue to champion a safeguarding system that is compassionate, effective, and rooted in the values of respect and justice.

Natalie Cowland
Independent Chair, Haringey Safeguarding Adults Board

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Glossary

ADASS	Association of Directors of Adult Social Services
ASC	Adult Social Care
ASSOP	Adult Social Services Outcomes Programme
BEH	Barnet, Enfield and Haringey Mental Health NHS Trust
BIA	Best Interests Assessor
CES	Community Equipment Service
CHC	Continuing Healthcare
CLaQC	Care, Learning and Quality Committee
CQC	Care Quality Commission
CSP	Care Support Plan
CSPRs	Child Safeguarding Practice Reviews
DA	Domestic Abuse
DAHA	Domestic Abuse Housing Alliance
DASH	Domestic Abuse, Stalking and Honour-Based Violence Risk Model
DBS	Disclosure and Barring Service
DHR	Domestic Homicide Review
DWP	Department for Work and Pensions
DoLS	Deprivation of Liberty Safeguards
EHC	Education, Health and Care
EPS	Engagement & Prevention Subgroup
FGM	Female Genital Mutilation
HAGA	Haringey Advisory Group on Alcohol
HHIT	Haringey Housing Improvement Team
HRB	High Risk Behaviour
HSAB	Haringey Safeguarding Adults Board
HSCP	Haringey Safeguarding Children Partnership
HSGL	Haringey Strategic Group for Learning
HWB	Health and Wellbeing Board
IMCA	Independent Mental Capacity Advocate
ISA	Information Sharing Agreement
LBH	London Borough of Haringey
LFB	London Fire Brigade
LMH	Local Mental Health
LPA	Lasting Power of Attorney
LPS	Liberty Protection Safeguards
LeDeR	Learning Disabilities Mortality Review Programme
MACC	Multi-Agency Case Conference
MACE	Multi-Agency Child Exploitation
MAPW	Multi-Agency Panel for Welfare
MASH	Multi-Agency Safeguarding Hub
MASP	Multi-Agency Safeguarding Plan
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MISPtR	Multi-Agency Individual Safeguarding Plan to Reduce Risk
MPS	Metropolitan Police Service
MSP	Making Safeguarding Personal
NCC	National Care Certificate
NCL ICB	North Central London Integrated Care Board
NHS	National Health Service
NHSE	NHS England
NLFT	North London Foundation Trust
NMUH	North Middlesex University Hospital
NRPF	No Recourse to Public Funds
PIPOT	Person in a Position of Trust
PP	Protection Plan
PSW	Principal Social Worker
QAF	Quality Assurance Framework
QAS	Quality Assurance Subgroup
RCRP	Risk, Care and Recovery Plan
SABs	Safeguarding Adults Boards
SAC	Safeguarding Adults Concern
SARs	Safeguarding Adults Reviews
SEND	Special Educational Needs and Disabilities
SPOC	Single Point of Contact
TVN	Tissue Viability Nurse
VAWG	Violence Against Women and Girls
VCS	Voluntary and Community Sector
WISP	Working in Safeguarding Partnership

Introduction

The Haringey Safeguarding Adults Board (HSAB)
The HSAB is a statutory body established by the Care Act 2014[1]. 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[2]** 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 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

[1] Care Act 2014
[2] London Multi-Agency Adult Safeguarding Policy and Procedures – LondonADASS

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).

Work of the HSAB

HSAB Away Day

In April 2024, the HSAB convened its first in-person meeting since the COVID-19 pandemic. This milestone event brought together members of the Board, to reflect on progress, assess current challenges, and collaboratively shape the strategic direction for the year ahead.

Exploring the Long-Term Impacts of COVID-19
This session aimed to examine the enduring effects of the pandemic on safeguarding practice and partnership working, in line with recommendations from recent SARs. The discussion was structured around identifying ongoing challenges, emerging risks, and opportunities for innovation.

Key themes included:
- **Rising Complexity of Safeguarding Concerns**: There has been a notable increase in referrals related to domestic abuse and self-neglect. These trends reflect both the direct and indirect consequences of the pandemic on vulnerable adults.
- **Need for In-Person Engagement**: Participants emphasised the importance of re-establishing face-to-face contact in safeguarding work. Virtual interactions, while necessary during the pandemic, were seen as limiting the ability to build trust and detect safeguarding concerns.

- **Digitalisation and Social Isolation**: The rapid shift to digital service delivery has contributed to increased isolation, particularly among individuals with limited digital literacy or access. This has had a disproportionate impact on people with learning disabilities and those already experiencing social exclusion.
- **Healthcare Access and Strain**: The rise in online GP consultations has coincided with increased medical emergencies and delays in accessing face-to-face care. This has placed additional pressure on primary care services and created barriers to identifying safeguarding issues.
- **Economic and Housing Pressures**: The pandemic, compounded by the cost-of-living crisis, has exacerbated housing instability, homelessness, and financial vulnerability. These factors have increased the risk of exploitation and abuse.
- **Safeguarding in the Provider Market**: Concerns were raised about the preparedness of newly recruited overseas care workers, who may lack familiarity with local safeguarding protocols and feel reluctant to report concerns.
- **Opportunities for Innovation**: The potential use of artificial intelligence to support emotional insight and early intervention was discussed, alongside the need to strengthen multi-agency collaboration and intelligence sharing.

Strategic Priorities for 2024/25

The session also focused on reviewing the HSAB's strategic priorities and identifying areas requiring further attention. Participants were asked to consider whether emerging safeguarding issues were adequately reflected in the Board's existing priorities and to propose new areas of focus.

Key insights included:

- **Financial Abuse**: Identified as an increasingly prevalent and under-reported issue, requiring targeted awareness and intervention strategies.
- **Self-Neglect and Hoarding**: The need to improve reporting pathways and develop more coordinated responses was highlighted.
- **Broadening Intelligence Sources**: There was consensus on the importance of drawing on a wider range of data and insights beyond SARs to inform strategic planning.
- **Capacity and Resource Allocation**: Limited capacity within subgroups was acknowledged, prompting a call for clearer prioritisation and more efficient use of resources.
- **Improving Partner Engagement**: Reports to the Board should be more engaging and clearly articulate the actions required from partners to ensure learning is translated into practice.
- **Clarifying Commissioning Expectations**: Questions were raised about how safeguarding responsibilities are embedded in commissioning processes, signalling a need for greater alignment and clarity.

The Board agreed on several key actions to strengthen safeguarding efforts going forward.

The April 2024 Away Day provided a valuable opportunity for reflection, learning, and strategic alignment. It reinforced the importance of face-to-face collaboration, highlighted the evolving nature of safeguarding risks, and generated a clear set of actions to guide the Board's work in 2024/25.

Annual Safeguarding Learning and Development Report 2024–2025

The Annual Safeguarding Learning and Development Report 2024–2025 provides the HSAB with assurance on the scope, quality, and impact of safeguarding training delivered across the partnership. It captures the breadth of learning activity undertaken by statutory, health, emergency services, and voluntary sector partners, and reflects the Board's ongoing commitment to building a confident, skilled, and responsive safeguarding workforce.

Key Highlights:

- **Level 1 Training**: 6,949 employees completed Level 1 safeguarding adults training. While e-learning remains the primary method for Level 1, some partners have adopted video-based materials, particularly for community and voluntary sector audiences.
- **Level 2 Training**: 6,327 employees completed Level 2 training, with a strong preference for live, in-person sessions (90% of delivery). This marks a significant shift away from e-learning, indicating a return to pre-pandemic training norms.
- **Specialist Training**: Over 5,000 additional sessions were delivered on topics such as domestic abuse, homelessness, hoarding, mental capacity, and Prevent. These sessions targeted both staff and residents, expanding safeguarding awareness across the borough.
- **New Topic-Specific Data Collection**: For the first time, partners reported attendance data for training on the Mental Capacity Act (MCA), Tissue Viability (TVN), and Self-Neglect/Hoarding. This supports more targeted learning aligned with SAR themes.

Partner-Delivered Safeguarding Training

- Whittington Health delivered over 3,250 joint sessions on the MCA and self-neglect/hoarding. Ran additional sessions on dementia, district nursing, and learning disabilities, reaching 181 participants and provided in-person Level 2 safeguarding training and briefings.
- North Middlesex University Hospital delivered 2,761 joint MCA and self-neglect/hoarding sessions. Provided 2,087 Level 2 safeguarding sessions, mostly in person. Ran topic-specific training on domestic abuse, self-neglect, and simulation-based safeguarding scenarios.
- Barnet, Enfield & Haringey Mental Health Partnership delivered training on eating disorders, harmful practices (e.g., FGM), hate crime, and safeguarding in homelessness. Used council training places for self-neglect and hoarding topics.
- Prevent Team reached over 4,000 people through awareness sessions, including targeted training for Tottenham Hotspur Foundation staff.
- VAWG Team delivered workshops on domestic abuse in LGBT and Deaf communities, sexual violence, and survivor support.

- London Fire Brigade delivered hoarding and fire safety awareness sessions.
- Conducted home fire safety visits and trained carers to identify hoarding risks.
- Metropolitan Police (North Area BCU) ran safeguarding inductions and “lunch and learn” sessions on financial abuse, vulnerable adults, and missing persons.

Trends and Analysis

- **Shift Toward In-Person Learning** There has been a marked return to in-person training, particularly for Level 2 and specialist sessions. This reflects a broader trend across partners to prioritise interactive, discussion-based learning environments that foster deeper understanding and engagement.
- **Training Reach and Coverage** Most partners met or exceeded their training targets. For example, Whittington Health achieved 90% coverage for Level 1 and 83% for Level 2; North Middlesex University Hospital reported 94% Level 1 and 93% Level 2 coverage; and the Metropolitan Police achieved 100% coverage for both levels among new starters and public protection officers.
- **Multi-Agency Collaboration** Partners increasingly deliver training to each other and to the wider community. This includes Prevent sessions reaching over 4,000 individuals; Domestic abuse workshops tailored for specific communities, including Deaf survivors; and Housing-related support sessions addressing homelessness and multi-exclusion vulnerabilities.
- **Evaluation and Impact** Evaluation was strengthened through follow-up surveys, case file audits, and reflective learning events. Case studies from health, social care, emergency services, and housing illustrate how training has translated into improved safeguarding practice

Looking Ahead to 2025–2026

- Multi-agency training will remain a priority, with continued alignment to the SAB Strategic Plan and SAR learning.
- The council will maintain its offer of workshop places to partners, subject to funding availability.
- Efforts will be made to improve monitoring of community-based training, particularly through the Haringey Community Collaborative.
- Partners will be encouraged to embed safeguarding themes into their internal training programmes and share best practices through the Practice and Improvement Subgroup.

The examples below show how training has improved professional confidence, enhanced multi-agency collaboration, and led to better outcomes for adults at risk.

Case Study 1: Supporting a Vulnerable Asylum Seeker Escaping Coercive Control

HC, a 22-year-old male asylum seeker from Turkey, was referred to Osborne Grove Assessment Centre in March 2024 by outreach services. He presented with multiple and intersecting vulnerabilities:

- **Physical health needs** resulting from a previous attempted murder.
- **Suspected PTSD** and trauma-related symptoms.
- **No Recourse to Public Funds (NRPF)** and an unsettled asylum claim.
- **Language barrier**, speaking only Turkish.

- **Coercive control** exerted by his significantly older female partner (ZH, aged 45).

Despite being allocated separate rooms at the centre, ZH insisted they share a room and moved HC's belongings into hers. She interfered with keywork sessions, demanded to be the sole point of contact, and prevented HC from speaking freely. These behaviours raised serious safeguarding concerns.

A Turkish-speaking support worker was assigned to HC, enabling culturally sensitive and linguistically appropriate support. Drawing on training in coercive control and trauma-informed practice, the support worker built trust with HC and created a safe space for disclosure.

HC revealed that ZH's two sons had attempted to murder him in an honour-based violence attack nine months earlier. He disclosed that ZH had prevented him from accessing medical care, collecting medication, and contacting the police. She had also threatened him to withdraw his police statement about the attack. This information was shared with the police discreetly to protect HC and avoid alerting ZH. The police confirmed they had been unable to contact HC for nine months, corroborating his account.

A coordinated safeguarding response was initiated involving:

- **Police**: Encouraged HC to report coercive control and supported him through the process.
- **RAMFEL (Refugee and Migrant Forum of Essex and London)**: Assisted with a NASS accommodation application for HC.
- **Housing Services**: Assessed ZH for private rented accommodation, facilitating separation from HC.

While awaiting accommodation decisions, HC was supported with:

- Care Act assessments.
- Hospital appointments and psychological support.
- Translation services.
- Discreet safeguarding planning to avoid escalating risk.

Outcome

ZH moved into private rented accommodation in April 2024. HC's Section 95 application was successful, and he was relocated to NASS accommodation in August 2025. He was able to provide a full statement to the police, leading to:

- ZH's arrest for coercive control and perverting the course of justice.
- Arrests of her two sons for attempted murder.
- All three individuals were charged and await trial.

Learning and Impact

This case demonstrates the critical importance of:

- Culturally competent and trauma-informed practice.
- Safeguarding training that equips staff to recognise and respond to coercive control.
- Strategic multi-agency collaboration to protect vulnerable individuals.
- Sensitivity and discretion in managing high-risk safeguarding scenarios.

- The ability to speak HC's language and understand the cultural context was pivotal in uncovering the abuse and securing a safe outcome. This case highlights how safeguarding learning directly translates into life-changing interventions for those most at risk.

Case Study: Complex Hospital Discharge and Safeguarding Coordination
Context:

A patient (SO) with complex health needs was admitted to hospital. Despite multiple multidisciplinary team (MDT) meetings, the discharge process was significantly delayed due to concerns around mental capacity, neglect, acts of omission, and limited engagement from the patient's next of kin, who held a Lasting Power of Attorney (LPA).

Safeguarding Challenge:
The case highlighted systemic issues, including:
- Poor communication between specialist teams.
- Unclear understanding of professional roles and responsibilities.
- Stress on hospital resources due to delayed discharge.

Learning Intervention:
A learning event was organised involving ward staff, mental health professionals, and the discharge team. The session focused on:
- Understanding LPA and best interest decisions.
- Clarifying escalation and referral pathways.
- Reflecting on professional responsibilities and inter-agency collaboration.

Outcome:
The event created a safe space for open discussion and reflection. It led to:
- Improved communication and mutual respect among professionals.
- A more coordinated approach to complex safeguarding cases.
- Successful discharge of the patient to a 24-hour care home.

Impact:
This case reinforced the importance of safeguarding training in:
- Enhancing professional curiosity.
- Promoting collaborative working.
- Supporting timely and safe discharge planning for vulnerable adults.

Person in a Position of Trust (PIPOT)

Last year, we reported that the HSAB had implemented the **Person in a Position of Trust (PIPOT)** guidance to provide a comprehensive framework for managing allegations against individuals in positions of trust. The aim of this guidance is to manage risks based on assessments of abuse or harm to adults with care and support needs.

The guidance was formally agreed upon by the HSAB at its board meeting in **January 2024**, with an expectation that all partner organisations would establish

their own internal PIPOT policies and report back to the Board. This ensures consistent and reliable safeguarding practices across the borough.

Aligned with the **Care Act 2014** and its statutory guidance, the PIPOT framework sets clear expectations for how allegations against individuals in positions of trust should be notified, assessed, and addressed. It emphasises the responsibility of local authorities to ensure that service providers have robust procedures in place to prevent and respond to abuse or neglect.

The guidance applies to **local authorities, partner agencies, and commissioned services**, and covers concerns arising from an individual's professional role, private life, or other capacities. It mandates clear, proportionate, and timely responses to allegations, ensuring that safeguarding remains at the heart of all professional conduct.

Summary of PIPOT Activity (Adult Services)
Between October 2023 and April 2025, Haringey Council and its partners responded to a range of PIPOT concerns involving professionals across Health, Housing, Cultural, and Community services. The cases reflect the diverse contexts in which safeguarding concerns can arise and the importance of robust multi-agency responses.

Nature of Allegations

- Allegations ranged from inappropriate relationships with vulnerable adults to sexual abuse, domestic abuse, and professional misconduct.
- Several cases involved boundary violations or conflicts of interest, particularly where professionals had personal relationships with service users.

Most cases involved multi-agency collaboration, including:

- Police investigations
- HR disciplinary processes
- Safeguarding enquiries under the Care Act (Section 42)
- Notifications to professional regulatory bodies

Outcomes varied depending on the severity and substantiation of the concerns:

- In some cases, no further action was taken following consultation or investigation.
- In others, disciplinary action, dismissal, and referrals to the Disclosure and Barring Service (DBS) were necessary.
- One case led to a worker being barred from employment across London .

Concerns arose across a broad spectrum of services, including:

- Local authority departments (e.g., libraries, housing, community enablement)
- Health services (e.g., district nursing, GP practices)

- Voluntary and community sector roles
- Housing providers and repair services

Cross-Boundary and Crossover Risks

- One case highlighted the crossover risk between adult and child safeguarding, reinforcing the need for joined-up safeguarding systems across age groups and services.

The PIPOT cases reviewed during this period demonstrate the continued vigilance and responsiveness of Haringey's safeguarding network. They also reflect the complexity of safeguarding in multi-agency environments and the importance of clear protocols, professional accountability, and trauma-informed approaches. The HSAB remains committed to strengthening the PIPOT framework, ensuring that individuals in positions of trust are held to the highest standards to protect those most at risk.

Missing Persons Landscape

The Board received a comprehensive presentation on the current landscape of missing persons in Haringey. The term "missing" is defined nationally as any individual whose whereabouts are unknown and whose wellbeing cannot be confirmed. This definition is standardised by the College of Policing and underpins the risk assessment and response protocols used by law enforcement and safeguarding partners.

The presentation outlined the use of the National Decision-Making Model and the Five Plus Framework to assess risk levels. Individuals reported missing are categorised into Low Risk, Medium Risk, and High Risk. These categories guide the urgency and nature of the response from police and partner agencies.

Due to system limitations, data on missing persons is currently tracked manually, which affects the efficiency and reliability of reporting. In addition, Adult Social Care receives a significant number of referrals monthly.

A key issue discussed was the legal limitation in care settings. Care homes cannot restrict residents from leaving unless a Deprivation of Liberty Safeguards (DoLS) authorisation is in place. While this protects individual rights, it poses challenges in managing residents who are prone to wandering or going missing, especially those with cognitive impairments or addiction issues.

Protocol Awareness and Escalation

- The Board emphasised the importance of timely reporting and protocol adherence by care providers and commissioners.
- There was concern about delays in reporting, particularly in high-risk cases.
- The Herbert Protocol was highlighted as a vital tool for recording and sharing information about vulnerable individuals at risk of going missing.
- The Universal Care Plan was also discussed. It allows concerns about vulnerable adults to be recorded and shared across London without requiring

consent, enabling quicker identification and response when individuals present at different locations.

Escalation Procedures

- A formal escalation protocol exists for cases where there is disagreement about whether an individual should be classified as missing.
- The role of the Vulnerable Adult Coordinator within the police was noted as a key contact for resolving such disputes and ensuring appropriate action is taken.

The Board agreed that greater assurance is needed from providers and commissioners regarding the timeliness and accuracy of missing person reports.

Ministerial Recommendations for Safeguarding Adults Boards (SABs) – Rough Sleeping

In May 2024, the Ministers for Housing and Social Care issued national recommendations to strengthen how Safeguarding Adults Boards (SABs) support individuals who are rough sleeping—recognising them as a group at high risk of abuse, neglect, and complex health and care needs. These recommendations align with the government's *Ending Rough Sleeping for Good* strategy[3].

The HSAB reviewed and responded to the ministerial recommendations and compiled evidence and actions demonstrating how Haringey is meeting the national expectations. A Designated a Named Lead Head of Housing-Related Support was appointed as the HSAB lead for safeguarding individuals rough sleeping.

What the HSAB will do going forward:

- Continue implementing the ministerial recommendations, including embedding rough sleeping into strategic plans and safeguarding procedures; Promoting system-wide accountability and outcome-focused governance; and Commissioning SARs where appropriate.
- Enhance workforce literacy around safeguarding and homelessness.
- Collaborate with national advisers through the Rough Sleeping Initiative to share best practices and overcome barriers to joint working.

Multi-Agency Safeguarding Hub

The Metropolitan Police Services (MPS) presented an update on the pan-London MASH (Multi-Agency Safeguarding Hub) Review, aimed at improving the identification and response to risks affecting vulnerable adults and children. The review focused on enhancing information sharing, aligning referral thresholds, and promoting a consistent, risk-based approach across boroughs. The review involved collaboration with Adult Social Care (ASC), health, and mental health partners, and was structured around strategic and tactical working groups.

[3] Ending rough sleeping for good - GOV.UK

Key outcomes included the development of a refreshed Adult Safeguarding Standard Operating Procedure (ASSOP), new MPS guidance on recognising vulnerability, and a training package for all officers. A new Adult Decision Making document was introduced to align BRAG (Blue, Red, Amber, Green) levels with ASC definitions, improving triage and referral clarity. Trials in Sutton, Croydon, and Bromley showed positive results, including reduced backlogs and faster support for adults at risk. A revised research process was also implemented, streamlining police workloads while maintaining safeguarding standards.

Strategic Terms of Reference and a Joint Response Protocol were created to formalise partnership working between MPS and ASC. These documents are being tailored for local use and will support both strategic planning and frontline responses. Final feedback is being gathered before borough-wide rollout, and ongoing strategic and tactical meetings will ensure the process remains responsive and iterative. The review marks a significant step toward a more coordinated and effective safeguarding system across London.

Homelessness and Safeguarding

Over the past year, Haringey has made significant strides in supporting people experiencing homelessness, with a strong focus on safeguarding and multi-agency collaboration. Key achievements include:

- **Integrated Support at Mulberry Junction**: Sixteen services now operate from this hub, offering extended hours and holistic support. This includes immigration advice, mental health and paramedic drop-ins, and evening scripting services.
- **Health Inclusion and Access**: 96% of residents in council-delivered services are now registered with a GP. Jointly commissioned health outreach services provided street and clinic-based care, including COVID-19 vaccinations and wellbeing events.
- **Targeted Interventions**: The Homeless Health Inclusion Team (HHIT) and Haringey Outreach Team delivered over 700 interventions combined, addressing complex needs through a multidisciplinary approach.
- **Cultural and Communication Improvements**: The year highlighted the need for better use of translation services and culturally competent care. These insights are shaping future training and service design.
- **Staff Wellbeing**: Emotional toll on frontline staff was acknowledged, with plans to introduce structured emotional support and reflective practice.

Looking Ahead
For 2025–26, the focus will be on:

- Sustaining and expanding health inclusion work
- Improving system coordination between housing, health, and safeguarding services to prevent missed interventions.
- Embedding learning from recent findings on language barriers, cultural competency, and staff wellbeing into safeguarding practice.

- Strengthening HSAB links, ensuring safeguarding remains central to homelessness strategy and that learning is shared across the partnership.

This work reflects a strong commitment to safeguarding adults at risk and ensuring no one is left behind due to homelessness.

Homelessness Strategy

At the January 2025 HSAB meeting, the Board received an update on the development of Haringey's new Homelessness Strategy (2025–2027). This strategy is a statutory requirement under the Homelessness Act 2002[4] and aims to prevent homelessness, ensure sufficient accommodation, and provide appropriate support for those at risk.

The strategy is being developed in two phases of co-design, engaging directly with people affected by homelessness, including young adults, probation services, and community groups. A formal consultation is scheduled for summer 2025, with adoption planned for September 2025. The strategy will be followed by a longer-term joint Homelessness and Rough Sleeping Strategy (2027–2032).

Key emerging priorities include:

- Strengthening partnership working across services
- Early intervention and prevention, particularly in the private rented sector
- Targeted support for high-risk groups such as care-experienced individuals, people leaving mental health or care settings, and those with no recourse to public funds
- Expanding and improving temporary and supported accommodation
- Enhancing access to affordable housing

The Board discussion emphasised the importance of safeguarding considerations throughout the strategy. Members highlighted the need to:

- Include care-experienced individuals and those transitioning from institutional settings as vulnerable groups
- Address language needs and risks of exploitation
- Improve inter-agency communication and learning from past safeguarding cases
- Use the SAB network to support consultation and feedback

The Homelessness Reduction Board (HRB), which includes council officers and external partners, is overseeing the strategy's development and delivery. HSAB will continue to be engaged to ensure safeguarding remains central to the strategy's implementation.

Tackling Health Inequalities

In 2024–25, the ICB continued to drive forward its commitment to reducing health inequalities across Haringey, with a strong emphasis on safeguarding adults at risk.

[4] Homelessness Act 2002

The work focused on improving access to care, addressing wider determinants of health, and strengthening partnerships across the system.

Key Highlights from the Year

- **Targeted Support for Vulnerable Adults**: Programmes such as the Longer Lives initiative and the Haringey Multi-Agency Care and Coordination (MACC) Team provided proactive, personalised care for adults with severe mental illness and frailty, helping to prevent hospital admissions and improve outcomes.
- **Inclusion Health Investment**: Sustained funding supported GP access for asylum seekers and enhanced the work of Haringey's Homeless Health and Inclusion Team and Rough Sleeper Mental Health Team.
- **Neighbourhood Working**: Integrated neighbourhood teams worked closely with the Voluntary, Community, and Social Enterprise (VCSE)[5] sector partners to deliver preventative care and support, particularly in the most deprived communities.
- **Safeguarding and Hospital Discharge**: The ICB reinforced a "no discharge to the streets" culture across hospital trusts. Poor discharge planning was recognised as a safeguarding concern, with new pathways and tools introduced to improve outcomes for people experiencing homelessness.

Strengthening Safeguarding and HSAB Links

- **Safeguarding Integration**: The ICB's Designated Safeguarding Lead for Adults will join the Live Well and Age Well Boards, ensuring safeguarding is embedded in strategic planning.
- **Data Sharing**: The ICB welcomes opportunities to work with HSAB to share safeguarding data, helping to inform service planning and better target support.
- **Out of Hospital Care Models**: Continued development of intermediate care pathways for people experiencing homelessness will reduce unsafe discharges and improve recovery.
- **Community-Based Mental Health Growth**: New investment will expand support for people with co-occurring conditions, building on successful local models.

HAGA Alcohol-Related Deaths Review

Between January 2023 and July 2024, Haringey Alcohol Action Group (HAGA) undertook its second review of alcohol-related deaths among clients in Haringey's substance misuse services. This work has provided vital insights into the complex needs of individuals affected by alcohol dependency and the safeguarding implications for local services.

Key Achievements and Improvements

- **Safeguarding Integration**: HAGA now has direct access to the Principal Social Worker to resolve safeguarding concerns and is awaiting the recruitment of a dedicated substance misuse social worker.

[5] NCL-ICB-Working-with-our-VCSE-2223_2526.pdf

- **Mental Health Support**: A dual diagnosis team from Barnet, Enfield, and Haringey (BEH) NHS Trust attends HAGA weekly, improving access to mental health support and strengthening links with local mental health teams.
- **Primary Care Collaboration**: Communication with GPs has improved, and from 2025/26, the GP Federation will provide weekly primary care clinics at HAGA.

Findings from the Review

- **Client Deaths**: 21 deaths were recorded across Haringey's substance misuse services, with 13 linked to alcohol use. Most individuals were male, with an average age of 54.
- **Complex Needs**: 86% had known mental health conditions, and all had physical health issues, commonly liver disease, respiratory conditions, and long-term illnesses such as diabetes and epilepsy.
- **Safeguarding Gaps**: Only 3 of the 21 individuals were known to adult social care, highlighting missed opportunities for safeguarding intervention.
- **Hospital Use**: High levels of Accident and Emergency (A&E) attendance were noted, with 108 visits across 11 clients. However, communication gaps meant that services were often unaware of clients' high-intensity use of emergency care.

Planned Actions and Future Focus

- **Enhanced Hospital Liaison**: HAGA is working with North Middlesex University Hospital (NMUH) to review client deaths and improve data sharing, particularly around emergency department use and missed outpatient appointments.
- **High Intensity User Monitoring**: Efforts are underway to better identify and support high-intensity users of health services, ensuring they are discussed in multi-agency forums where appropriate.
- **Liver Health Monitoring**: There is a renewed focus on early identification of liver disease, with plans to increase the use of fibroscans and improve follow-up care.

The review underscores the importance of multi-agency collaboration in safeguarding adults with complex needs. The findings have informed HSAB's priorities around early intervention, improved data sharing, and proactive safeguarding responses. The Board will continue to monitor progress and support system-wide learning to reduce preventable deaths and improve outcomes for vulnerable adults.

Department of Work & Pensions Joint Working Protocol

In 2024, a national Joint Working Protocol was developed between the Department for Work and Pensions (DWP) SABs, following key recommendations from two SARs. This protocol aims to strengthen collaboration between DWP and SABs under Sections 42[6] and 44[7] of the Care Act 2014, focusing on safeguarding enquiries and reviews.

[6] Care Act 2014
[7] Care Act 2014

Key achievements this year:

- The protocol formalises DWP's engagement with SABs, encouraging local boards to include DWP Advanced Customer Support Leads in strategic discussions and safeguarding reviews.
- It clarifies DWP's role in identifying and referring safeguarding concerns, despite not having statutory duties under the Care Act.
- DWP staff are now empowered to share safeguarding concerns proactively with relevant authorities, even without claimant consent, where there is a clear risk to welfare or safety.
- The protocol supports DWP's participation in SARs, including sharing relevant information and contributing to learning and improvement processes.

Looking ahead:

- The HSAB will continue to build on this strengthened relationship with DWP, ensuring their involvement in safeguarding enquiries and reviews where appropriate.
- The protocol will be evaluated nationally within 12 months of implementation to assess its effectiveness and impact.
- HSAB will support the aspiration for a national Thematic Impact Report from DWP, summarising learning and strategic changes from safeguarding cases.

HSAB Escalation Policy Update (2025–2028)

In January 2025, the Board reviewed and endorsed a revised version of the **HSAB Multi-Agency Escalation Protocol**, which will guide safeguarding dispute resolution across partner organisations until 2028.

This updated protocol reflects learning from SARs and reinforces the importance of professional challenge and timely resolution of interagency disagreements. It simplifies previous procedures while maintaining a clear, staged approach to resolving disputes, starting at the lowest operational level and escalating to senior management only when necessary.

A key feature of the protocol is the provision for a **Safeguarding Adults Board Resolution Panel**, convened by the Independent Chair when disputes cannot be resolved through usual channels. This panel includes representatives from multiple agencies and ensures that safeguarding concerns are addressed collaboratively and decisively.

The protocol also introduces a **fast-track mechanism** for complex, high-risk cases requiring urgent multi-agency resolution, and outlines how learning from disputes will be fed back into training and policy development via the Board's Practice and Learning subgroup.

This development marks a positive step in strengthening multi-agency safeguarding practice in Haringey, promoting accountability, partnership, and continuous improvement. The Board's commitment to this protocol ensures that safeguarding

concerns are addressed with transparency, urgency, and a shared focus on protecting vulnerable adults.

Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS): Staff Procedure and Guidance Update

In 2024–25, the HSAB endorsed a significant update to the MCA DoLS Staff Procedure and Guidance, marking the first revision since 2016. This update followed an audit, which recommended modernising the policy to reflect current practice and legal expectations. The revision had been delayed due to anticipated legislative changes with the Liberty Protection Safeguards (LPS), which have since been postponed.

The updated guidance now aligns with current case law, national standards, and operational procedures, ensuring that staff across Haringey are equipped to identify, assess, and authorise deprivations of liberty in line with the MCA 2005[8]. It includes clearer definitions, streamlined referral pathways, and improved clarity on roles and responsibilities across the DoLS process.

The revised policy was approved by the Quality Assurance Subgroup (QA) and formally signed off by the HSAB in January 2025. This reflects a strong commitment to safeguarding adults who may lack capacity and ensuring their rights are protected through lawful and proportionate care arrangements.

Looking Ahead

The HSAB will continue to monitor developments around the implementation of the LPS and ensure that local practice remains compliant with evolving legal frameworks.

[8] Mental Capacity Act 2005

Work of the HSAB Subgroups

The HSAB has established five key subgroups to support its aim of protecting adults at risk and promoting their well-being. These subgroups focus on specific areas of safeguarding practice and policy development.

The subgroups are designed to ensure that safeguarding work in Haringey is coordinated, evidence-informed, continuously improving and responsive to local needs. Each subgroup has a defined purpose and remit, contributing to the overall effectiveness of the Board.

Chairs Executive Subgroup

To ensure strategic oversight and alignment, the HSAB has established a Chairs Executive Subgroup (CES). This group brings together the chairs of all five subgroups and is responsible for:

- Overseeing the delivery of the HSAB Strategy Delivery Plan,
- Promoting collaboration and information-sharing between subgroups,
- Escalating issues or concerns to the full Board where necessary, and
- Ensuring that subgroup activity remains focused, impactful, and aligned with the Board's vision and statutory responsibilities.

In preparation for the 2025–2026 financial year, the CES convened to undertake a comprehensive review of the current delivery plan. This strategic exercise was aimed at ensuring the Board's priorities, objectives, and actions remain responsive to emerging safeguarding challenges, reflect learning from past reviews, and align with both local and national developments in adult safeguarding.

The review process involved a detailed evaluation of each objective within the existing plan. The group assessed progress made, relevance to current safeguarding needs, and alignment with the Board's overarching vision and statutory responsibilities. As a result of this review:

- Some objectives were retired where they had either been successfully delivered or were no longer deemed strategically necessary.
- Other objectives were refreshed and carried forward into the 2025–2026 plan to ensure continuity and sustained impact.
- New objectives were introduced to address evolving safeguarding concerns, such as the cost-of-living crisis, transitional safeguarding, and quality assurance in care provision.

The refreshed delivery plan continues to be structured around three strategic priorities:

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

Each priority is underpinned by the six principles of adult safeguarding; Empowerment, Prevention, Proportionality, Protection, Partnership, and Accountability, and is supported by clear objectives, lead subgroups, and measurable indicators of success.

The plan reflects a strong commitment to multi-agency collaboration, community engagement, and continuous learning, ensuring that safeguarding adults in Haringey remains a dynamic, inclusive, and evidence-informed endeavour.

HSAB Priorities and Objectives 2025/2026

PRIORITY 1: PREVENTION AND AWARENESS		
Aligned Principle: Prevention		
Objectives	**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.	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.	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).
Objective 1.3 Delivering a communication and engagement plan for 2024/25 to raise awareness of	Review and refresh the Haringey Safeguarding Prevention Delivery Plan in line with the new HSAB priorities and objectives.	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	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
safeguarding in Haringey.	Deliver a communication engagement plan for **2025/26.** Defining and prioritising communication and engagement based on national priorities and the Board Strategic Plan. Establishment of a robust framework for ongoing monitoring and evaluation of the Haringey Safeguarding Prevention Delivery and Communications 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.
Objective 1.4 To consider the safeguarding impact of the cost-of-living crisis (including food and fuel poverty).	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.
Objective 1.5 Creating a Collaborative and Impactful Programme for Safeguarding Adults Week 2025.	Partner with local authorities, community organisations, and advocacy groups. Engage with the NCL to align with regional priorities and resources. Plan and focus on different themes focusing on different aspects of safeguarding, such as financial abuse, domestic violence, and mental health.	Collect feedback from participants through surveys and feedback forms. Positive feedback and high satisfaction ratings from participants. Active engagement during events.

PRIORITY 2: LEARNING, REFLECTION AND PRACTICE IMPROVEMENT		
Aligned Principle: Empowerment, Protection, Proportionality		
Objectives	**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	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 synergies between local and regional efforts, with the need for comprehensive	Measurable improvements in knowledge, practice, and outcomes related to these themes. The improvement in the quality and consistency of Mental Capacity Assessments.
	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.
	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.
	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. The Board is assured that practice has improved

PRIORITY 2: LEARNING, REFLECTION AND PRACTICE IMPROVEMENT		
Aligned Principle: Empowerment, Protection, Proportionality		
Objectives	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
		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.	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 innovations into practice improvement.	Contribute to National Policy and practise through our active participation in regional and national networks and forums.	There is evidence of two-way information sharing between regional and national networks.
	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	**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 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.	The Board will continue to support with on-going work in the following areas: • Homelessness and Safeguarding • Modern Day Slavery • Transitional Safeguarding and Think Family jointly with the Childrens Partnership • Violence Against Women and Girls • Serious Youth Violence • DHR	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.
Objective 3.3 The Board meets its statutory responsibilities.	• 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 (CQC) 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

PRIORITY 3 SAFEGUARDING AND QUALITY OF SERVICES		
Aligned Principle: Accountability, Partnership		
Objectives	**To meet this objective over the coming years we will:**	**Key indicators of success and impact**
		sleeping issues; and data on homelessness and rough sleeping is integrated into the quarterly performance reports within the agreed reporting periods.

Safeguarding Adult Review (SAR) Subgroup

The purpose of the SAR Subgroup is to consider referrals for any case which may meet the criteria for a SAR under Section 44 of the Care Act 2014[9]. The Subgroup makes decisions according to the statutory criteria, arranges and oversees all SARs, and ensures SAR recommendations are made, and messages disseminated to all SAB partners so that lessons are learned from these cases.

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

A SAB 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.

Achievements in 2024/25:
The SAB has published three SARs in 2024/25, and the SAR Subgroup has continued to discuss other cases, making clear decisions about referrals meeting the SAR criteria and progressing cases for review where relevant.

SAR referrals
Four SAR referrals were received for consideration during 2024/25. One of the referrals is in the process of being commissioned as a discretionary SAR. One referral was found not to meet the SAR criteria, and the remaining two referrals are still under consideration.

Most of the SAR referrals made to the SAR Subgroup in 2024/25 involved either suspected neglect/acts of omission or self-neglect. Suspected domestic abuse also featured in one referral. Three of the four SAR referrals involved adults who had died at a relatively young age (under 65), a trend that has been observed in previous

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

years. Ethnicity data continues to be collected on SAR referrals; two referrals were for people from Eastern European backgrounds, one related to a person from a Black Caribbean background and one related to a person from a Northern European background. The SAR Subgroup will continue to monitor trends through the collection of information about each person's protected characteristics within the SAR referral form and will ensure that these are considered in any SARs undertaken.

Safeguarding Adults Reviews (SARs)
During 2024/25, the Victoria, Eleanor and Adult Safeguarding and Provider Concerns Thematic SARs were published on the Haringey website: https://www.haringey.gov.uk/adult-social-care/safeguarding-adults/haringey-safeguarding-adults-board/safeguarding-adults-reviews. 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 Victoria SAR to identify learning from the events leading to the death of Victoria, who sadly passed away, aged 38, from sepsis of unknown aetiology. Type 2 diabetes mellitus, cardiac failure, liver cirrhosis, obesity, right below knee amputation, and learning disability were recorded as contributing to Victoria's death but not related to the disease or condition causing it. The SAR recommended improvements, including:

- Reviewing the SAB's Self-Neglect and Hoarding Procedure to ensure that the level of risk an individual exposes themselves to is fully assessed in cases of self-neglect.
- Reviewing SAB policy, guidance and training content relating to mental capacity assessment.
- Ensuring feedback is given when safeguarding concerns are referred.
- Ensuring concerns raised about a care provider are shared with the relevant commissioning team.
- Considering the benefits of wider roll out of the London Urgent Care Plan to share information across the healthcare system.

The Eleanor SAR looked at learning arising from the events leading to the death of Eleanor, who sadly passed away, aged 74, from heart failure, heart disease and obesity. The SAR recommended improvements, including:

- Raising awareness of the Multi-Agency Solutions Panel (MASP).
- Improving understanding of how medical needs are considered in housing allocations.
- Reviewing arrangements for authorising urgent packages of social care.
- Seeking assurance from housing providers that safeguarding risks are considered in the context of housing repairs.

The Adult Safeguarding and Provider Concerns Thematic SAR identified learning from the events leading to the deaths of Rosemarie and Mearl, who were living at a local care home. Rosemarie sadly passed away, aged 53, of multi-organ failure and disseminated breast carcinoma. Mearl sadly died, aged 83, with cause of death

recorded as pneumonia alongside infected pressure sore, bed bound secondary to degenerative lumbar/cervical spine, and type two diabetes and hypertension. The SAR recommended improvements, including:

- Reviewing resource allocation for quality assurance of care providers.
- Mental health support for residents in care settings.
- Health/Local authority monitoring of pressure ulcer care.
- Care provider management of complaints.
- Audits of hospital discharge.
- Collaboration between agencies in preventing and responding to abuse/neglect.

SAR Implementation Subgroup

The SAR Implementation Group ensures that learning from Haringey SARs leads to change and improvement. ASC and the ICB are standing members of the group, with other agency representatives invited to the meeting depending on the action plans being reviewed. In 2024/25, the SAR Implementation Group oversaw progress against recommendations from SARs, including the Steve and Paulette SARs. The following improvements have been implemented:

- Review of the effectiveness of the MASP. This has led to better signposting to other multi-disciplinary forums and raised awareness of the MASP through promotion activities with various agencies including the SAB, voluntary and community sector, GPs and Housing. Information about the MASP has also been made available on the Council website.
- Improved interagency communication between Environmental Health, Housing and the MASP about concerns in private sector housing.
- Changes to the adult safeguarding referral process to ensure referrers receive appropriate feedback on safeguarding concerns.
- Improvements to Deprivation of Liberty processes and capacity, which has led to improved performance in the number and timeliness of assessments completed.
- An improved approach to quality assurance of local care provision, guided by the Quality Assurance and Contract Management Framework which was launched in November 2023. In addition, regular quality assurance meetings are now held between the local authority, NCL ICB and the Care Quality Commission (CQC) to share intelligence and any concerns.
- Work has begun with care providers in Haringey to review access to specialist wheelchair services and provision in care homes.
- Supervision audits in ASC have led to delivery of supervision training for managers. A support group that includes reflective group supervision has also been established in ASC.

Practice & Improvement Subgroup

The HSAB Practice & Improvement Subgroup (PIS) plays a pivotal role in enhancing safeguarding practices across Haringey. Its primary remit is to drive continuous improvement in adult safeguarding by:

- Overseeing and supporting the implementation of SARs in line with the Care Act.
- Collaborating with the SAR subgroup to identify areas for development and ensure lessons are embedded into practice.
- Facilitating cross-agency collaboration to identify concerns, share expertise, and promote best practice.
- Focusing on key thematic areas such as the MCA, mental health, and tissue viability nursing (TVN), especially where these arise from SARs.
- Establishing a working group to ensure streamlined action planning and delivery.

The subgroup meets at least quarterly. It reports quarterly to the HSAB and Chairs Executive, ensuring transparency and accountability.

The PIS has played a pivotal role in advancing safeguarding practice across Haringey over the past year. A key achievement has been the development of a stable and increasingly engaged membership, which has strengthened inter-agency collaboration and information sharing. This has enabled more coordinated responses to safeguarding concerns and improved the quality of care, particularly in areas such as tissue viability, where joint working between health services, the local authority, and voluntary and community sector (VCS) partners has led to tangible improvements in risk management.

The subgroup has taken a proactive and creative approach to embedding learning from SARs. A range of accessible and engaging formats have been used to disseminate learning, including:

- Interactive workshops
- 7-minute briefings
- Reflective supervision reviews
- “Lunch and Learn” sessions co-delivered with VCS partners

These initiatives have helped ensure that learning is not only shared but also meaningfully understood and applied by a wide range of professionals across the safeguarding system.

Despite these successes, the subgroup has faced challenges, particularly around sustaining long-term engagement from key stakeholders and the lack of dedicated funding for multi-agency safeguarding work. These were addressed through flexible use of existing networks and resources, ensuring that safeguarding training and engagement continued despite financial and logistical constraints.

Key Initiatives in 2024–25:

- Lunch and Learn Sessions: Informal, cross-sector learning opportunities focused on key themes from SARs, fostering shared understanding and trust.
- Supervision Audits: Conducted across adult social care, NHS partners, and VCS agencies to assess and improve how supervision supports safeguarding practice.

- Provider Engagement: Active involvement in forums related to SARs (e.g., Paulette and Steve), promoting collaborative learning and improved practice.
- Tissue Viability Training: Broader dissemination of training through health partners, ensuring best practice reaches a wider audience.

Learning from SARs
The subgroup has promoted the use of the MASP to support complex safeguarding cases, translating SAR learning into practical service improvements. Learning is embedded through:

- Regular electronic learning updates
- Community engagement with providers
- Monitoring and assurance via contract management and quality visits

Equality and Inclusion
All partner agencies deliver mandatory training aligned with the Equality Act 2010[10], ensuring staff understand and apply principles of equality, diversity, and human rights in their daily work. This is supported by supervision audits to monitor compliance and effectiveness.

Priorities for 2025–26
Looking ahead, the subgroup will align with HSAB's strategic direction and focus on:

- Clarifying roles and responsibilities across subgroups to reduce duplication
- Sustaining engagement in the face of workforce turnover
- Securing sustainable resources for multi-agency safeguarding roles
- Improving impact measurement, including better reporting and analysis of safeguarding outcomes
- Continuing to embed SAR learning and promoting a preventative, person-centred approach to safeguarding

Engagement & Prevention Subgroup

The Engagement and Prevention Subgroup (EPS) is a key working group reporting to the HSAB. Its primary purpose is to support the delivery of Priority 1: Prevention and Awareness from the HSAB Strategic Plan. The subgroup plays a central role in promoting safeguarding awareness, leading on prevention initiatives, and fostering meaningful engagement with the local community and stakeholders.

The subgroup is responsible for:

- Overseeing the Haringey Safeguarding Adults Prevention Strategy and coordinating multi-agency safeguarding training.
- Delivering safeguarding awareness campaigns and ensuring accessible communication about HSAB's work.
- Engaging with community groups, Healthwatch Haringey, and the voluntary sector to promote safeguarding.

[10] Equality Act 2010

- Collaborating across NCL London boroughs (Enfield, Barnet, Camden, and Islington) on shared safeguarding priorities.
- Using data to target engagement activities and monitor their impact.
- Developing a communications and engagement plan to raise awareness and encourage reporting of safeguarding concerns.
- Organising events for Safeguarding Adults Week and contributing to the HSAB Annual Report.

Key Achievements

Strengthened Multi-Agency Collaboration
The subgroup prioritised in-person attendance at meetings, which significantly improved communication and trust among partners. This approach fostered a more cohesive and responsive safeguarding network across health, social care, police, and the voluntary sector.

Borough-Wide Public Awareness Campaign

During Safeguarding Adults Week in November 2024, the subgroup led a successful campaign focused on financial abuse. Key elements included:

- A learning and information-sharing event for community organisations
- A targeted social media campaign
- Public advertising at GP surgeries and bus stops
- Distribution of safeguarding leaflets through voluntary sector partners

This campaign enhanced public understanding of safeguarding and supported the Board's prevention agenda by encouraging community vigilance.

Promoting a Culture of Learning and Reflection
The subgroup championed continuous professional development through:

- Regular safeguarding briefings and reflective supervision
- Mandatory and specialist training, including Missing Persons (MISPER) training in partnership with local police
- Monthly case discussions led by the Principal Social Worker (PSW)

Challenges and Responses

Managing Competing Priorities
Coordinating schedules among subgroup members was occasionally challenging due to operational pressures. However, the consistent engagement of core members ensured the subgroup remained productive and focused throughout the year.

Partnership in Practice
A multi-agency event during the financial abuse campaign showcased the roles of various organisations in supporting at-risk residents. This initiative strengthened inter-agency understanding, improved referral pathways, and highlighted best practices in safeguarding.

Learning from Reviews
The subgroup has actively embedded learning from SARs and Learning from Lives and Deaths Reviews (LeDeR) by:

- Promoting awareness of executive capacity
- Encouraging multi-agency professional meetings and the identification of lead workers to improve communication and risk management

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Priorities for 2025–26
Looking ahead, the subgroup will focus on:

- Addressing self-neglect and hoarding behaviours among residents
- Supporting a comprehensive programme of activities during Safeguarding Adults Week 2025
- Embedding learning from SARs and LeDeR reviews into communications with both staff and residents
- Promoting safeguarding as “everyone’s business” across all partner agencies

Quality Assurance Subgroup (QAS)

The HSAB QA subgroup is a key component of the HSAB, established to ensure that safeguarding arrangements across Haringey are effective, robust, and person-centred. Its overarching purpose is to support the HSAB in fulfilling its statutory duty to protect adults at risk by holding local agencies accountable for their safeguarding responsibilities.

The subgroup operates under the guidance of the HSAB’s Quality Assurance Framework (QAF), which provides the structure for monitoring, evaluating, and improving safeguarding practices. Through a coordinated annual work plan aligned with the Board’s strategic priorities, the QA subgroup delivers regular performance reports, audits, and thematic analyses to inform and influence safeguarding policy and practice.

The QA Subgroup has strengthened safeguarding oversight and market assurance across Haringey. Over the year it established new governance, embedded risk-based monitoring, escalated systemic risks to CQC, and supported providers to

improve care quality. Learning from SARs has been shared and embedded to drive system-wide improvement.

Achievements for the year

- Governance: Subgroup convened quarterly meeting and reviewed Terms of Reference.
- Frameworks: Rolled out the Quality Assurance & Contract Management Framework (QACMF) to place safeguarding at the core of contracts and escalation.
- Market oversight: Identified 91 services overdue CQC inspection (5–6 years); HSAB formally escalated to regional and national level. Arranging to discuss with the regional CQC leads to consider improvement of the inspection rates in Haringey.
- Joint reporting: Embedded Joint Provider Monitoring Report and Safeguarding Dashboard as routine scrutiny tools.
- Provider engagement: Forums and workshops strengthened partnership working; providers to participate in QA subgroup meetings.
- Learning: SAR Paulette recommendations implemented; Implementation Group established; 12-month audit scheduled.

Quality Assurance Activity has continued to monitor High-risk providers and deal with any suspension / closure of providers both in Haringey and out of placements. The HSAB QA subgroup jointly worked with North London ICB / LA to formulate action plan in focusing on training and monitoring of care quality for a large Nursing Care provisions in Haringey.

Embedding of Key Learning from SARs - The QA Subgroup has engaged with SAR and follows up recommendation of key reports to ensure the issues raised in the reports such as culture of effective challenge to poor care, the providers and care staff to work with families who often identified risks first, but their voices may have been undervalued. In addition, the QA subgroup has followed up the SAR recommendations on Workforce issues on quality of recruitment, training gaps, and weak culture.

Actions Taken

- Escalation: HSAB formally raised inspection backlog with CQC; local escalation protocol in development.
- Referral process: QA referral inbox introduced; promoted at locality team meetings.
- Family voice: Engagement strengthened through forums and monitoring that includes resident/family feedback.
- Workforce improvement: Providers required to implement and evidence action plans on recruitment, training, and supervision.
- Joint working: Regular CQC liaison re-established; joint monitoring reports reviewed at each QA meeting.

- Learning: SAR implementation overseen by dedicated group; 12-month audit planned.

Based on the above activity, the subgroup has identified the following priorities for 2025/26:

1. Finalise and embed the local escalation protocol.
2. Sustain monitoring of suspended/RI providers and verify improvement delivery.
3. Complete QA data-mapping to ensure robust reporting.
4. Advocate for CQC inspections of long-overdue services.
5. Deliver the SAR audit to test embedded learning.
6. Assess safeguarding impact of the cost-of-living crisis using resident survey data.

Conclusion:
The QA Subgroup has shifted from reactive oversight to a proactive, risk-based approach. Governance, escalation, and joint monitoring are stronger; provider engagement and SAR learning are improving culture and practice. Next year will focus on embedding escalation pathways, testing SAR learning through audit, and pressing for CQC inspections to address systemic gaps.

Joint Working Between the HSAB and the Haringey Children's Partnership (HSCP)

Introduction

The HSAB and the Haringey Children's Partnership (HSCP) work together to ensure that safeguarding is a continuous and coordinated effort across all stages of life. While each board has distinct responsibilities, our collaboration reflects a shared commitment to protecting vulnerable residents and supporting families holistically.

This joint working is formalised through biannual meetings, where both boards come together to address shared challenges, align strategies, and ensure that transitions between services are smooth and effective. The collaboration is particularly vital for young people moving from children's to adult services, and for families who require support from multiple agencies.

Why Joint Working Matters
Joint working between HSAB and HSCP ensures:

- Continuity of care for young people transitioning into adulthood.
- Whole-family support, recognising that safeguarding one individual often involves supporting their wider family.
- Shared learning from serious case reviews and safeguarding adult reviews.
- Integrated responses to complex issues such as exploitation, housing insecurity, and mental health.
- Efficient use of resources through coordinated planning and service delivery.

The Transitions Programme: A Joint Initiative

A major focus of joint work this year was the development and implementation of a borough-wide Transitions Programme. This initiative was launched to address longstanding concerns about the experiences of young people moving from children's to adult services, particularly those with special educational needs and disabilities (SEND), mental health needs, or care experience.

Many young people do not meet the strict eligibility criteria for adult services, even though they remain vulnerable. Transitional Safeguarding aims to bridge this gap by ensuring that support is not abruptly withdrawn at age 18, and that services work together to provide a smooth, coordinated journey into adulthood.

Why It Matters in Haringey

In Haringey, the need for a robust Transitional Safeguarding approach has been highlighted by both local experience and national inspections. Ofsted[11] previously identified inconsistent planning and late assessments as key concerns. In response, the borough has taken significant steps to improve how young people are supported during this crucial life stage.

Strategic Improvements

- A new team was established, including social workers and a team manager, with plans to expand to include mental health professionals and key workers.
- A Disability Register is being developed to identify children from age 5 with additional needs, enabling earlier planning.
- Transition planning is being embedded into EHC Plans from Year 9.
- A transitions page will be added to the SEND Local Offer website, alongside a short video to explain the process to families.
- Co-production with parents and carers is central to the programme, with parent representatives contributing to planning and delivery.
- Care Act Assessments: The programme aims to complete assessments this year, ensuring that eligible young people receive the support they need under adult social care.

Looking Ahead: Priorities for 2025–26

- Expanding the multidisciplinary team to include mental health and employability specialists.
- Increasing the number of Care Act assessments and support plans.
- Strengthening early identification of young people who may not meet statutory thresholds.
- Embedding safeguarding risk assessments into all transition planning.
- Publishing a clear, accessible transitions pathway for families and professionals.
- Continuing to co-produce services with young people and their families.

[11] Ofsted - GOV.UK

Think Family: A Whole-Family Approach to Safeguarding and Support

Think Family is a borough-wide approach that recognises the interconnected needs of children, adults, and families. It ensures that services do not work in isolation but instead consider the whole family when assessing needs, planning support, and delivering interventions.

Why Think Family Matters in Haringey

Haringey is a diverse borough with a wide range of social, economic, and health challenges. Many families face multiple and overlapping issues, such as:

- Poverty and housing insecurity
- Domestic abuse
- Mental health difficulties
- Substance misuse
- Learning disabilities or special educational needs

In such cases, a siloed approach where services only focus on one individual or issue can lead to missed opportunities for early intervention and increased risk of harm. Think Family helps to break down these silos and ensures that families receive joined-up, compassionate, and effective support.

The COVID-19 pandemic further highlighted the importance of this approach, as families experienced increased stress, isolation, and service disruption. Think Family provides a framework for recovery and resilience.

Progress in 2024–25

During the year, the Joint Board received updates on how Think Family is being embedded across services in Haringey. Key developments included:

- **Early Help Strategy Refresh (2024–2027)**
  - The new strategy places Think Family at the heart of Early Help services.
  - Family Support and Youth Justice teams are working together to deliver whole-family plans.
  - A new “Early Help Journey” has been developed to map how families access and move through support.
- **Workforce Development**
  - Training on Think Family principles is now available to all social care teams.
  - Parenting programmes have been redesigned to reflect whole-family needs.
  - The Family Hubs programme has strengthened partnerships and improved access to support.
- **Partnership Integration**
  - Stronger links have been built between Children’s Services, ASC, SEND, and Health.
  - Substance misuse services have embedded Think Family into their practice.

- Health partners have aligned their work with the Supporting Families Programme.

Next Steps for 2025–26
The following priorities have been identified to strengthen the Think Family approach:

- Refresh the Think Family Protocol and ensure it reflects the voices of families and frontline practitioners.
- Audit current practice to identify strengths, gaps, and opportunities for improvement.
- Develop a model of best practice that can be shared regionally.
- Ensure all agencies report on how they are embedding Think Family in their work.
- Continue to build workforce capacity through training, supervision, and shared learning.

Learning from Reviews: The Case of Adult H

The board reviewed the case of a care leaver who died in another borough in 2021. This case highlighted critical issues around transition planning, mental health support, and safeguarding for vulnerable young adults.

Although the death occurred outside the borough, Adult H's journey began in Haringey. This case is a powerful reminder that safeguarding responsibilities do not end at borough boundaries. It also highlights the importance of:

- **Continuity of care** for care leavers placed out of borough
- **Robust transition planning** from children's to adult services
- **Effective multi-agency working**, especially for young people with complex needs
- **Learning from others** to improve local practice and prevent future tragedies

The case of Adult H is not unique. Many local authorities face similar challenges in supporting care leavers and young adults with overlapping vulnerabilities. By engaging with the findings of this SAR, Haringey demonstrates its commitment to continuous learning and improvement, even when the learning originates elsewhere.

Key Learning Points for Haringey

- Transitions Must Be Planned Early and Holistically
- Care Leavers Need Stable, Supported Housing
- Mental Health and Neurodiversity Require Integrated Responses
- Exploitation Risks Must Be Recognised in Adults
- Cross-Borough Collaboration is Essential

What the Board is Doing in Response

- Track progress and ensure that learning is embedded across services.
- Discussions are underway to expand trauma-informed training across the workforce, recognising the long-term impact of adverse childhood experiences.

- The Board is reviewing how care leavers placed outside Haringey are monitored and supported.
- The case will be used as a learning tool in upcoming workshops and training sessions.

The case of Adult H is a sobering reminder of the consequences when systems fail to work together. It reinforces the importance of transitional safeguarding, whole-family approaches, and cross-borough collaboration. By learning from this case, Haringey is taking proactive steps to strengthen its safeguarding arrangements and ensure that vulnerable young people receive the care, protection, and dignity they deserve.

Housing and Safeguarding

In Haringey, housing-related issues are increasingly recognised as central to safeguarding both adults and children. Poor housing conditions, homelessness, overcrowding, and insecure tenancies can all increase the risk of harm, exploitation, and neglect. For vulnerable residents such as care leavers, people with disabilities, survivors of domestic abuse, and families living in poverty, housing is often the tipping point between resilience and crisis. That's why the HSAB and the HSCP have made housing a key area of joint focus.

Progress in 2024–25

1. New Housing Policies to Support Safeguarding
   - Vulnerable Tenants Policy: Designed to identify and support tenants at risk of harm, including those with safeguarding concerns.
   - Safeguarding Adults and Children's Policy: Embeds safeguarding responsibilities across housing services and registered providers.
   - Housing Allocations Policy: Approved for public consultation, with a focus on prioritising families with safeguarding needs.
2. Tackling Damp, Mould, and Unsafe Conditions
   - Joint work is underway with registered housing providers to address damp and mould, particularly in homes where children or vulnerable adults are present.
   - Cases involving SEND families are being prioritised, especially where poor housing is impacting health or education.
3. Responding to Exploitation and Criminal Risk
   - Housing teams are working with the Multi-Agency Child Exploitation (MACE) panel to identify social housing tenants at risk of being groomed or exploited by gangs.
   - This includes young people in temporary accommodation or those living independently without adequate support.
4. Fire Safety and Overcrowding
   - Collaboration with the London Fire Brigade (LFB) has been strengthened to support overcrowded households.
   - Fire safety checks are being targeted at homes with vulnerable residents, including those with mobility issues or complex needs.

Learning from Reviews and Casework
Housing issues have featured prominently in recent SARs and Child Safety Practice Reviews (CSPRs). These cases have highlighted:

- Delays in securing appropriate accommodation for care leavers and vulnerable adults.
- The impact of unsuitable housing on mental health and wellbeing.
- The need for better legal literacy among housing professionals regarding safeguarding duties.

The Joint Board has committed to using these lessons to inform future policy and practice.

Next Steps for 2025–26
The following priorities have been identified to strengthen the link between housing and safeguarding:

- Embed safeguarding training across all housing teams and registered providers.
- Monitor the impact of new housing policies on safeguarding outcomes.
- Improve data sharing between housing, social care, and health to identify risks earlier.
- Develop joint protocols for responding to housing-related safeguarding concerns.
- Ensure care leavers and vulnerable adults have access to safe, stable, and supported accommodation.
- Address systemic issues such as overcrowding, temporary accommodation, and out-of-borough placements.

By embedding safeguarding into housing policy, practice, and partnerships, Haringey is taking a proactive approach to building safer, healthier communities for all.

Corporate Parenting and Care Leavers: A Shared Responsibility Across Haringey

Care leavers often face significant challenges as they transition into adulthood. As a corporate parent, the Council must act with the same care, commitment, and ambition as any good parent would. This means ensuring that care leavers have access to safe housing, meaningful opportunities, and trusted relationships.

During the year, the Joint Board received an update on the development of Haringey's **Corporate Parenting Strategy**, which was co-produced with care-experienced young people. This group has played a vital role in shaping the Council's understanding of what good corporate parenting looks like.

Key Developments:

1. **Whole-Council Engagement**
    - The strategy calls for every department and partner agency to understand and act on their corporate parenting responsibilities.
    - This includes areas such as housing, leisure, digital access, and health.

2. **The "Postcard Promise" Initiative**
    - Agencies are being invited to create a "Postcard Promise" that outlines their commitment to care leavers.
    - This initiative encourages reflection on what corporate parenting means in practice and how each service can contribute.
3. **Housing and Accommodation**
    - Concerns raised by care leavers about homelessness and unsuitable placements are being addressed through a dedicated Housing Subgroup.
    - An action plan is being developed to improve housing pathways and ensure that care leavers are not placed in unsafe or unsupported accommodation.
4. **Participation and Voice**
    - Care leavers are being supported to speak directly to services and decision-makers.
    - Participation workers are helping to build bridges between young people and the Council, ensuring their voices shape policy and practice.

Next Steps for 2025–26
The Joint Board has identified the following priorities to strengthen corporate parenting in Haringey:

1. Launch the Postcard Promise across all agencies and monitor its impact.
2. Improve housing pathways for care leavers, with a focus on safety, stability, and choice.
3. Ensure access to leisure, digital tools, and community resources as part of a holistic support offer.
4. Embed corporate parenting training across the workforce, including in adult services and housing.
5. Continue to co-produce services with care-experienced young people and ensure their voices are central to decision-making.

In Haringey, the Joint Board is committed to ensuring that care leavers are not only safeguarded but also empowered to lead fulfilling, independent lives. By working together across services, we can ensure that no young person is left behind.

Right Care, Right Person (RCRP): A New Approach to Emergency Response

The Right Care, Right Person (RCRP) initiative is a significant change in how emergency services respond to individuals experiencing mental health crises or other health-related concerns. Introduced by the MPS in November 2023, the RCRP model aims to ensure that people in distress receive the most appropriate care from the right professionals, whether that be health, social care, or emergency services.

Why This Matters
Historically, Police officers have often been the first responders to incidents involving individuals in mental health crisis, even when no crime has been committed. While

police play a vital role in public safety, they are not always best placed to provide the specialist care and support that vulnerable individuals need. The RCRP model seeks to change this by:

- Reducing unnecessary police involvement in health-related incidents.
- Ensuring that health and social care professionals lead on cases where their expertise is more appropriate.
- Freeing up police resources to focus on crime prevention and public safety.

Impact in Haringey
Since the launch of RCRP, the number of police deployments to health-related calls in Haringey has decreased significantly, from 41% to 29% compared to the same period the previous year. This 12% reduction reflects a shift in how services are working together to respond more effectively to people in need.

The data shared with the Joint Board showed a breakdown of incidents by type and location, helping partners understand where further improvements can be made. The reduction in police involvement has allowed officers to respond to a wider range of calls, while also prompting a broader conversation about how health and social care services can step in more proactively.

Safeguarding Considerations
The Joint Board recognised that while RCRP is a positive step, it also raises important safeguarding questions:

- How are children and vulnerable adults affected by the change in response?
- Are there sufficient health and social care resources in place to meet the increased demand?
- How can services ensure that no one falls through the cracks during a crisis?

To address these concerns, the Board agreed to:

- Monitor the impact of RCRP on children and families.
- Include updates from health and social care services in future meetings.
- Explore opportunities to triangulate data across agencies to identify trends and gaps.

CQC Inspection outcomes (2024)

CQC Inspection Outcomes
The recent CQC inspection has rated our safeguarding practice with a score of **3**, indicating a **good standard** overall. The inspection highlighted several key strengths across safeguarding systems, local risk response, and personalised safeguarding approaches, while also identifying areas for improvement.

Key Strengths

Safeguarding Systems and Processes
The service benefits from a well-structured central safeguarding team that triages referrals within defined timeframes, screening within 24 hours and allocation within

48 hours. The median processing time for safeguarding concerns stands at 13 days. A person-centred approach is consistently evident, even in cases where formal processes are not fully followed. Strong multi-agency collaboration is in place, particularly with the HSAB and local Police. Internal audits have driven operational improvements, including enhanced documentation consistency and more proactive planning.

Responding to Local Risks
The service demonstrates a proactive approach to local safeguarding risks, with a particular focus on homelessness and transitional safeguarding for young people. SAB subgroups are actively engaged in prevention, community engagement, and risk reduction initiatives. Learning from SARs has led to tangible improvements, such as updates to the Mental Capacity Practitioner Manual.

Section 42 Enquiries
CQC inspection highlighted a clear guidance, and frameworks support the handling of Section 42 enquiries, with a median processing time of 21 days. Notably, 71% of referrers were informed of the outcomes, which is considered good practice. However, feedback suggests that communication in this area could be further strengthened.

Making Safeguarding Personal (MSP)
Staff consistently engage with individuals to understand their desired outcomes, and continuity of care is supported by allocating enquiries to familiar staff members. There is strong evidence of staff understanding personalised safeguarding principles and relevant legislation, including the Mental Capacity Act (MCA) and the Equality Act.

Areas for Improvement

Communication
Feedback from voluntary, community, and social enterprise (VCSE) partners and care providers indicates inconsistencies in receiving updates on safeguarding referrals and outcomes. This highlights a need for improved communication protocols.

Advocacy Access
Access to statutory advocacy remains a challenge, with waiting times of up to six weeks. Only 14.29% of individuals lacking capacity were supported by an advocate, family member, or friend, significantly below the national average of 83.38%. This gap suggests a need for urgent review and improvement in advocacy provision.

Provider Learning
There is inconsistency in how learning from safeguarding investigations is shared with care providers. Strengthening this feedback loop would enhance provider practice and service user outcomes.

Data and Recording
Some performance issues may be linked to recording errors, which could be affecting the accuracy of key statistics, particularly in relation to advocacy support.

Performance Metrics
While 95% of individuals felt their safeguarding outcomes were met or partially met, other performance indicators fell below national averages. Specifically, 68.12% of service users reported feeling safe (compared to the national average of 71.06%), 81.16% felt services made them feel safe (national average: 87.82%), and 78.35% of carers felt safe (national average: 80.93%). These figures indicate areas where further improvement is needed to align with national benchmarks.

HSAB Performance Data

Safeguarding adults is a critical responsibility, and collecting accurate data is essential to evaluating the effectiveness of protection measures. This information enables the HSAB to set strategic priorities and respond to emerging risks. Both local and national safeguarding data are monitored, encompassing all reported concerns and formal inquiries. The council tracks each case from initial referral through to resolution, analysing key factors such as the nature of harm, demographic details, and outcomes.

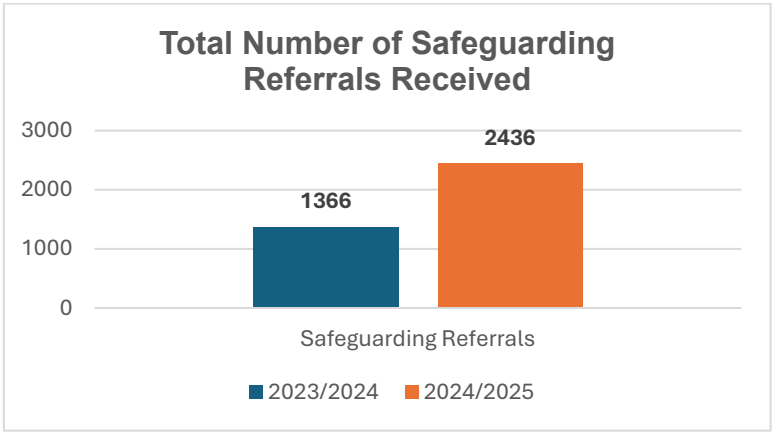
The QA subgroup plays a vital role in reviewing this data, identifying trends, and reporting significant findings to the HSAB to inform decision-making and service improvements.

Under the Care Act 2014, local authorities have a legal duty to safeguard adults at risk. This includes conducting Section 42 inquiries when specific criteria are met. The following sections summarise safeguarding activity recorded during 2023/24, including both reported concerns and formal inquiries. This part of the report presents a detailed analysis of safeguarding performance data in Haringey Adult Social Care. The data spans two financial years 2023/24 and 2024/25 and is reviewed quarterly by the QA subgroup and the HSAB.

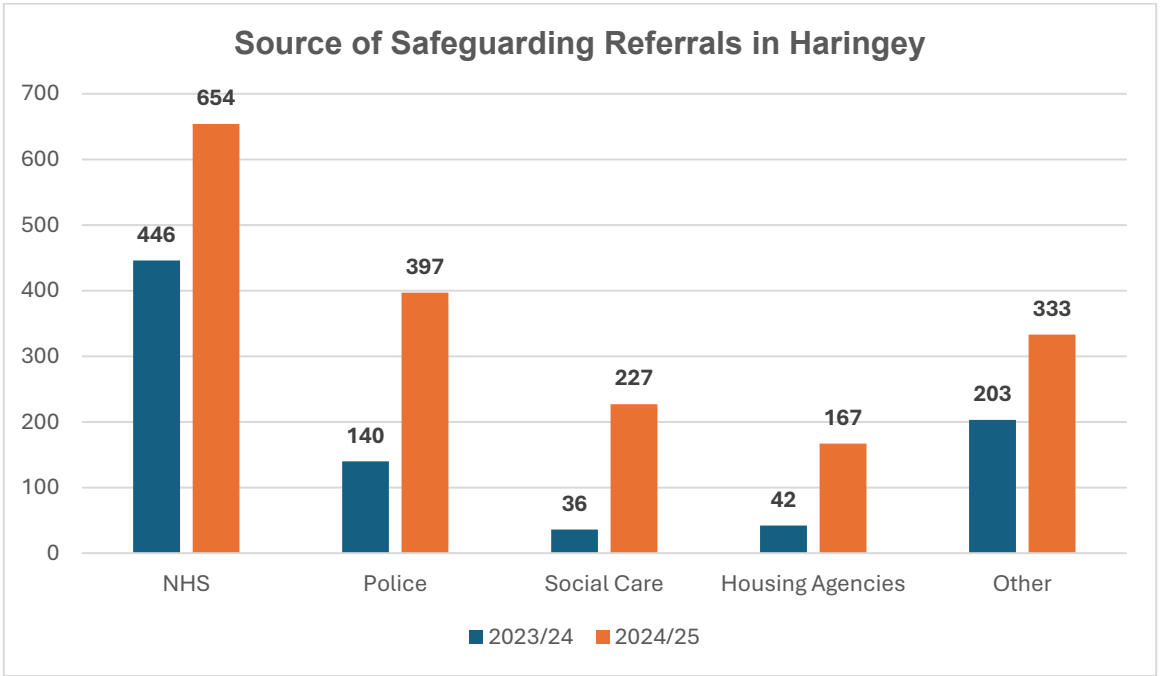
Understanding Safeguarding Concerns
A safeguarding concern arises when someone reports suspected abuse or neglect involving an adult who requires care and support. If the concern meets certain thresholds and is investigated further, it progresses to a formal safeguarding inquiry.

Other Safeguarding Concerns
Many referrals do not meet the threshold for a Section 42 inquiry but are still significant. These are classified as 'Other' safeguarding concerns. Although not statutory, these cases are managed carefully to ensure appropriate responses, such as preventative actions, referrals to support services, or community-based interventions. This proactive approach ensures that safeguarding responsibilities are upheld even when formal inquiries are not required.

These are non-statutory enquiries initiated by the local authority when it is deemed necessary and proportionate to investigate a concern. While they fall outside the scope of Section 42, they are aligned with the broader safeguarding principles of the Care Act, particularly the duty to promote well-being. Examples include cases involving carers or individuals who do not meet the statutory criteria but still face risks. The growing number of these inquiries reflects the council's commitment to safeguarding all residents, extending protection beyond legal mandates.



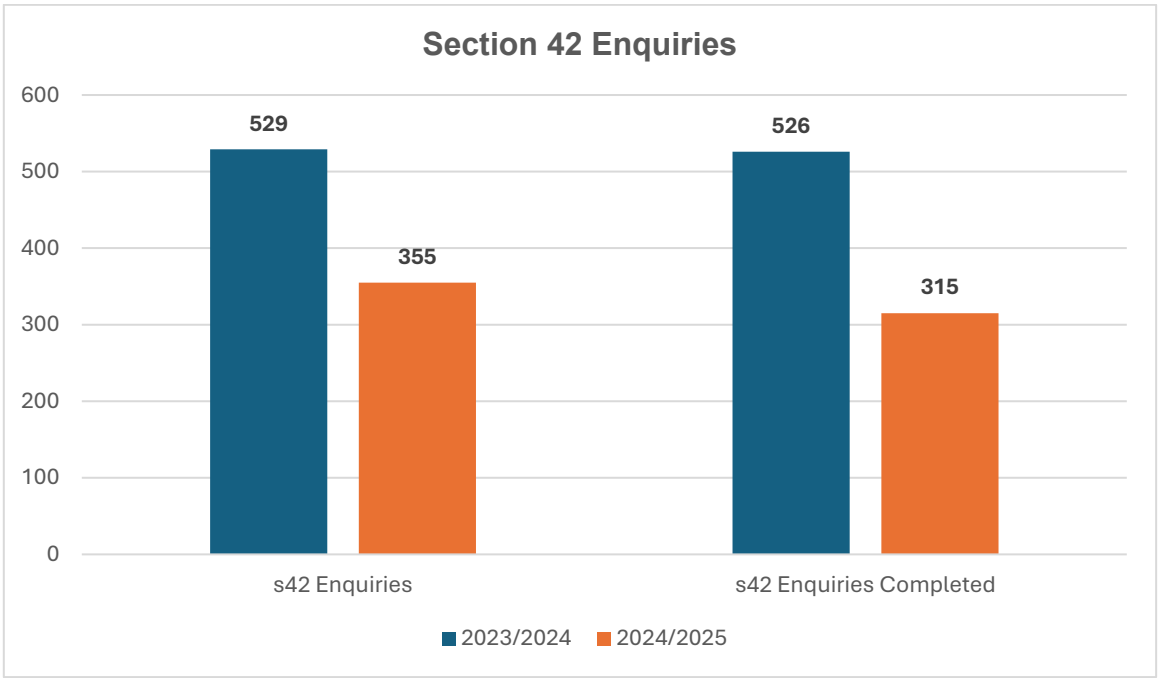
The number of safeguarding referrals increased from **1,366 in 2023/2024** to **2,436 in 2024/2025**, representing a **78% increase**. This rise reflects improved reporting mechanisms, heightened awareness, and increased safeguarding concerns within the community.



In adult safeguarding, the source of referral refers to the individual, agency, or organisation that raises a safeguarding concern to Haringey. These referrals are a critical first step in identifying adults who may be at risk of abuse or neglect and ensuring they receive timely support and protection.

Understanding the source of referrals helps us identify where awareness is strong, where training may be needed, and how well different sectors are engaging with safeguarding responsibilities. It also provides insight into how accessible and responsive our safeguarding system is to the needs of the community.

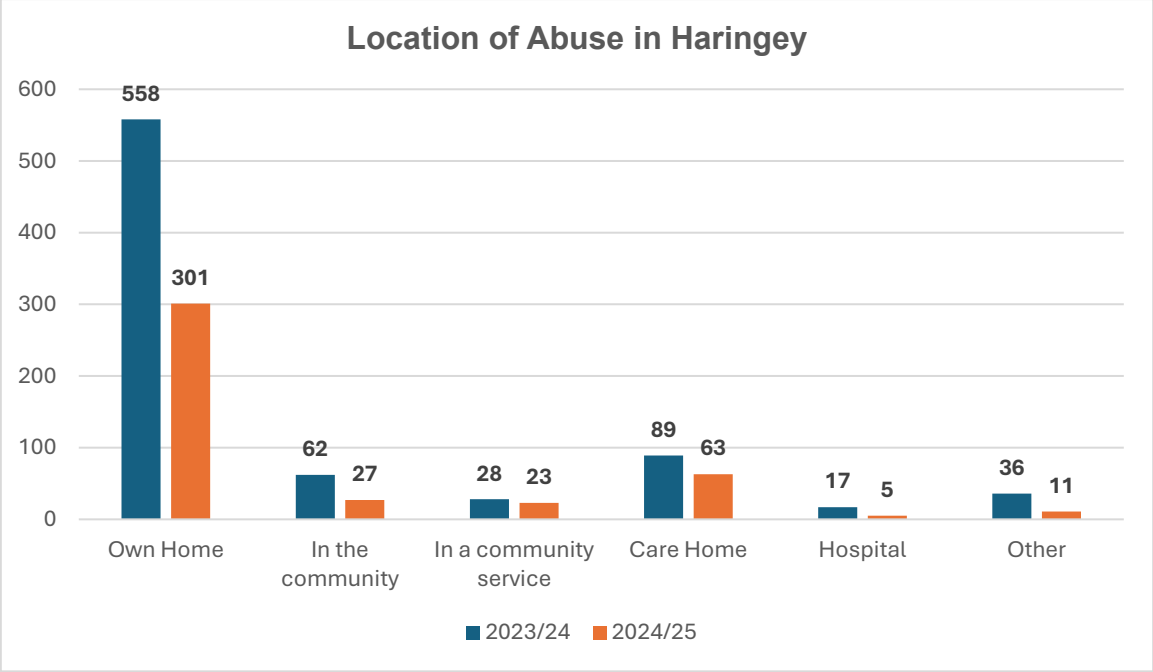
The data shows a significant increase in safeguarding referrals across all sources between 2023/24 and 2024/25. Notably, referrals from Social Care and Housing Agencies. Police saw a sharp rise, while NHS referrals increased by 47%. These trends reflect improved multi-agency collaboration, heightened awareness, and improved reporting.



What is a Section 42 (s42) Enquiry?
A Section 42 enquiry is a statutory duty under the Care Act 2014, which requires local authorities to undertake enquiries when they have reasonable cause to suspect that an adult has needs for care and support (regardless of whether those needs are being met), is experiencing or at risk of abuse or neglect, and, as a result of those needs, is unable to protect themselves from the abuse or neglect or the risk of it.

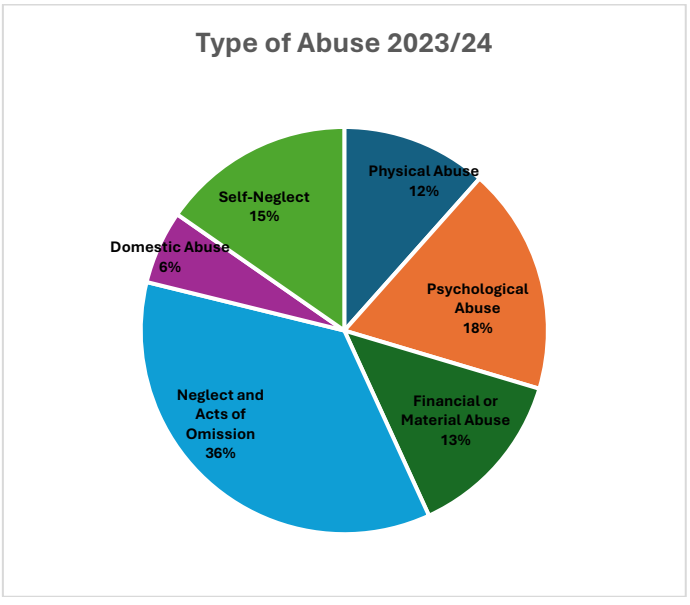
If all three criteria are met, Haringey Adults Services must initiate a s42 enquiry to determine what action is needed to support and protect the individual.

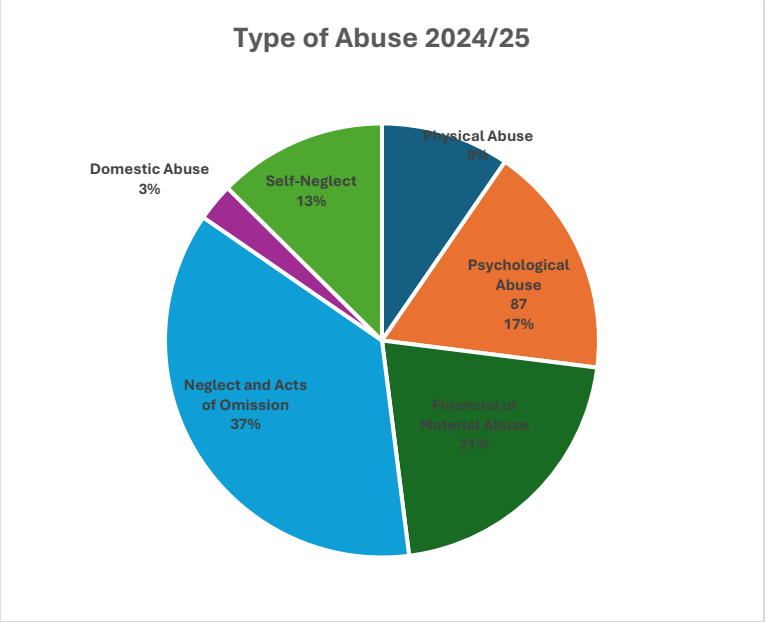
The number of Section 42 safeguarding enquiries has decreased in 2024/25 compared to the previous year. Both the enquiries started and completed show a downward trend, which reflect changes in operational processes, or the nature of safeguarding concerns being addressed.



Understanding where abuse occurs is essential to shaping effective safeguarding strategies. The location of abuse provides critical context for identifying risk environments, targeting preventative measures, and allocating resources. Abuse can take place in a variety of settings, including private homes, care facilities, hospitals, and community spaces. Each setting presents unique challenges and requires tailored safeguarding responses.

The data shows a general decline in safeguarding concerns across most locations in 2024/25 compared to the previous year. Fewer cases were recorded in settings such as own homes, community environments, hospitals, and nursing care homes. However, there was a slight increase in concerns reported in residential care homes (grouped under Care Home). These trends reflect changes in service delivery, reporting practices, or the nature of risks being identified.





The Type of Abuse categorises the different forms of abuse identified in safeguarding cases. These include physical, emotional, financial, neglect, and other types of abuse. This classification helps in understanding the nature and prevalence of abuse affecting vulnerable individuals in the borough and supports targeted interventions.

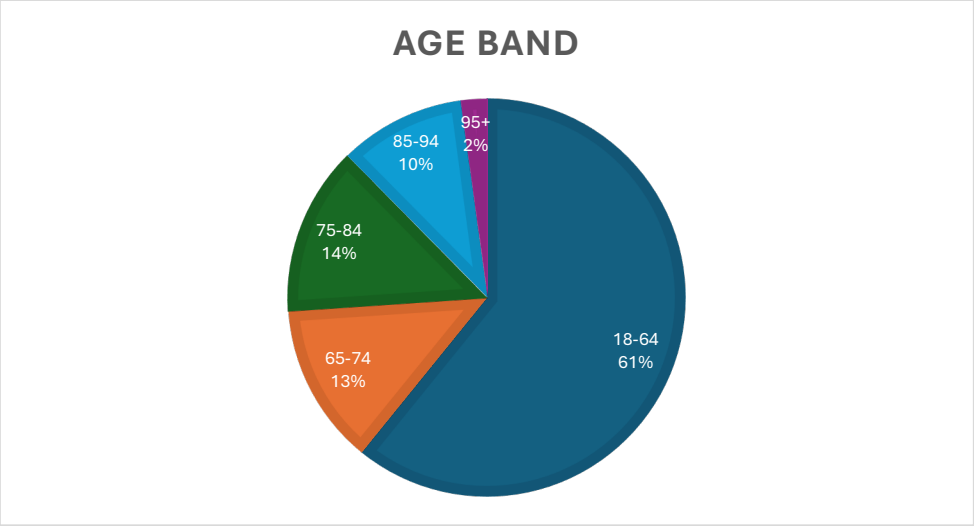
The number of safeguarding concerns investigated across all types of abuse has decreased in 2024/25 compared to the previous year. Notably, cases of physical, psychological, and neglect-related abuse have seen a marked reduction. While financial or material abuse remains relatively consistent, other categories such as domestic abuse and self-neglect have also declined. This trend may reflect changes in reporting patterns, service access, or broader shifts in safeguarding activity.

Making Safeguarding Personal (MSP) Outcomes

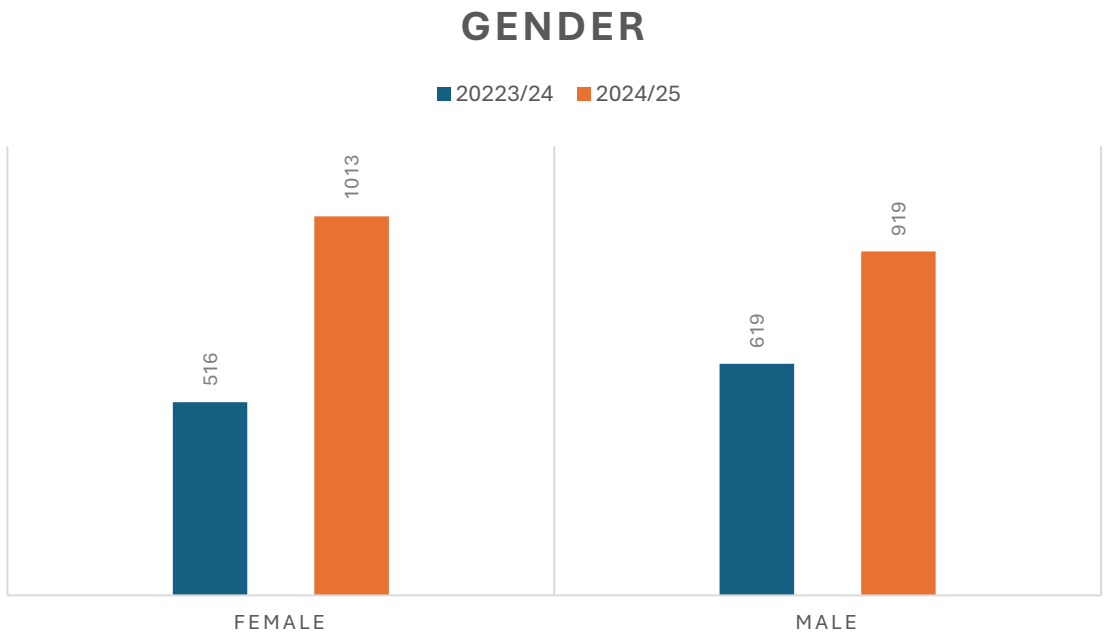
Outcome Type	2024/25
Fully Achieved	257
Partially Achieved	66

Making Safeguarding Personal (MSP) is a national approach embedded in the **Care Act 2014**, which places the individual at the centre of safeguarding practice. In Haringey, MSP is a core principle guiding adult safeguarding work, ensuring that interventions are not only protective but also empowering. The focus is on understanding what outcomes the adult at risk wants to achieve and working collaboratively to support those outcomes. Haringey Adult Social Care, through the HSAB partnership, promotes MSP by encouraging person-led decision-making, improving communication, and tailoring safeguarding responses to individual needs and circumstances

In **2023/24**, Haringey Council achieved a **fully achieved outcome** in **82%** of its Section 42 safeguarding enquiries, demonstrating strong alignment with the principles of MSP. In contrast, **2024/25** saw a decrease to **72%**, indicating a slight drop in the proportion of cases where individuals' desired outcomes were fully met. This shift may reflect increasing complexity in safeguarding cases or evolving challenges in achieving person-centred outcomes.



Understanding the age distribution of adults involved in safeguarding concerns is crucial for tailoring services and interventions. The MSP framework emphasises person-centred safeguarding, and age is a key factor in shaping how risks are experienced and addressed. By analysing age trends, local authorities like Haringey can better allocate resources and design age-appropriate safeguarding responses.



Understanding the gender of individuals involved in safeguarding concerns is essential for ensuring that services are inclusive, accessible, and culturally appropriate. These demographic insights help us tailor their safeguarding responses.

While safeguarding concerns and s42 enquiries have increased overall, the rise in female cases is proportionately higher. This may reflect demographic factors (e.g., more older women), increased identification of abuse types that disproportionately affect women, and improved reporting mechanisms. Further analysis by abuse type and referral source will help confirm these trends.

Conclusion

The 2024/25 data reveals both progress and emerging challenges in safeguarding adults in Haringey. While referral numbers have significantly increased, and multi-agency collaboration have improved, concerns remain around the timeliness of Section 42 enquiries, the rise in discriminatory abuse, and the increase in repeat referrals. These trends underscore the importance of continuous quality assurance and targeted interventions.

The significant increase in referrals received is a combination of greater awareness among partner agencies and the team receiving a high number of referrals that do not meet the safeguarding criteria but are recorded as initial referrals for triage

To manage demand the current practice is to triage all cases, adopting a two-stage process; and as necessary to ensure immediate protective measures are put in place to safeguard vulnerable adults and record this in the client record case notes, with S42 enquiry forms updated on the client database subsequently. The current adopted two-stage process is as follows.

The **first stage 42 (1)** includes determining if an adult meets the safeguarding criteria; and gathering further information to decide of whether the next stage 42 (2) is warranted which is a comprehensive multiagency safeguarding enquiry.

During **section 42 (1)** it can be determined that a single agency approach is required as a protective measure for example:

- Information, advise and signposting
- Referrals to third sectors organisations
- Referral to Locality Front Doors or Assessment Team (for longer term pieces of work e.g. hoarding and self-neglect which requires social care practitioners to develop relationships with the adults concerned; and multi-professional input coordinated by a social care practitioner),
- Request specific activity for Single Provider / Organisation to resolve the issue(s) causing risk to the vulnerable adult and provide feedback.

Section 42 (stage 2) requires more comprehensive intervention and planning / strategy meetings and discussions, chaired by the Safeguarding Adult Manager (SAM) with a wider range of stakeholders.

These are the cases with several layers of complexity that are allocated and section 42 forms fully completed on the client record system for example:

- Mental Health as well as physical health issues
- Challenging behaviour
- Substance abuse – drug and alcohol
- Homelessness and housing issues
- Chaotic lifestyle
- Domestic abuse
- Financial exploitation
- Modern slavery
- Acts of a criminal nature – emotional abuse, coercive control, sexual abuse, physical abuse.

The Board recognises that Higher referral numbers demonstrate stronger awareness and vigilance across agencies. The Board also acknowledge that staff are working on higher number of safeguarding concerns which include screening emails, gathering further information to determine if the safeguarding criteria has been met or not, providing information, advice and signposting as appropriate, following up S42 (1), and conducting section 42 (2) enquiries. Despite the increase in referrals, the progressing to Section 42 enquiries has fallen in absolute numbers. Reasons given include Thresholds not being met – many referrals involved risk/vulnerability but did not strictly meet Care Act s.42 criteria. Alternative safeguarding responses through multi-agency support, housing, or community services; Preventative interventions (case conferences, health input, voluntary sector support) addressing issues before escalation; Repeat referrals that, while concerning, did not meet the statutory test for inquiry. More consistent use of the “other concern” category, in line with national practice.

The Haringey Safeguarding Adults Service in the coming year will:

1. Develop targeted strategies for individuals with multiple referrals.
2. Allocate resources to ensure Section 42 enquiries are completed and closed promptly.
3. Enhance Community Engagement: Particularly with younger adults and underrepresented groups.
4. Promote equity and cultural competence through targeted engagement with diverse communities.
5. Monitor performance through quarterly dashboards and benchmarking against national and local comparators.
6. Review safeguarding functions and performance in Haringey Adult Social Care.

HSAB Partner Statements

Each year, the HSAB invites its partner agencies to contribute a statement to the Annual Report. These statements are a vital part of our collective commitment to transparency, accountability, and continuous improvement in safeguarding adults across the borough.

The agencies that make up the HSAB represent a wide range of statutory, voluntary, and independent sector organisations. Each plays a crucial role in preventing harm, identifying risk, and responding effectively to concerns of abuse or neglect. Their contributions to this report highlight the breadth and depth of safeguarding activity taking place across Haringey.

This year, we are pleased to have received partner contributions from:

- **Violence Against Women & Girls (VAWG)**
- **London Fire Brigade**
- **Haringey Metropolitan Police**
- **North Central London Integrated Care Board**
- **North London Mental Health Partnership (Barnet, Enfield and Haringey Mental Health NHS Trust)**
- **Royal Free London NHS Foundation Trust**
- **Whittington Health NHS Trust**

In their partner statements, agencies reflect on their key achievements over the past year, sharing examples of good practice, innovation, and collaborative working. These reflections not only demonstrate the progress made in strengthening safeguarding arrangements but also provide valuable insights into the challenges faced and lessons learned.

Looking ahead, each partner outlines their priorities and plans for the coming year. These forward-looking commitments help ensure that safeguarding remains a dynamic and evolving area of practice responsive to emerging risks, changing needs, and the voices of those with lived experience.

Together, these statements reinforce the shared vision of the HSAB: to ensure that adults at risk in Haringey are supported to live safe, empowered, and independent lives, free from abuse and neglect.

Haringey's Violence Against Women and Girls (VAWG)

Haringey's commitment to tackling Violence Against Women and Girls (VAWG) is underpinned by its comprehensive **10-year VAWG Strategy (2016–2026)**, which sets out a borough-wide vision to end gender-based violence and ensure every woman and girl can live free from abuse and reach their full potential.

The strategy is built around **four key priorities**:

1. **Developing a Coordinated Community Response** – ensuring all agencies and community partners work together to prevent and respond to VAWG.
2. **Prevention** – embedding early intervention and education to stop violence before it starts.
3. **Support for Victim/Survivors** – providing tailored, survivor-led services that meet the diverse needs of those affected.
4. **Holding Perpetrators Accountable** – ensuring those who cause harm are challenged and supported to change their behaviour.

Haringey's approach is rooted in the understanding that VAWG is both a **violation of human rights** and a **manifestation of gender inequality**. The strategy recognises the disproportionate impact of abuse on women and girls, while also acknowledging that men and boys can be victims too. It promotes a **whole-community response**, where residents, services, and local organisations share responsibility for creating a borough where abuse is not tolerated and support is accessible.

Key Achievements

- **Domestic Abuse Policy for Residents**:
    - A comprehensive, zero-tolerance policy was introduced to support all residents affected by domestic abuse, including those in temporary accommodation or experiencing homelessness.
    - The policy was co-produced with tenants and leaseholders, ensuring lived experience shaped the response.
    - It mandates regular training for all housing staff and contractors, embedding safeguarding into frontline housing practice.
    - This aligns with the Social Housing Regulator's consumer standards and strengthens the safeguarding framework for vulnerable adults.

- **Domestic Abuse Policy for Staff**:
    - Introduced a modernised approach to DA, including a discussion checklist, safety planning tools, and guidance on welfare loans.
    - Promoted across council buildings and supported by joining the Employers' Initiative for Domestic Abuse.
    - This internal safeguarding measure ensures staff experiencing abuse are supported and protected.

- **Training Initiatives**:
    - Delivered targeted training on DA in the LGBT+ and Deaf communities, addressing intersectional safeguarding needs.
    - North London Rape Crisis provided training on sexual violence, including child sexual exploitation and trafficking.
    - A new training programme focused on coercive control, DASH risk assessment, and reflective practice for social workers.
    - A pioneering training on **DA and Suicide** was launched, recognising that 50% of suicide attempts are linked to DA, critical for adult safeguarding.
    - A borough-wide DA awareness module for all LBH staff is being rolled out, supporting policy implementation and DAHA accreditation.

- **Multi-Agency Practice Week (MAPW)**:
  - The March 2025 theme was Domestic Abuse, with “Lite Bite” sessions delivered to multi-agency staff.
  - VAWG team led sessions on recognising abuse and making appropriate referrals, reinforcing safeguarding pathways.

- **UEFA Men’s Football Tournament Campaign**:
  - Haringey led a London-first campaign using beermats in pubs and cafes to challenge gender-based violence and promote help-seeking among men.
  - Over 3,000 materials were distributed, raising awareness in informal community settings.

- **Walk for Women**:
  - A flagship event during the UN’s 16 Days of Activism, showcasing partnership efforts to tackle VAWG.
  - Included speakers from key safeguarding partners and was featured on BBC Radio London.

- **International Women’s Day**:
  - Delivered a borough-wide presentation on recognising and responding to VAWG, including referral pathways.

- **Relaunch of the VAWG Operational Forum**:
  - Now meets quarterly with expanded membership and a focus on solution-oriented discussions.
  - Strengthens multi-agency safeguarding coordination.

- **Collaboration with the Metropolitan Police**:
  - VAWG team contributed to the refresh of the Met’s VAWG pledges and strategy.
  - Participated in ride-alongs and community engagement sessions, ensuring safeguarding concerns are addressed in real time.
  - Regular attendance at the NA-BCU VAWG Strategic Board and Haringey’s own VAWG Strategic Board.

- **Children’s Social Care Engagement**:
  - Delivered a 7-minute briefing for the HSCP and presented at the Designated Safeguarding Lead Network.
  - Focused on tackling misogyny in schools and raising awareness of gender-based abuse.

- **Alcohol Strategy Integration**:
  - VAWG team worked with Public Health to embed safeguarding into the borough’s Alcohol Strategy.
  - Addressed how alcohol intersects with abuse, both as a coping mechanism and a control tactic.

    - Ensured alcohol services are trained and represented in safeguarding forums.

- **DAHA Accreditation**:
    - Achieved through embedding a culture of accountability and best practice across housing services.
    - Focused on prevention, early intervention, and multi-agency working.

- **Recommissioning of VAWG Services**:
    - Despite extensive consultation, the initial tender received few bids and was withdrawn.
    - Interim contracts are in place to ensure continuity while the process is revised under the new procurement act.

- **Domestic Homicide Reviews (DHRs)**:
    - 1 DHR ready for publication, 2 nearing sign-off, 2 in early stages, and 1 awaiting confirmation.
    - These reviews are vital for learning lessons and improving safeguarding responses.

London Fire Brigade

Key Achievements:
- LFB maintained strong safeguarding awareness among all staff, emphasizing the importance of reporting safeguarding and welfare concerns during public interactions.
- Staff were encouraged to submit referrals promptly and follow up on their progress, contributing to tangible changes for residents.
- Collaborative work with local partners was a highlight, with positive feedback received from the local authority on referrals made by LFB.

Key Challenges:
- Some communication issues arose in specific cases, but these were resolved over time.

Safeguarding Initiatives and Training:
- Borough-wide safeguarding training was delivered to LFB staff.
- Engagement with carers helped identify and report fire risks, enhancing early intervention and prevention efforts.

Case Study – Good Practice Example:
- A resident in Haringey received threats of arson. The MPS promptly informed LFB, who conducted a home fire safety visit and installed an arson-proof letterbox.
- The individual was also referred by MPS to the MASP, demonstrating effective inter-agency collaboration.

Plans and Priorities for the Coming Year:

- Continue to raise safeguarding awareness among all LFB staff.
- Ensure referrals are submitted within recognised timeframes and followed up appropriately.
- Due to staff turnover, LFB is reviewing safeguarding training and staff knowledge to ensure continuity and compliance.

Dissemination of SAR Learning:

- Learning from SARs is shared and embedded through monthly and quarterly meetings.

Metropolitan Police

Key Achievements:

- Significant increase in staffing within the Public Protection (PP) unit, reaching 98% capacity—the highest in years. This unit focuses on safeguarding vulnerable adults and children.
- Haringey is the only borough in London with a **dedicated Adults Coordinator**, enabling:
    - Faster investigations
    - Stronger relationships with social care and hospitals
    - Improved multi-agency collaboration

Key Challenges:

- Ensuring appropriate police units respond to safeguarding concerns that may not initially appear criminal.
- Communication barriers, especially identifying the right contacts across agencies. This has been mitigated by:
    - Regular meetings between the Adults Coordinator and Haringey Social Care managers
    - Establishing a Single Point of Contact (SPOC) to streamline communication and response

Safeguarding Initiatives and Training:

- Bespoke training for all officers following a major IT system overhaul, including:
    - Safeguarding and triage awareness
    - Missing Person Training for both police and partners
    - Creation of an **Adult Safeguarding Glossary** for officers
    - Training on the **RCRP** approach to clarify when police involvement is appropriate, especially in mental health cases
    - Financial abuse awareness sessions for partner agencies

Case Studies – Good Practice Examples:

1. **Hospital Safeguarding Lead (HSGL)** contacted police about a non-verbal woman with learning needs. The police HSGL identified her as a missing person from a South London care home and coordinated her safe return.
2. A vulnerable woman, placed in Haringey, repeatedly reported sexual offences. Joint working between police teams and a Haringey social worker led to effective safeguarding and ongoing support.

Plans and Priorities for the Coming Year:

- Navigate internal restructuring with minimal disruption to safeguarding work.
- Continue participation in subgroups, especially around financial abuse.
- Expand officer training on vulnerable adults and missing persons.
- Develop and disseminate new training on vulnerable adult triage.

Organisational Changes in Response to SARs:

- Retention of the SPOC role despite budget pressures, with plans to expand it across the Met.
- Comprehensive review of how missing adult cases are reported and investigated.
- Launch of the **Local Missing Hub (LMH)** in June 2025 to manage all missing person reports from start to finish.

Dissemination of SAR Learning:

- Bespoke training days tailored to each unit.
- Use of internal platforms (Intranet/SharePoint) to share partner information.
- Regular newsletters to keep staff informed of safeguarding updates.

North Central London Integrated Care Board (NCL ICB)

As a key strategic partner within the HSAB, the ICB is committed to promoting a culture of prevention, professional curiosity, and continuous learning. Over the past year, NCL ICB has demonstrated strong leadership in embedding safeguarding across the health and care system through workforce development, multi-agency collaboration, and a focus on addressing health inequalities. Their contribution to this year's report highlights a proactive and reflective approach to safeguarding, with a clear emphasis on system-wide improvement, community engagement, and person-centred care.

The ICB has made significant progress in promoting awareness and preventing abuse and neglect through multi-agency collaboration, education, and community engagement.

- **Safeguarding Conference – Promoting Curiosity (April 2024):**
  NCL ICB hosted its first in-person safeguarding conference, attracting 130 delegates from health, social care, and voluntary sectors. The event, themed *Promoting Curiosity*, showcased cutting-edge research and powerful service user narratives. Topics included:
  - New pathways for victims of non-fatal strangulation
  - The lived experience of women affected by FGM
  - Coercive control and its insidious impact
  - Links between gaming and radicalisation
  - Practitioner resilience and reflective practice
  - Feedback was overwhelmingly positive. Evaluation data is informing future training offers.

- **NCL Safeguarding Learning Event (July 2024):**
  A co-produced partnership with the NCL System Learning Group addressed key themes from recent CSPRs, RRs, DHRs, and SARs. Feedback indicated a strong appetite for system-wide reflection.

- **Best Interest Assessor Training (August 2024 & March 2025):**
  Two cohorts were commissioned for Best Interest Assessor (BIA) training across the ICS. Building workforce capacity in complex decision-making and promoting patient rights.

- **Level 4 Safeguarding Training (Summer 2024):**
  Commissioned through UCLH, aimed at senior practitioners to meet the requirement. A follow-up session is scheduled for summer 2025.

- **Public and Community Awareness:**
  Through engagement with community groups and third-sector partners, the ICB has continued to promote safeguarding awareness. Targeted outreach focused on vulnerable adults who may not be known to services, and social media campaigns have helped to highlight the signs of abuse and encourage public reporting.

Learning, Reflection and Practice Improvement
NCL ICB has embedded a system wide improvement programme through structured training, reflective events, and dissemination from statutory reviews.

- **Safeguarding Learning Events and Training:**
  Regular training, including Level 4 safeguarding and Best Interest Assessor training, have enhanced the professional competence of staff across the system.
- **Policy and Procedure Updates:**
  Learning from SARs and other reviews has been integrated into revised safeguarding policies and procedures, ensuring alignment with national standards and best practice.
- **Dissemination of Learning:**
  7-minute briefings, thematic learning reports, and review summaries have been widely circulated across NCL to ensure that frontline practitioners benefit from emerging knowledge and shared experiences.

The ICB has maintained oversight of the quality of safeguarding services and supported safe practice across its provider landscape.

Monitoring of Provider Quality:
The ICB receives safeguarding assurance from all our providers regarding their safeguarding activity and performance quarterly. The designates work closely with the Trusts to ensure safeguarding responsibilities are delivered and we provide assurances to the ICB and NHSE that our duties are met.
Safeguarding Policy Governance:
The ICB supports the development and implementation of robust safeguarding policies across commissioned services. These policies mandate

rigorous recruitment processes, staff training, and accessible reporting mechanisms.

- **Culture of Openness and Safety:**
  Through leadership engagement and training, we have promoted a culture where staff feel empowered to raise concerns. The emphasis on practitioner resilience and psychological safety in training events has supported this agenda.
- **Workforce Training and Competency:**
  Staff across the ICS continue to receive training on recognising and responding to abuse, neglect, and exploitation. This includes mandatory safeguarding training and opportunities to build specialist skills such as undertaking capacity assessments and complex casework.

Key challenges
One of the key challenges we faced was the lack of interoperability between different IT systems used across health and partner agencies. This often-made communication and timely information sharing more complex and time-consuming. However, we addressed this through strengthened multi-agency relationships within our Borough, which have been instrumental in enabling safe and proportionate information sharing.

We also provided ongoing support and guidance to staff regarding appropriate information sharing under safeguarding legislation, ensuring clarity and confidence in decision-making.

Case study
Collaborative Safeguarding Response for an Adult at Risk in NCL

In early 2024, concerns were raised about Mr. A, a 72-year-old man with complex physical health needs, cognitive impairment, and a history of self-neglect. He lived alone in temporary accommodation following a hospital discharge and had no known family support. Multiple missed appointments, deteriorating living conditions, and poor engagement with services triggered a safeguarding referral from his GP.

Initial Response:
The safeguarding concern was triaged through the local authority's adult safeguarding team, who initiated a Section 42 (Care Act 2014) enquiry. The case highlighted systemic challenges in coordinating care for adults with fluctuating capacity and multiple needs. A multi-agency safeguarding meeting was convened, involving professionals from:

- Local authority adult social care
- The ICB's Continuing Healthcare (CHC) team
- The community mental health team
- Housing services
- A voluntary sector advocacy provider
- The GP practice and community nursing team

Through the safeguarding meeting, the following actions were agreed:

- A full mental capacity assessment to determine Mr. A's ability to engage with care.
- A Best Interest meeting coordinated by the CHC team to explore safe and appropriate accommodation.
- Urgent cleaning and hazard removal from Mr. A's property was arranged.
- Referral to local advocacy services to ensure Mr. A's voice was represented.
- Weekly visits by community nurses to monitor his health and administer medication.
- Joint visits by social worker and community mental health practitioner to build trust and assess needs holistically.

Outcomes

- Mr. A was moved into supported accommodation with onsite carers, tailored to his health and cognitive needs.
- Better engagement with mental health and social care professionals, supported by the advocate
- Regular medication support was established, leading to improved physical health and reduced hospital admissions
- His overall wellbeing improved, with reduced incidents of self-neglect and greater social inclusion

Partnership Learning and Impact:

This case demonstrated the value of strong multi-agency communication, shared ownership of risk, and flexible working to meet complex needs. Key enablers of success included:

- The ICB's leadership in facilitating multi-disciplinary collaboration across health and care
- The role of advocacy in ensuring that safeguarding practice was person-centred and rights-based
- Joint visits and consistent follow-up, which built trust and allowed for a better understanding of Mr. A's lived experience

Consequently, the local safeguarding partnership has:

- placed the individual at the centre of well-co-ordinated care.
- Developed guidance for responding to self-neglect in adults with cognitive impairment.
- Strengthened referral pathways to advocacy services.
- Provided briefings to frontline teams on conducting joint visits and building engagement with hard-to-reach individuals.

Evidenced effective safeguarding practices through proactive case coordination and joint working practices.

Next Steps

As we transition into the next phase of integrated care, our safeguarding priorities will align closely with the evolving strategic direction of the North Central London Integrated Care Board (ICB) and the implementation of the new neighbourhood model of care. Our key priorities include:

- **Embedding Safeguarding within the Prevention and Health Inequalities Agenda.** With the roll-out of the neighbourhood model, we will undertake a strategic review to understand how safeguarding can be more effectively integrated into prevention strategies. This includes aligning safeguarding practice with broader objectives around reducing health inequalities and improving access and outcomes for marginalised and at-risk populations. This work will be done in collaboration with system partners including local authorities, voluntary sector organisations, and public health teams**.**
- **Strengthening System-Wide Approaches to Complex Harm, Including Knife Crime.** In partnership with Public Health, the ICB is committed to supporting multi-agency efforts to reduce serious youth violence and knife crime, recognising the impact on young adults and families. Our role will focus on developing trauma-informed commissioning pathways and safeguarding responses that are aligned with early intervention and prevention priorities.
- **Enhancing Service User and Carer Involvement in Commissioning and Safeguarding Practice.** We will continue to embed meaningful user and carer engagement in our commissioning cycles and service design. Our aim is to ensure that lived experience informs safeguarding priorities, quality assurance processes, and outcome measurement. This will help ensure that the voice of the adult at risk is central to how services are shaped, delivered, and improved across the system.

Response to SARs and embedding learning

Over the past year, we have taken several proactive steps to embed learning from Haringey SARs and wider reviews across our system. Upon publication, the key findings and recommendations were disseminated promptly, including to the specific practices involved, and cascaded through our internal governance and safeguarding networks to ensure system-wide awareness and alignment.

To further embed this learning, we have scheduled a dedicated session at the upcoming GP Forum in July 2025. This will focus on enabling primary care professionals to reflect on the SAR recommendations, identify individuals at risk, and take a preventative approach by reviewing patient caseloads for others who may be vulnerable.

We have also worked closely with commissioners to explore actions that address healthcare inequalities highlighted in these reviews particularly in Haringey, by reviewing service access, coordination, and information-sharing pathways.

Our CHC teams and provider partners have been engaged to review internal processes to better support individuals with complex or escalating needs.

In addition, we contribute to the NCL Safeguarding System Learning Group, which actively shares learning from SARs across NCL and nationally, encouraging implementation across local providers. Notably, we co-produced and participated in the NCL Safeguarding Learning Event (July 2024) a collaborative forum that reflected on themes from recent CSPRs, RRs, DHRs, and SARs. The event was well received, with strong feedback on the value of system-wide reflection and shared accountability for embedding learning into practice.

The ICB has a clear, multi-layered approach to disseminating and embedding learning from Haringey SARs. We routinely share key findings through our System Learning and Development Group, ensuring representation from providers, commissioners, and safeguarding leads across NCL. This enables cross-sector reflection and coordinated implementation.

Locally, designated professionals cascade learning directly to primary care colleagues and Haringey Place Team. For example, following recent SARs, we provided targeted support to GP practices in reviewing patient registers to identify and safeguard individuals with similar risk profiles. Learning is further discussed in GP safeguarding forums, where practical implications and case-based learning are explored.

We also share national SAR and DHR learning via provider safeguarding meetings and include summaries in regular safeguarding bulletins. All reviews and associated resources are uploaded to the GP safeguarding webpage and distributed through GP safeguarding leads to ensure wide accessibility.

North London Foundation Trust

North London Foundation Trust (NLFT) is an NHS foundation trust established in November 2024 through the merger of Barnet, Enfield and Haringey Mental Health NHS Trust and Camden and Islington NHS Foundation Trust. The Trust provides a wide range of community and mental health services across five London boroughs: Barnet, Camden, Enfield, Haringey, and Islington. With a workforce of approximately 6,000 staff and an annual budget of £670 million, NLFT is committed to delivering high-quality, person-centred care that promotes recovery, resilience, and safeguarding for all individuals it serves

Key Achievements in Safeguarding Adults
Over the past year, NLFT has implemented several initiatives to enhance adult safeguarding practices:

- **Safeguarding Surgeries**: Weekly one-hour sessions were introduced to provide practitioners with advice and support on complex cases.
- **Domestic Abuse Response**: Improved identification and response mechanisms, supported by regular training and a weekly drop-in surgery.
- **Policy Integration**: Consolidation of policies (e.g., Domestic Abuse, Adult and Children Safeguarding) into streamlined, user-friendly documents.

- **Level 3 Safeguarding Training**: Transitioned from e-learning to interactive Microsoft Teams presentations, enabling real-time discussion and deeper learning.

Key Challenges and Responses
- **Staff Turnover**: Ongoing recruitment and training efforts are required to maintain safeguarding standards.
- **IT Integration Issues**: The merger of two former Trusts led to data collection inefficiencies, which are being addressed through system improvements.

Safeguarding Initiatives and Training (2024–25)
- **Weekly Drop-in Surgery**: Focused on Domestic Abuse and Harmful Practices, supporting staff with high-risk and complex cases.
- **Training Delivered**:
    - Hate Crime and VAWG
    - Harmful Practices: Female Genital Mutilation/Cutting (FGM/C)
    - Supporting Jewish Women Experiencing Domestic Abuse
    - White Ribbon Day: Non-fatal Strangulation
    - International Men's Day (Parts 1 & 2): Mental Health, Suicidality, and Male Victims of Domestic Abuse & Stalking

Case Study: Partnership and Safeguarding Practice
Service User X (diagnosed with Schizophrenia) was discharged in August 2024. Despite initial support, concerns arose regarding medication adherence and self-neglect. A multi-agency response was initiated:
- Safeguarding concern raised
- Home visit and mental health review
- Referral to Home Treatment Team
- Review of care and support needs
- GP contacted regarding medication compliance

Outcomes:
- Hospital admission prevented
- Service user moved to supported accommodation with advocacy support

Learning Points:
- Importance of robust discharge planning
- Regular GP communication
- Capacity assessments
- Advocacy involvement

Future Plans and Priorities
- Implementation of a new incident reporting system with a safeguarding module to streamline processes and improve data collection.

Learning from Safeguarding Adult Reviews (SARs)
- Development of a **formulation checklist** to guide holistic assessments upon hospital admission, ensuring all aspects of a patient's life are considered.
- SAR reports, 7-minute briefings, and Chair statements are cascaded across Trust divisions.
- Webinars and learning events are promoted Trust-wide.
- Key themes are discussed in monthly divisional meetings.

Royal Free London NHS Foundation Trust
North Middlesex University Hospital (joined in 2025)

The Royal Free London NHS Foundation Trust is one of the largest and most respected healthcare providers in the UK, serving a population of over 1.6 million people across 70 sites in north London and Hertfordshire. With a workforce of more than 17,000 staff from 120 countries, the Trust is renowned for delivering world-class expertise and local care.

Key Achievements

- **Integration of Services:** North Middlesex Hospital joined the Trust on 1 January 2025. Safeguarding teams across both sites aligned governance and assurance processes.
- **Training Initiatives:** Developed and delivered Level 3 safeguarding adults training with a Think Family approach, focusing on domestic abuse.
- **Referral Improvements:** Enfield community safeguarding referrals now routed through the MASH portal for improved triage and personalization.
- **Champion Network:** 35 Safeguarding Adult Champions support early identification and team-based learning.
- **SOP Development:** New Standard Operating Procedure for medical photography in safeguarding cases, improving documentation (e.g., pressure ulcers).
- **Training Compliance:** Targeted initiatives addressed gaps, aligning training across business units.
- **Multi-Agency Collaboration:** Improved hospital discharge processes with best-interests decision-making and collaborative care planning.
- **Clinical Pathway Leadership:** Contributed to Non-Fatal Strangulation work across North Central London (NCL), leading on acute hospital services pathway.

Key Challenges and Responses

- **Staffing Gaps:** Community safeguarding vacancies now filled.
- **Data Capture Issues:** Discrepancies between incident reporting and electronic patient records are being addressed.
- **Discharge Delays:** Complex planning and social care capacity issues led to prolonged admissions. Weekly senior safeguarding meetings proposed to improve communication.
- **Referral Triage Delays:** Ongoing efforts to enhance partnership engagement and timely protection planning.

Safeguarding Initiatives and Activities

- Level 3 safeguarding training with a Think Family approach.
- MCA/DoLS training across clinical teams.
- Safeguarding Adults Week with webinars and Champion-led resource sharing.
- Simulation training with role play.
- Alignment of statutory policies across the Trust.
- Enhanced Prevent training with a new video resource.

- Delivery of two MCA masterclasses, with plans for expansion.
- Integration of Equality Act 2010 duties in training.
- Commitment to NHS Sexual Safety Charter and its 10 core principles.

Case Studies

1. **Multi-Agency Best-Interests Discharge (Enfield):**
   Collaborative discharge planning for a patient with prolonged disorder of consciousness, ensuring adherence to the Mental Capacity Act and safeguarding principles.
2. **Effective Discharge through Partnership (Royal Free London):**
   Joint meeting with ASC, discharge teams, and family enabled timely, safe discharge using a Think Family approach.

Future Plans and Priorities

- Expand safeguarding training to include neglect.
- Increase Prevent awareness.
- Standardize safeguarding in maternity care.
- Review team structures for efficiency.
- Develop a robust non-fatal strangulation pathway with NCL partners.
- Expand sexual safety initiatives and anonymous reporting.
- Continue MCA masterclass delivery Trust-wide.
- Respond to safeguarding system reforms and social care changes.

Learning from Safeguarding Adult Reviews (SARs)

- **Dissemination:** 7-minute briefings shared across teams and embedded in training.
- **SAR: Eleanor:** Emphasised multi-agency collaboration and timely identification of safeguarding contacts.
- **SAR: Paulette:** Highlighted communication between health and social care; led to discharge team restructuring and improved information sharing.
- **SAR: Steve:** Reinforced professional curiosity; staff encouraged to explore underlying causes of disengagement.
- **Safeguarding Newsletter:** Shares SAR and DHR learnings.
- **7-Minute Briefings:** Available on intranet for staff engagement.
- **Training Integration:** SAR themes embedded in Level 3 safeguarding training. A new module on self-neglect is in development.

Whittington Health NHS Trust

Whittington Health NHS Trust is a key partner of the HSAB, actively contributing to the Board's strategic objectives and safeguarding priorities. As a provider of acute and community health services across North London, Whittington Health plays a vital role in identifying, responding to, and preventing abuse and neglect of adults at risk. The Trust's Adult Safeguarding Team works collaboratively with local authorities, health partners, and other agencies to ensure the safety and wellbeing of vulnerable individuals in Haringey.

Key Achievements

- Active participation in HSAB and its subgroups.

- Maintained face-to-face Safeguarding Adults Level 1 & 2 training, with 3,288 staff trained and 83% compliance as of 31 March 2025.
- Strengthened safeguarding leadership with the appointment of a permanent Head of Vulnerable Adults and a new Adult Safeguarding Lead.
- Delivered bespoke training to acute departments (e.g., Emergency Department, Preceptorship, Health Care Support Workers) and community teams (e.g., District Nursing Managers).
- Increased safeguarding presence in community settings, leading to Adult Community Services making the most referrals in the last two quarters.
- Continued reporting of staff allegations to local authorities across SAB partnerships.
- Hosted regular virtual drop-in sessions for community staff and managers.
- Promoted Safeguarding Awareness Week (18–22 November 2024) with intranet resources and case studies.

Key Challenges

- Rising volume and complexity of safeguarding referrals across acute and community services.
- Resource-intensive nature of safeguarding work.
- High demand for training, met with tailored support for specific teams.

Safeguarding Initiatives

- Face-to-face Level 1 & 2 training across acute and community settings.
- Bespoke training on self-neglect, courageous conversations, and safeguarding escalation.
- Monthly “10 at 10” meetings in the Emergency Department.
- Increased visibility in health centres to support safeguarding awareness.

Case Study – Partnership Working

A 92-year-old female patient with multiple safeguarding concerns was admitted to Whittington Health. The case involved:

- Six safeguarding alerts in 2024, including neglect.
- Barriers to care posed by the patient's son.
- Severe health issues including pressure sores and maggot-infested wounds.
- Collaboration with the Office of the Public Guardian, ward teams, discharge teams, and local authority.
- Appointment of an Independent Mental Capacity Advocate (IMCA).
- Best Interest meetings leading to safe discharge to step-down care while Section 42 safeguarding enquiries were completed.

This case exemplifies effective multi-agency collaboration and safeguarding practice.

Future Plans and Priorities

- Sustain high levels of face-to-face training.
- Expand safeguarding presence in community settings.
- Continue responsive support for staff on safeguarding, domestic abuse, homelessness, and Prevent.
- Maintain fortnightly meetings with Haringey safeguarding and discharge teams.

- Enhance domestic abuse awareness using new Trust resources.

Learning from Safeguarding Adult Reviews (SARs)

- SAR learning embedded in Level 1 & 2 training, regularly updated to reflect emerging themes.
- Dissemination through Whittington Improvement and Safety Paper (WISP) and seven-minute briefings.
- Presentations delivered to community teams and Clinical Leads and Quality Committee (CLaQC).

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Report for: Adults & Health Scrutiny Panel – 16th December 2025

Title: Local Government & Social Care Ombudsman – Upheld Complaints

Item number: **9**

Report authorised by: Ayshe Simsek, Democratic Services & Scrutiny Manager

Lead Officer: Dominic O'Brien, Principal Scrutiny Officer

Ward(s) affected: All

Report for Key/ Non Key Decision: N/A

1. Describe the issue under consideration

1.1 The reports provided set out details of Adult Social Care complaints upheld by the Local Government & Social Care Ombudsman (LGSCO). This item will be considered in two parts.

1.2 **PART A** – This part concerns the publication of a public report by the LGSCO following an investigation into a complaint concerning Adult Social Care which involved delays in responding to safeguarding concerns and shortcomings in complaint handling. The reports on this investigation and the Council's response to the LGSCO findings were considered by the Cabinet at a meeting on 11th November 2025. (Minutes: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=83908)

1.3 **PART B** – This part involves an overall overview of Adult Social Care complaints.

2. Recommendations

2.1 That the Panel give consideration to the contents of the reports relating to both parts of this item and, following questions to Cabinet Member for Health Social Care & Wellbeing, the Corporate Director for Adults, Housing & Health and the Service Director for Adult Social Services, submits any recommendations that arise to the Overview & Scrutiny Committee.

3. Background information

3.1 At a meeting of the Overview & Scrutiny Committee on 18th September 2025, a Quarter 1 Update Report on the Corporate Delivery Plan was considered. A Key Performance Indicator (KPI) in the report was:

Number of complaints upheld by the Local Government and Social Care Ombudsman per 10,000 population *- The Ombudsman investigated 61 complaints and 53 were upheld (87%). Adjusted for Haringey's population, this is*

20.2 upheld decisions per 100,000 residents. The average for authorities of this type is 9.1 upheld decisions per 100,000 residents.

3.2 Following a discussion about this KPI at a meeting of the Adults & Health Scrutiny Panel on 22nd September 2025, it was agreed by the Panel that an agenda item on this issue should be scheduled in December to allow for more detailed consideration.

3.3 A summary of the discussion at the Adults & Health Scrutiny Panel can be viewed at: https://www.minutes.haringey.gov.uk/mgAi.aspx?ID=82981

4. Statutory Officers comments

4.1 Refer to the report provided on the LGSCO to the Cabinet (11th November 2025 – Section 9) for statutory officer comments.

5. Use of appendices

- PART A1 – Report to Cabinet, 11th November 2025
- PART A2 – Report from the LGSCO, August 2025
- PART A3 – The Council's Action Plan Tracker for actions required in response to the LGSCO's findings.
- PART B – Adult Social Care Complaints Overview (ASC Improvement Board – October 2025)

Report for: Cabinet - 11 November 2025

Item number: 13

Title: Local Government & Social Care Ombudsman Public Report

Report authorised by : Sara Sutton, Corporate Director, Adults, Housing & Health
Fiona Alderman, Director of Legal & Governance (Monitoring Officer)

Lead Officer: Jo Baty, Director of Adult Social Care

Ward(s) affected: All

Report for Key/ Non Key Decision: Non Key Decision

1. Describe the issue under consideration

1.1. The Local Government & Social Care Ombudsman (LGSCO) has issued a public report (Ref: 24 014 203) following an investigation into a complaint concerning Adult Social Care. The Ombudsman upheld the complaint and found fault and injustice relating to delays in responding to safeguarding concerns and shortcomings in complaint handling.

1.2. In accordance with Section 31(2) of the Local Government Act 1974, the Council is required to formally consider the Ombudsman's report and agree its response within three months of publication. This report sets out the findings, actions already taken, and the improvement work underway to address the issues identified.

2. Cabinet Member Introduction

2.1. As a council we recognise the seriousness of the findings in this case. We fully accept that mistakes were made and apologise unreservedly for those errors. We are working tirelessly to improve both our Adult Social Care provision and our complaint handling practice.

2.2. We provide care for thousands of residents every day in Haringey, often supporting people in very challenging and difficult moments in their lives. Feedback in all its forms is a critical tool for understanding how residents and their carers experience that support. It is vital that we learn from complaints and put things right quickly without residents needing to seek the support of the Ombudsman.

2.3. Historic practices have changed fundamentally since the events that gave rise to this case. We no longer have backlog of unread emails and safeguarding concerns are triaged in a timely manner. Relevant staff have received training and complaint handling is being improved.

2.4. The Council is focused on the right things, as set out in this report and also our Adult Social Care Improvement Plan. We are determined to continue to improve how we deliver for our residents and those who care for them.

3. Recommendations:

Cabinet is asked to:

3.1. Note the findings of the Local Government & Social Care Ombudsman's public report (Ref: 24 014 203) Appendix 1.

3.2. Approve the Council's response and endorse the action plan set out in Appendix 2.

3.3. Authorise the Director of Adult Social Care to provide evidence to the Ombudsman of the Council's compliance with the recommendations by 19 November 2025.

3.4. Agree to that further assurance updates will be provided to the Adults and Health Scrutiny Panel

4. Reasons for decision

4.1. The decision will ensure that the Council meets its statutory duty under Section 31(2) of the Local Government Act 1974 to formally consider the Ombudsman's public report within three months of publication.

4.2. The recommendations also provide assurance that the Council is taking appropriate steps to address the issues identified, provide redress to those affected, and strengthen systems to reduce the risk of recurrence.

5. Alternative options considered

5.1. There are no alternative options. The Council is legally required to formally consider the Ombudsman's report and to respond within the required timeframe. It is not mandatory to follow the Ombudsman's recommendations, but it is recommended that the Council does.

6. Background information

6.1. The Ombudsman's public report relates to how the Council communicated and managed safeguarding concerns regarding a resident in 2023/24. The Ombudsman upheld the complaint, finding that the Council could not evidence timely action in relation to safeguarding referrals, and identified shortcomings in the handling of the complaint. The Council has accepted the

Ombudsman's findings and recommendations in full, and formal apologies and compensation payments have been made to those affected.

6.2. The public report was published by the Ombudsman on 2 October 2025. The Council has arranged for the statutory public notices to be placed and for the report to be available at Council offices, in line with legal requirements.

6.3. The Council has already taken forward a number of improvements to strengthen safeguarding arrangements and enhance service delivery since the implementation of the localities model in 2024. This report highlights the actions already completed, and the further work underway to ensure continued progress and accountability.

6.4. Actions completed to date include:

- **Safeguarding Pathway Transformation**: Referral pathways have been redesigned and the safeguarding operating model strengthened
- **Backlog clearance:** We no longer have backlog of unread emails and safeguarding concerns are triaged in a timely manner.
- **Workforce Development**: Staff at the 'Front Door' have received targeted training to improve safeguarding awareness and response times.
- **Governance and Oversight:** Governance and escalation procedures have been enhanced to ensure timely escalation and improved senior-level oversight.
- **Complaint handling:** Implemented a streamlined approach to managing complaints and ombudsman cases within the adult social care service.
- **External Validation:** The Council received a rate of "Good" for the safeguarding theme within the recent Care Quality Commission (CQC) inspection.

6.5. In addition to the actions already completed, further work is underway to ensure sustained improvement and accountability. This includes a formal independent review of our safeguarding service and practice, that is being conducted in partnership with the newly appointed Chair of the Adult Safeguarding Board and will provide an objective assessment of current arrangements, identify further areas for improvement, and inform future service development. The review is expected to be completed by January 2026.

6.6. Further workforce development is also planned, led by the newly appointed Interim Principal Social Worker, with a focus on targeted training and embedding best practice across the service.

6.7. As part of a wider corporate approach to improve complaint handling across the organisation, the Feedback and Resolutions Team are taking proactive steps to improve performance. This includes:

- Quarterly performance presentations the Council Leadership Team (CLT)

Training for staff drawing on the learning from this and other Ombudsman cases

- New triage arrangements implemented to ensure complaints are accurately categorised first time
- Procuring and implementing a new, modern case management system to support improved complaint handling
- Monthly performance reviews with the key services leadership teams, focusing on Ombudsman outcomes, maladministration decisions, reducing upheld complaint rates, and minimising Complaint Handling Failure Orders.

6.8. Implementing organisational change involves not just adjustments to processes, but also a shift in culture. Through our efforts to embed the principles of the Haringey Deal, we encourage staff to prioritise the resident experience and consider their perspectives at the heart of their work. A crucial element of this is improving how feedback is received and acted upon, enabling officers not only to address concerns but also to resolve underlying issues and enhance service delivery.

6.9. The service is committed to learning from this case and ensuring that safeguarding processes are robust, timely, and person-centred and the actions taken specifically in relation to the ombudsman's recommendations in this case are detailed in Appendix 2.

6.10. This report is presented to Cabinet alongside the Adult Social Care Improvement Plan that highlights the wider journey of improvement within Adults Social Care and it is proposed that the report and subsequent assurance updates will be considered by the Adults and Health Scrutiny Panel.

7. Contribution to the Corporate Delivery Plan 2024-2026 High level Strategic outcomes'?

7.1. This work directly supports the Council's priorities around providing high quality, safe, and responsive services for residents, and reflects a commitment to learning from feedback, strengthening safeguarding practice, and improving accountability. The improvement programme contributes to the delivery of the Adult Social Care Improvement Plan, ensuring services are sustainable and trusted by residents.

8. Carbon and Climate Change

8.1. There are no direct carbon or climate change implications arising from this report.

9. Statutory Officers comments (Director of Finance (procurement), Head of Legal and Governance, Equalities)

9.1. Finance

9.1.1. The Council the Council is required to formally consider the Ombudsman's report and agree its response within three months of publication. The Council's action plan and any associated costs have and will continue to be met within Adult Social Care's financial budget envelope.

9.2. Procurement

9.2.1. Strategic Procurement note the contents of this report and confirm there are no procurement related matters preventing Cabinet approving the Recommendations stated in paragraph 3 above.

9.3. Director of Legal & Governance

9.3.1. Under the Local Government Act 1974 (the Act), the LGSCO has the power to investigate the complaint and to issue a report where there has been maladministration causing injustice; a failure in a service that it was the Council's function to provide; and a total failure to provide such service. The LGSCO has the power to make recommendations to the Council on how to improve its services and to put things right for the complainant. However, these recommendations are not mandatory, and the Council does not have to accept or follow them.

9.3.2. Within 2 weeks of receiving the LGSCO's report, the Council is required to give public notice by advertisements in newspapers stating that copies of the report will be available to inspect by the public for a period of three weeks (s.30 of the Government Act 1974).

9.3.3. The Council complied with this requirement.

9.3.4. The Act provides that the report shall be laid before the "authority" for consideration. In the case of a local authority operating executive arrangements, "the authority" includes the Executive which under current governance arrangements means the Cabinet.

9.3.5. Where a finding of 'maladministration' is made the Council's Monitoring Officer is obliged to prepare a report for the Executive following the LGSCO

findings and to consult with the Head of Paid Service and Chief Finance Officer for this purpose.

9.3.6. This report must also be sent to each member of the Council, and the Executive must meet within 21 days thereafter. The Executive is required to consider this Monitoring Officer report on the findings of and response to the LGSCO's report.

9.3.7. Where the Executive considers a LGSCO's report and it is considered that a payment should be made or other benefit given to a person who has suffered injustice, such expenditure may be incurred as appears appropriate (s.31(3) Local Government Act 1974).

9.3.8. Within 3 months of receiving the LGSCO's report or such longer period as may be agreed in writing with the LGSCO, the Council must notify the LGSCO of the action which the Council have taken or propose to take (s.31(2) Local Government Act 1974). If the LGSCO is not satisfied with the action which the Council has taken or propose to take, the LGSCO shall make a further report. The LGSCO can also require the Council to make a public statement in any two editions of a newspaper circulating the area within a fortnight (s.31(2A) and (2D) Local Government Act 1974).

9.3.9. An Ombudsman's report should not normally name or identify any person (s.30 Local Government Act 1974). Therefore, the complainant should not be referred to by name and officers are not identified.

9.4. **Equality**

9.4.1. The *council* has a Public Sector Equality Duty (PSED) under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not

9.4.2. The three parts of the duty apply to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation.

9.4.3. Marriage and civil partnership status applies to the first part of the duty. Although it is not enforced in legislation as a protected characteristic, Haringey Council treats socioeconomic status as a local protected characteristic.

9.4.4. This report is regarding the Ombudsman's public report relating to how the Council communicated and managed safeguarding concerns regarding a resident in 2023/24. The Ombudsman upheld the complaint, finding that the Council could not evidence timely action in relation to safeguarding referrals, and identified shortcomings in the handling of the complaint.

9.4.5. Acknowledgement of the report and implementation of the action plan will have a neutral impact on equalities. Individuals with protected characteristics particularly disability, race, age, and sexual orientation, are disproportionately likely to be referred for safeguarding. This is not due to the characteristics themselves, but because of the systemic inequalities and barriers they may face. Factors like poverty, care experience, and overlapping vulnerabilities can increase exposure to harm. Therefore, failure to respond to the report and implement the action plan would have a negative impact on equalities in Haringey.

10. Use of Appendices

10.1. Appendix 1: LGSCO Public Report (Ref: 24 014 203)

10.2. Appendix 2: ASC Action Plan

11. Background papers

None

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Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint about London Borough of Haringey (reference number: 24 014 203)

19 August 2025

The Ombudsman's role

We independently and impartially investigate complaints about councils and other organisations in our jurisdiction. If we decide to investigate, we look at whether organisations have made decisions the right way. Where we find fault has caused injustice, we can recommend actions to put things right, which are proportionate, appropriate and reasonable based on all the facts of the complaint. We can also identify service improvements so similar problems don't happen again. Our service is free.

We cannot force organisations to follow our recommendations, but they almost always do. Some of the things we might ask an organisation to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

We publish reports to raise awareness of significant issues, encourage scrutiny of local services and hold organisations to account.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mr Y	The complainant
Ms X	His friend and co-complainant

Report summary

Adult care services – safeguarding

Ms X complained the Council did not act when she raised concerns about Mr Y's welfare. She also complained about the Council's handling of her complaint. Ms X said the Council's actions caused distress to Mr Y, his family and Ms X. The Council was at fault. It has not evidenced it considered if it needed to act to safeguard Mr Y. This left Mr Y at risk of harm and caused Ms X, Mr Y and his family uncertainty. The Council's complaint handling was poor and this caused frustration to Ms X.

Finding

Fault causing injustice and recommendations made.

Recommendations

The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. (Local Government Act 1974, section 31(2), as amended)

In addition to the requirements set out above, to remedy the injustice caused the Council should carry out the following actions within one month of the date of this report:

- apologise to Mr Y and Ms X for the injustice caused by the fault identified in this case. We publish guidance on remedies which sets out our expectations for how organisations should apologise effectively to remedy injustice. The organisation should consider this guidance in making the apology we have recommended in our findings.
- pay Mr Y £2,000 for leaving him at risk of harm.
- pay Ms X £200 to acknowledge the time and trouble she has spent pursuing this complaint.

Within three months of the date of this report the Council should:

- undertake a lessons learned exercise with all relevant staff and develop an action plan to prevent the same problems recurring in future;
- as part of the action plan, review its safeguarding policy to ensure the Council considers safeguarding referrals, rather than requiring a completed form;
- provide training to relevant staff on accepting safeguarding referrals based on whether it meets the threshold, rather than whether they are in a certain format;
- provide training, with reference to our guidance, to relevant staff on effective complaint handling. This should include identifying the appropriate procedure, sending responses on the correct templates and resolving issues quickly using a common sense approach;
- provide an update on progress against the Council's action plan to deal with the backlog in email communications and police reports and any further action planned if progress is not as planned; and
- refer this report, the lessons learned outcomes and the Council's two action plans to the Cabinet Member for Adult Social Care and the relevant scrutiny committee and keep both regularly updated on progress.

The Council has accepted these recommendations.

The complaint

1. Ms X complained the Council did not act when she raised concerns about Mr Y's welfare. She also complained about the Council's handling of her complaint. Ms X said the Council's actions caused distress to Mr Y, his family and Ms X.

Legal and administrative background

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. (Local Government Act 1974, sections 26(1) and 26A(1), as amended)

3. We may investigate matters coming to our attention during an investigation, if we consider that a member of the public who has not complained may have suffered an injustice as a result. (Local Government Act 1974, section 26D and 34E, as amended)

4. We may investigate complaints made on behalf of someone else if they have given their consent. (Local Government Act 1974, section 26A(1), as amended)

5. An organisation should not adopt a blanket or uniform approach or policy that prevents it from considering the circumstances of a particular case. We may find fault in the actions of organisations that 'fetter their discretion' in this way.

6. Under our information sharing agreement, we will share this decision with the Care Quality Commission (CQC).

7. We cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. (Local Government Act 1974, sections 26B and 34D, as amended)

8. We exercised discretion to consider events in this case back to June 2023. Ms X continued to pursue this matter and the Council did not fully or meaningfully respond to her complaints.

Legal background

9. A council must make enquiries if it thinks a person may be at risk of abuse or neglect and has care and support needs which mean the person cannot protect themselves. An enquiry is the action taken by a council in response to a concern about abuse or neglect. An enquiry could range from a conversation with the person who is the subject of the concern, to a more formal multi-agency arrangement. A council must also decide whether it or another person or agency should take any action to protect the person from abuse. (section 42, Care Act 2014)

10. Councils should have clear procedures to deal with social care complaints. Regulations and guidance say they should investigate and resolve complaints quickly and efficiently. A single stage procedure should be enough. The council should include in its complaint response:

    - how it considered the complaint;
    - the conclusions reached about the complaint, including any required remedy;

- whether it is satisfied all necessary action has been or will be taken by the organisations involved; and
- details of the complainant's right to complain to the Local Government and Social Care Ombudsman. (Local Authority Social Services and National Health Service Complaints (England) Regulations 2009)

11. The Mental Capacity Act 2005 is the framework for acting and deciding for people who lack the mental capacity to make particular decisions for themselves. The Act (and the Code of Practice 2007) describes the steps a person should take when dealing with someone who may lack capacity to make decisions for themselves. It describes when to assess a person's capacity to make a decision, how to do this, and how to make a decision on behalf of somebody who cannot do so.

12. A key principle of the Mental Capacity Act 2005 is that any act done for, or any decision made on behalf of a person who lacks capacity must be in that person's best interests. The decision-maker also has to consider if there is a less restrictive choice available that can achieve the same outcome. Section 4 of the Act provides a checklist of steps decision-makers must follow to determine what is in a person's best interests.

13. Sections 9 and 10 of the Care Act 2014 require councils to carry out an assessment for any adult with an appearance of need for care and support. They must provide an assessment to everyone regardless of their finances or whether the council thinks the person has eligible needs. The assessment must be of the adult's needs and how they impact on their wellbeing and the results they want to achieve. It must also involve the individual and where suitable their carer or any other person they might want involved.

14. Councils must carry out assessments over a suitable and reasonable timescale considering the urgency of needs and any variation in those needs. Councils should tell people when their assessment will take place and keep them informed throughout the assessment.

15. The Care Quality Commission (CQC) is the statutory regulator of care services. It keeps a register of care providers that meet the fundamental standards of care, inspects care services, and reports its findings. It can also enforce against breaches of fundamental care standards and prosecute offences.

16. The Council's complaint procedure says it would review the complaint to determine the correct process. It says the Council will acknowledge the complaint within two to five working days. It says it would respond to the complaint within 10 working days.

How we considered this complaint

17. We read Ms X's complaint and spoke to her about it on the phone.

18. We considered evidence provided by Ms X and the Council as well as relevant law, policy and guidance.

19. We gave the complainant and the Council a confidential draft of this report and invited their comments. The comments received were taken into account before the report was finalised.

What we found

What happened

20. This is a summary of events, outlining key facts and does not cover everything that has occurred in this case. We have purposely avoided giving precise details and information to protect Mr Y's anonymity.

21. Ms X contacted the Council in June 2023. She reported concerns about Mr Y, who experiences seizures. The Council told Ms X to fill out a safeguarding form. Ms X completed the safeguarding form and sent it to the Council a week later.

22. The Council recorded a referral from another person. The referral reported Mr Y accidentally caused damage to his property following seizures resulting in his landlord wanting to evict him.

23. Ms X contacted the Council at the end of June 2023. She reported Mr Y had been in hospital following a seizure, which led to damage to the property and placed him at significant risk of harm. Ms X confirmed Mr Y was now back at home, but she asked the Council to contact her. The emergency service which attended the scene at the time also sent a referral to the Council raising concerns about Mr Y.

24. Ms X chased the Council in July 2023. The Council asked Ms X to resend her referral form. Ms X resent the form. She raised concerns with her local councillor after no response from the Council.

25. Ms X chased the Council again in August 2023. The Council rejected Ms X's referral as she had not followed the correct process. The Council reconsidered Ms X's reports. It decided to refer Mr X to his GP because of the concerns. A manager then decided the Council needed to complete an assessment of Mr Y's social care needs, ability to make decisions for himself and complete referrals for the home environment.

26. Mr Y's landlord issued him an eviction notice in September 2023.

27. The emergency services again referred Mr Y to the Council in October 2023. It made the referral after Mr Y had a seizure and raised concerns about his care and support and living situation.

28. The Council recorded a police referral in January 2024. The police noted its concerns about Mr Y's home environment, his seizures and considered Mr Y a "possible vulnerable adult". Ms X repeated her concerns to the Council.

29. The emergency services sent another referral in June 2024. The referral details concerns about Mr Y's home environment and his seizures. The Council decided it would allocate a social worker to Mr Y.

30. In July 2024, the Council recorded it tried to contact Mr Y but could not. It noted it would complete a visit a month later.

31. Mr Y was admitted to hospital in September 2024. The Council recorded he suffered an injury from falling while having a seizure.

32. Ms X complained to the Council in September 2024. She said Mr Y was vulnerable and needed help. Ms X said she had been contacting the Council for over a year without response. Ms X confirmed Mr Y had suffered a serious and life-changing injury following the last fall.

33. Ms X chased the Council a week after her complaint. She explained the situation and confirmed Mr Y's landlord was evicting him.

34. The Council issued a stage one corporate complaint response in October 2024. The response confirmed it received a referral from the emergency services in June 2024 and allocated a social worker to complete an assessment. It said the social worker tried to contact Mr Y but could not speak to him. The response confirmed a social worker would complete the assessment.

35. The landlord evicted Mr Y at the end of October 2024. Ms X asked the Council to escalate her complaint to stage two.

36. In November 2024, the Council told Ms X it considered the complaint under its corporate complaint procedure, but it related to adult social care. The Council asked Ms X to submit a new complaint under this process.

37. At the end of November 2024, the Council accepted its response to the stage two request was not suitable and directed Ms X to us.

38. Ms X was not satisfied with the Council's response and has asked us to investigate. Ms X would like the Council to appropriately support Mr Y and financially compensate him.

39. In response to our enquiries the Council stated this case "was a serious oversight by several staff working in the Council at the time". Given the issues raised in the case we were concerned others may also be affected. We made further enquiries to establish the extent of some of the issues we had identified. The Council confirmed it had over 1,100 unread emails in its social work inbox, including over 500 police reports. The Council provided an action plan, detailing how it intended to deal with this backlog. The plan included allocating daily time to clear the backlog with specific targeted action.

Our findings

40. The law says a council "must make whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case". The Council received repeated concerns from Ms X. It also received referrals from another person, the police and emergency services. The Council has not evidenced it considered if it should make safeguarding enquiries despite several concerns and referrals from individuals and professionals. This is fault. The Council did not consider if it needed to safeguard Mr Y and so placed him at risk of harm.

41. After one referral the Council triaged this case. It recommended a referral to a doctor. The Council changed this recommendation after management oversight. The Council then recommended a care and support needs assessment and assessments considering Mr Y's ability to make decisions around his care and support and living situation. The Council confirmed it would meet his assessed needs and consider referrals to other agencies. The Council has not evidenced it completed any of the actions it decided it should. This is fault. Mr Y's circumstances were not assessed, leaving him at risk of harm.

42. The Council recorded it rejected Ms X's referral because it did not follow the correct process. The Council has a duty to consider safeguarding concerns. It is unacceptable for a council not to consider concerns because a process is not completed in a particular way. The Council has not shown it assessed the situation and fettered its discretion by applying a blanket policy to a safeguarding referral. This is fault. The Council did not assess Mr Y's circumstances, leaving him at risk of harm.

43. The Council allocated a worker to complete an assessment after the fourth professional referral, a year after the initial concerns were raised. The Council did not attempt to contact Mr Y for a month. When it tried to contact him but could not, it recorded it would try to visit one month later. The Council has not evidenced it completed this visit. The Council should assess the safeguarding concern and act within a reasonable timescale. Taking one month to contact Mr Y then another month to arrange to visit him is not a reasonable timescale. This is fault. This placed Mr Y at risk of harm during this delay.

44. Mr Y injured himself while falling during a seizure. Ms X and Mr Y's family feel the accident could have been prevented. We cannot say what action the Council would have taken if it had properly considered this case. We cannot say if the Council had acted to safeguard Mr Y and provided support, he would not have been injured. However, the Council did not assess Mr Y. Ms X, Mr Y and his family are left with the uncertainty of asking if his injuries would have happened if the Council had acted, completed the assessment and supported Mr Y.

Complaint handling

45. Ms X's complaint reported she had raised concerns for over a year. The Council only commented on the three months before the complaint. It did not fully consider and respond to the complaint. This is fault, frustrating Ms X.

46. The Council considered this complaint using its corporate complaint procedure. This matter was about adult social care, so it should have used the adult social care complaint procedure. This is fault, frustrating Ms X.

47. The Council offered Ms X the right to escalate her complaint to stage two. It then refused to escalate the complaint to stage two. It said it should not have used the corporate complaint procedure. It asked Ms X to put in a new adult social care complaint. The Council's policy says it would decide the correct complaint process. The Council should have considered this complaint under the correct procedure. It should not need Ms X to resubmit a complaint because it did not do this. This is fault, frustrating Ms X.

48. In failing to robustly investigate the case via its own procedures the Council lost the opportunity to identify and begin to address the systemic issues involved. This adds to the risk of others being affected by the Council's failings.

Recommendations

49. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. (Local Government Act 1974, section 31(2), as amended)

In addition to the requirements set out above, to remedy the injustice caused the Council should carry out the following actions within one month of the date of this report:

- apologise to Mr Y and Ms X for the injustice caused by the fault identified in this case. We publish guidance on remedies which sets out our expectations for how organisations should apologise effectively to remedy injustice. The organisation should consider this guidance in making the apology we have recommended in our findings.
- pay Mr Y £2,000 for leaving him at risk of harm.

- pay Ms X £200 to acknowledge the time and trouble she has spent pursuing this complaint.

50. Within three months of the date of this report the Council should:

- undertake a lessons learned exercise with all relevant staff and develop an action plan to prevent the same problems recurring in future;
- as part of the action plan, review its safeguarding policy to ensure the Council considers safeguarding referrals, rather than requiring a completed form;
- provide training to relevant staff on accepting safeguarding referrals based on whether it meets the threshold, rather than whether they are in a certain format;
- provide training, with reference to our guidance, to relevant staff on effective complaint handling. This should include identifying the appropriate procedure, sending responses on the correct templates and resolving issues quickly using a common sense approach;
- provide an update on progress against the Council's action plan to deal with the backlog in email communications and police reports and any further action planned if progress is not as planned; and
- refer this report, the lessons learned outcomes and the Council's two action plans to the Cabinet Member for Adult Social Care and the relevant scrutiny committee and keep both regularly updated on progress.

51. The Council should provide us with evidence it has complied with the above actions.

Decision

52. We have completed our investigation. We have found fault by the Council, which caused injustice to Mr Y and Ms X. The Council has agreed to take the action identified in paragraphs 49 and 50 to remedy that injustice.

LGSCO
Action Plan Tracker

October 2025

Ref	Action	Deadline	Update	Status
001	Issue formal apologies to Mr Y and Ms X	19/09/25	Apology letters issued	COMPLETED
002	Pay £2000 to Mr Y	19/09/25	Payment made	COMPLETED
003	Pay £200 to Ms X	19/09/25	Payment made	COMPLETED
004	Notify LGSCO of meeting date / response	19/09/25	Provided by Corporate Feedback	COMPLETED
005	Ensure report is available at Council Offices	02/10/25	Printed copies will be made available at Alex House within 2 weeks of the report being published	COMPLETED
006	Place 2 public notices in newspapers/websites	16/10/25	Notices will be published in Haringey Independent by 16th October	COMPLETED
007	Schedule/hold Council or Cabinet consideration	19/11/25	This is on the forward plan for 11th November Cabinet	COMPLETED
008	Lessons learned exercise and action plan	19/11/25	All lessons learned and the action plan is being fed into the wider ASC Improvement Plan	IN PROGRESS
009	Safeguarding policy review	20/2/26	A full Safeguarding review of policy, and practice has been commissioned and is expected to be completed by early 2026. Evidence that this has been commissioned will be provided to the LGSCO.	IN PROGRESS
010	Training: safeguarding referrals	19/11/25	Several training sessions took place in April ’25 for all front door staff, with clear pathways and processes produced. In addition, the Safeguarding Adults Board is providing a programme of targeted staff training to strengthen safeguarding practice and reinforce learning across the workforce. Workforce development in this area is continuous and ongoing.	IN PROGRESS
011	Training: complaint handling	19/11/25 - ongoing	A workforce development programme of training is being implemented, as per the LGSCO guidance on complaint handling and good administrative practice. This will include but not exclusive to: Principles of Good Administrative Practice & Effective Oversight of Complaint Systems.	IN PROGRESS

012	Backlog progress update	19/11/25	The safeguarding team no longer have a backlog of unread emails and safeguarding concerns are triaged within 48 hours.	COMPLETED
013	Refer report & action plans to Cabinet & Scrutiny	19/11/25	This is on the forward plan for November Cabinet and Scrutiny	IN PROGRESS
014	Provide evidence to LGSCO	19/11/25		

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Adults Social Care Complaints Overview

ASC Improvement Board - October 2025

Contents

- Complaint Volumes: Context
- Statutory vs Corporate: Clarifying complaint pathways
- Stage 1 Complaints & On-time Responses
- LGO: Performance Overview
- LGO: Themes From Upheld Decisions
- LGO Public Report: Mitigation and Improvement
- Feedback & Resolutions Improvement Plan
- Closing Reflections: Commitment to Improvement

Complaint Volumes: Context

The table below presents a comparison between complaints raised and general contact during 2024/25.

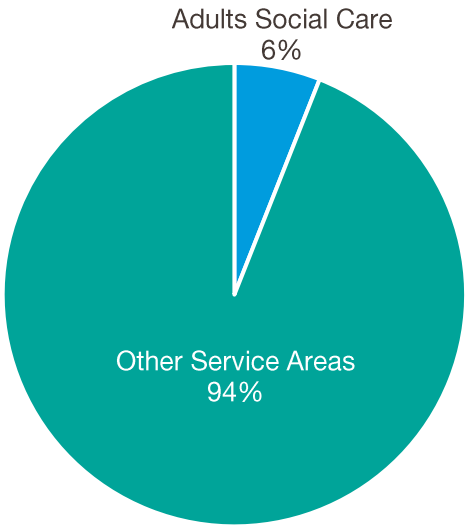
It's important to highlight that the vast majority initial interactions are resolved outside the formal complaints process, through early engagement and service-led resolutions:

Stage of contact	Vol. of cases	% of cases vs initial contacts
Initial contacts*	14,836	-
Stage 1 complaints	295	2%
Escalations beyond Stage 1	48	0.3%
Upheld Ombudsman decisions	20	0.1%

*Initial contacts recorded on Liquidlogic for Adults Social Care.

Adults Social Care accounts for 6% of all Stage 1 Complaints received into the council. For further context, Housing Repairs accounts for 30%, Environment 16%, Housing Management 11%, Housing Demand 10%, and Childrens Social Care also 6%.

ASC share of Haringey's total S1 complaints



Statutory vs Corporate: Clarifying complaint pathways

When a complaint is received by the Feedback Team, it must be assessed to determine whether it should follow the **Statutory** or **Corporate** complaints process. This decision is based on the nature of the complaint and the services involved.

Route	Stages	Timeframes	Haringey Practice
Corporate	Stage 1 → Stage 2 → LGO	10 working days (S1), 20 working days (S2)	10-day target
Statutory	Stage 1 → LGO	20 working days (S1) or up to 6 months (complex cases)	Also 10-day target (not using extended timeframes)

Note: Although statutory complaints allow extended timeframes, Haringey currently applies a 10-day response target across both routes. This may be placing **undue pressure on services** and increasing escalation rates, especially for complex statutory cases.

2024/25 Observations:
- 63% of complaints were processed as Statutory, 37% as Corporate.
- Of the 18 Stage 2 Corporate complaints, 8 of these should have followed the Statutory route.
- Of the 42 Ombudsman decisions, 1 had incorrectly gone through Stage 2 first.

2025/26 Improvements:
- A new filtering process was introduced: all Adults complaints are now reviewed by a Manager before route assignment.
- Early data shows a shift: 70% Statutory, 30% Corporate — indicating improved accuracy.

Recommendations:
- Training from Adults colleagues to help further improve initial triage.
- Consider amending our internal timeframes for statutory complaints to align with national guidance and reduce service pressure.

Stage 1 Complaints & On-time Responses

Responding to Stage 1 Complaints On Time

Against our Corporate 10-day SLA, 254 complaints were responded to in 2024/25, with 42% answered on time — a notable improvement from 33% the previous year. When assessing the Statutory share of cases against the LGO's 20-day SLA, performance increases to 63% and 51%, respectively.

Current year-to-date figures for 2025/26 remain broadly in line with last year's performance:

% of S1 responses sent on time (higher is better)				
Response timeframes	2023/24	2024/25	YTD	Direction
10-day for both case types	33%	42%	49%	↑
10-day for corporate / 20-day for statutory	51%	63%	63%	↑

Adults Social Care is reviewing its complaints process to improve efficiency, resolutions and response times, by:

- Introducing a **Complaints Lead Officer** role to streamline caseload management, reduce duplication, and maintain oversight.
- Adopting a **de-escalation approach:** focus on resolving issues collaboratively rather than escalating to the Ombudsman, while preserving residents' rights.
- Considering the **20-day investigation timeframe** to support timely, meaningful resolutions.

LGO: Performance Overview

LGO Decisions 2023/24 vs 2024/25

In 2024/25, the total number of decisions increased by 68% compared to the previous year. However, of the 42 decisions made, **20 cases (48%) were assessed and closed without progressing to a formal investigation:**

	Assessed & Closed		Accepted & Investigated			
Period	Not ready / not for the LGO	Closed after initial enquiries	Not upheld	Upheld	Total Decisions	Upheld rate (%)
2023/24	13	4	1	7	25	88%
2024/25	8	12	2	20	42	91%

Remedy and Compliance Outcomes 2024/25

Among the 20 upheld complaints in 2024/25, a satisfactory remedy had already been offered prior to LGO involvement in 1 case (5%). The LGO issued compliance actions in 16 cases, with 100% compliancy achieved:

Upheld complaints	Upheld rate (%)	Satisfactory remedy offered before reaching LGO (%)	Cases with a compliance outcome recorded	Compliance satisfaction rate (%)
20	91%	5%	16	100%

LGO: Breakdown of Upheld Decisions

📊 Outcomes

- 20 upheld from 22 investigated (91%)
- **Satisfactory remedy** offered before LGO involvement in 1 upheld case (5%)
- **Compliance action** required in 16 cases with 100% compliance satisfaction achieved.

💰 Compensation

- **Total** payments ordered: £18,030
- Ordered in 17 of the 20 upheld cases
- **Average** payment per upheld case: £902

🛠️ Common Issues:

- **Poor complaint handling** (e.g. delays, incomplete responses) in 5 upheld cases.
- **Financial assessment/appointee** errors or delays in 6 cases.
- **Carers assessments** delayed or completed incorrectly in 4 cases.
- **Residents charged for care** that we should have provided in 3 cases.
- Delays in **DFG applications/adaptations** in 3 cases.
- **Unsuitable supported housing / placement** issues in 2 cases.

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LGO: Themes From Upheld Decisions

⏳ Service Delivery Delays

- Extended timelines for care assessments and adaptations
- Delays in providing necessary equipment
- Disabled Facilities Grant (DFG) delays

💬 Poor Communication

- Limited or infrequent updates to service users
- Unclear processes in complaint resolution
- Responses to enquiries lacking sufficient detail or timeliness

💰 Financial Process Issues

- Errors in care-related billing
- Delayed financial assessments
- Poor invoicing and account management

📋 Support Planning Gaps

- Delays in reassessing care needs
- Missing or outdated care plans
- Lack of advocacy or carer assessments

🛡️ Safeguarding & Risk Oversight

- Safeguarding referrals not handled in a timely or appropriate manner
- Missed mental capacity assessments
- Known risks not adequately addressed or followed up

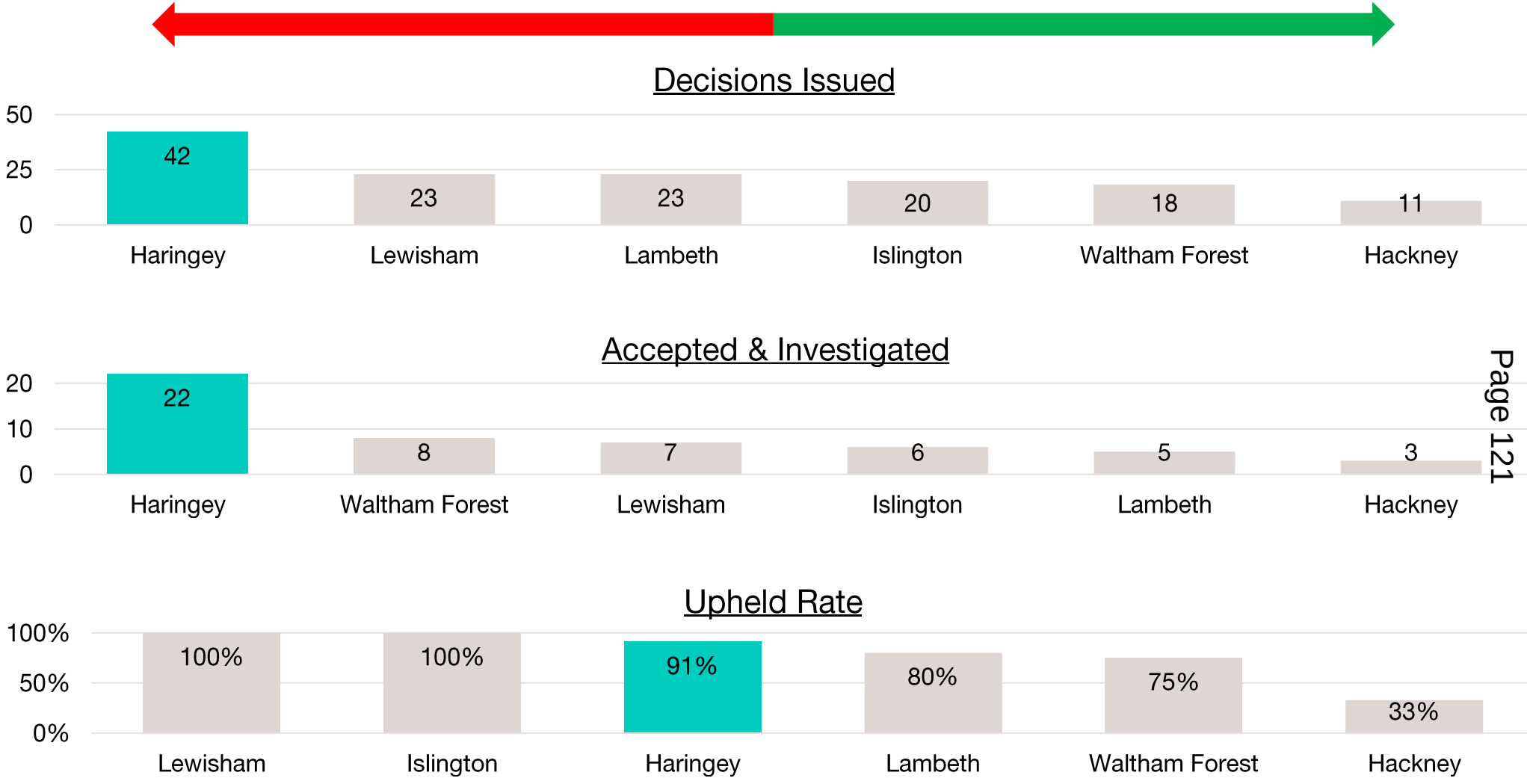
🧍 Impact on Dignity & Independence

- Unmet needs affecting daily living
- Emotional distress from unresolved issues
- Barriers to independent living

LGO Performance Benchmarking

These figures alone do not necessarily reflect poor performance. For example, high complaint volumes may indicate an accessible process, not poor service. As the LGO notes:

"…the number of new cases received doesn't simply reflect the number of problems people have with local services. There are lots of other factors to consider. For example… A high number of received complaints might reflect an organisation that is good at letting people know they can ask us for an independent investigation"



Data taken from the LGO Annual ASC Review of Councils 2024/25. Other London boroughs selected with a similar population size, demographic profile, and levels of deprivation.

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LGO Public Report: Mitigation and Improvement

✅Steps Completed

- **Cleared Correspondence Backlog**
  Successfully cleared backlog of emails and police reports following transfer to the new Frontline Response Team (May 2024) and Central Safeguarding Team.
- **Delivered Safeguarding Learning Sessions**
  Delivered Safeguarding "Lunch & Learn" sessions for staff in August 2025; "Learning from Ombudsman" session scheduled for Adults Safeguarding Week in November 2025.
- **Enhanced Governance Through Board Engagement**
  Strengthened governance and communication through proactive engagement with the new Safeguarding Adults Board Chair.
- **Review of the ASC Operating Model**
  The project is progressing well, with community support mapping nearing completion and aligned to the Digital Roadmap. Red Quadrant has been engaged to support the redesign of the ASC Front Door, which will integrate the new IEI team (formerly Connected Communities).

📌Next Steps

- **Adopt a De-escalation Approach**
  Focus on resolving issues collaboratively rather than escalating to the Ombudsman, while preserving residents' rights. Leveraging the 20-day investigation timeframe to support timely, meaningful resolutions.
- **Safeguarding Review scheduled for Autumn 2025**
  Led by the Safeguarding Circle and the new Chair of the Safeguarding Adults Board, aiming to improve triage and strengthen governance.
- **Workforce Development Plan**
  To meet growing demand and boost resilience, we're expanding the workforce and introducing new roles in social work, occupational therapy, and complaints management.
- **Review/Add New Complaints Lead Officer**
  Introduce a Complaints Lead Officer role to streamline caseload management, reduce duplication, and maintain oversight.
- **Full Representation at Key Governance Meetings**
  Feedback Team to be invited to Jo's quarterly management meetings and Sara's ASC/Housing Board sessions every six months.

Feedback & Resolutions Improvement Plan

✅Steps Completed

- **Expanded Feedback Team**
  The feedback team has expanded to improve Stage 2 and Ombudsman complaint handling, and ensure timely, comprehensive responses.

- **Oversight of Ombudsman Casework**
  Feedback Management retains oversight of all Ombudsman casework, with a strengthened focus on compliance, adherence to deadlines, and relationship management with the Ombudsman's office.

- **Case Tracking System**
  Implemented a centralised case tracking system to improve visibility and coordination across services, ensuring timely updates and consistent communication on complex cases (phase 2 to launch soon).

- **Enhanced Reporting**
  Enhanced reporting mechanisms to provide monthly insights to senior leadership on complaint trends, compliance risks and service-learning opportunities.

📌Next Steps

- **Power BI Dashboard Development**
  Creating a real-time dashboard to track Stage 2 and Ombudsman casework for improved monitoring and faster intervention.

- **Senior Management Briefings**
  Deliver targeted briefings to senior managers on emerging themes identified through Ombudsman decisions, enabling targeted response and resource allocation, and informing potential process changes or improvements.

- **Establishment of Ombudsman Learning Group**
  Form a cross-departmental group to share insights, embed learning and drive continuous improvement in complaint handling.

- **Complaint Handling Training**
  Integrate Ombudsman learning into staff training to enhance skills in managing complaints effectively and empathetically.

Closing Reflections: Commitment to Improvement

- We recognise the seriousness of the findings in the LGO Public Report and the impact this has on our residents' trust and experience.
- We are fully committed to improving our complaint handling performance, with clear actions underway — including policy revisions, strengthened oversight, and enhanced collaboration across services.
- We acknowledge the significant increase in casework volumes, particularly at Ombudsman level, which reflects both service pressures and the need for earlier, more effective resolution.
- To prevent recurring issues, we must embed learning from complaints into our culture, systems, and service design — ensuring that every case contributes to better outcomes for residents.
- This is a collective responsibility, and we are taking steps to ensure that governance, accountability, and transparency are at the heart of our approach.

Appendices

- LGO ASC review of councils: https://www.lgo.org.uk/information-centre/reports/annual-review-reports/adult-social-care-reviews
- Information on interpreting LGO complaint data: https://www.lgo.org.uk/information-centre/reports/annual-review-reports/interpreting-local-authority-statistics
- LGO good practice guide for Adults Social Care complaints: https://www.lgo.org.uk/information-centre/information-for-organisations-we-investigate/councils/guidance-notes/adult-social-care-complaints-reviews-and-appeals-a-good-practice-guide-for-local-authorities?chapter=4
- Haringey Annual Feedback & Resolutions Report 2024/25: https://www.minutes.haringey.gov.uk/documents/s153512/Feedback%20Resolutions%20Annual%20Report%202024-25%201.pdf

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Adults and Health Scrutiny Panel

Work Plan 2025 - 26

30th June 2025	• Adult Carers Strategy • Finance & Performance update (Q3) • Cabinet Member Questions – Adults & Health
22nd September 2025	• Finance & Performance update (Q1) • Connected Communities • Joint Partnerships Board review
13th November 2025	• Scrutiny of 2026/27 Budget and MTFS
16th December 2025	• Haringey Safeguarding Adults Board (HSAB) Annual Report • Local Government & Social Care Ombudsman – Upheld Complaints • Community Healthcare Equipment suppliers
9th February 2026	• Finance update (Q2) • Quality Assurance/CQC Overview • *Reablement Review (provisional)* • *Dementia update (provisional) (last update in Sep 2024)* • *Health and Wellbeing Strategy update (provisional) (last update in July 2024)* • *Adult Social Care Commissioning and Co-production Board (provisional) (last update in Nov 2023)*

Possible additional items

Issues arising from scrutiny consultation exercise:

- **Communications with residents**
- **Impact of Housing Conditions on Health and Wellbeing**
- **Autism Strategy 2021-2031**

Issues arising from previous work programme or follow up from current work programme:

- **Maternity Services** (North Middlesex University Hospital)
- **CQC Inspection** – Last update provided in March 2025. Several points specified for follow up, see minutes of meeting.
- **Aids & Adaptations** - Last update provided in March 2025. Several points specified for follow up, see minutes of meeting.
- **Aids & Adaptations** (Housing) – Possible joint meeting with Housing Panel on aids & adaptations and the bespoke housing programme.
- **Self-neglect and hoarding** – The Council's policy on self-neglect and hoarding is due to be refreshed in 2025.
- **Weight Management –** Panel to consider receiving information/data on performance on weight management initiatives.
- **Adult social care: New ways of working -** Panel to consider receiving more information about this in 2025/26 e.g. Invest-to-save, recruitment/retention, digital transformation, assistive technology, multidisciplinary working around adults, housing and health.
- **Care homes -** Panel to monitor shortage of care home places in Haringey and ongoing pressure on the sector.
- **Leisure Services** – While this is not directly under the remit of the Panel, it was suggested that there could be some joint scrutiny work on how the AHC Department could have an input into the promotion of leisure services to improve health and wellbeing.
- **Budget** – Some detailed work on what proportion of proposed savings from previous years were actually achieved and how they have been mitigated, including through the use of reserves.
- **Osborne Grove Nursing Home**
- **Health & Wellbeing Strategy** – Last update provided in July 2024. Next update suggested for late 2025/early 2026. A number of recommendations for issues to be included in the next update was specified in July 2024.
- **Gambling harms**
- **Dementia services** – Last update provided in September 2024. Next update suggested for summer 2025. A number of recommendations for issues to be included in the next update was specified in September 2024.

- **Smoke-free Strategy -** Last update provided in September 2024. Further update suggested for 2025/26 on work in schools on vaping, PSHE education and links with mental health teams.
- **Continuing Healthcare** – Last update provided in July 2024.
- **Modern Slavery** (including training for Police)
- **LGA Peer Review** – Further update to be scheduled. Previous update was in June 2023. Strategic plan is expected to be in place by Jan 2024.
- **Workforce reform agenda** – Further update to be scheduled. Previous update was in June 2023. At the previous update it was noted that the 30% vacancy rate in Adult Social Care represented a risk and so it would be useful to monitor staff turnover and the vacancy rate at the next update on this issue.
- **Integrated Care System** (ICS) – At a meeting in July 2022 it was suggested that a further report be brought to a future meeting including details on: a) the development of the co-design/co-production process; and b) the communications/engagement process for the next suitable new project.

Issues arising from savings tracker:

- **Direct Payments** – Panel to consider further scrutiny on how information about Direct Payments was being communicated to residents.
- **Grant Review (BCF-S75) –** Pressures on both sides and the potential impact on joint commissioning to be noted as an ongoing risk.
- **Supported Living Review –** Panel to monitor review and ensure that support levels for clients were being maintained as the savings were being achieved.

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