Haringey Safeguarding Adults Board

Annual Report 2019-20

This report details the work carried out by the Haringey Safeguarding Adults Board in 2019/20 and highlights our draft objectives and priorities for 2020-21.

http://www.haringey.gov.uk

Haringey LONDON

Forward

I am very pleased to introduce the Annual Report published on behalf of the Haringey Safeguarding Adults Board (HSAB), which includes contributions from its member agencies. The Board is statutory and its role is to coordinate local partnership arrangements to safeguard adults at risk of abuse or neglect. This report details the work carried out by the HSAB last year (2019/2020) and highlights the draft outline priorities for 2020/2021.

The current Coronavirus (COVID-19) pandemic has heightened uncertainty over the economy, employment, finances, relationships, and of course, physical and mental health.

Safeguarding adults remains a statutory duty and safeguarding adults' duties have not been 'eased'. Consequently, safeguarding adults in Haringey continues to be the responsibility of the HSAB, and all partner agencies, to keep everybody safe from abuse or neglect.

The HSAB would like to reassure you that we are working hard to maintain business continuity and remain committed to our statutory responsibilities for safeguarding adults with care and support needs in Haringey.

We have adapted our day to day work to include 'virtual' meetings and acknowledge that the pandemic continues to present new challenges for all partners.

We would ask all agencies to continue to remain vigilant in recognising and responding to potential additional safeguarding demands, especially those arising from the pandemic.

I am very grateful to HSAB partners for their continued commitment to safeguarding adults in Haringey, despite the wider pressures on their time and resources, especially during these difficult times.

Our work together over the last year demonstrates effective partnership working, which provides a sound basis to approach our priorities going forward. There continues to be an important adult safeguarding agenda in Haringey to reduce the risks of abuse and neglect in our communities, and I look forward to working with the partnership in the coming year.

Dr Adi Cooper
Independent Chair of Haringey Safeguarding Adults Board

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Where can you go for support?

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

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

What should I do if I suspect someone is being abused?

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

- **Telephone 020 8489 1400**
- **Email** Firstresponseteam@haringey.gov.uk

Out of hours emergency contact numbers

The numbers below are for emergency contacts only. For all other queries please use our online self-service tools (https://www.haringey.gov.uk/contact-haringey-council) which will get you to the information you need quickly and easily, and help you get a message to a Customer Service Officer if you have a complicated problem.

Haringey Council out of hours number

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

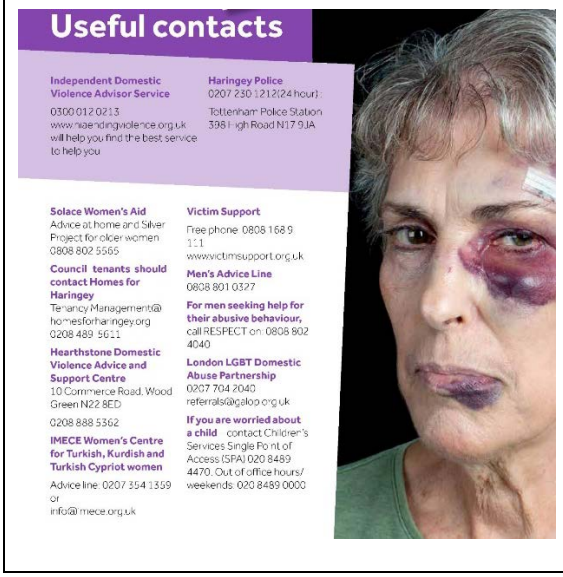
- **For emergencies and serious incidents requiring the police, fire brigade or ambulance service please call 999**
- **For non-emergency police advice or assistance please call 101**
- **For non-emergency medical advice or assistance please call 111**

GET SMART TO FINANCIAL ABUSE

WHAT IS FINANCIAL ABUSE?
This is when someone takes money or belongings without your proper consent, or through pressure or control

WHO COULD DO THIS (TO ME)?
Anyone can perpetrate financial abuse, whether they know you or not. It could be a family member, a friend, neighbour, carer, stranger or anyone you come into contact with.

WHO CAN HELP ME?
Share your concerns with someone you trust: a friend or relative, your GP, care worker, or social worker. Remember that financial abuse can involve criminal activity and should be reported so that it can be stopped.



ARE YOU A VULNERABLE ADULT EXPERIENCING DOMESTIC ABUSE?

WHAT IS DOMESTIC ABUSE?
It's any type of controlling, bullying, threatening or violent behaviour between people in a family, relationship or past relationship over the age of 16.

WHAT COULD HAPPEN?
Stopping you going out or seeing friends, taking your phone away, controlling your money, using physical and/or sexual violence

WHO CAN HELP?
You can contact the independent domestic abuse advisor who will help you find the right support. You can also contact Haringey police, your doctor, Hearthstone or Solace.

KNOW SOMEONE AFFECTED BY SELF-NEGLECT OR HOARDING?

WHAT IS SELF NEGLECT?
Self-neglect is when a person does not attend to their basic care and support needs, such as personal hygiene, appropriate clothing, feeding or taking care of their health or any medical conditions they may have.

WHAT COULD HAPPEN?
High levels of clutter make it much easier for a fire to start and create a greater risk of fire spreading, increasing the risk of injury and death.

WHO CAN HELP?
If you are concerned about immediate safety call emergency services. You can contact the Fire Brigade for a home fire safety visit. Contact the council for safeguarding concerns and a range of organisations can provide support.

Introduction

The HSAB annual report covers the period 1st April 2019 to 31st March 2020 and is produced as one of the Board's statutory duties under *The Care Act 2014* and described in Chapter 14[1] of the Care & Support Guidance. The SAB must publish an annual report in relation to the preceding financial year, on the effectiveness of safeguarding activity in the local area.

The report gives details of progress on our priorities and the Haringey Strategic Plan 2018-21[2]. It sets out how effective the HSAB has been during 2019-20; providing detail on the SARs that it has commissioned and describing how its partners have contributed to the work of the Board to promote effective adult safeguarding.

What does safeguarding adults mean?

Safeguarding means protecting the health, wellbeing and human rights of adults at risk, enabling them to live safely, free from abuse and neglect. Safeguarding is everyone's responsibility.

It is about people and organisations working together to prevent and reduce both the risks and experience of abuse or neglect. It also means making sure that the adult's wellbeing is supported and their views, wishes, feelings and beliefs are respected when agreeing on any action.

Staff should work together in partnership with adults so that they are:

- Safe and able to protect themselves from abuse and neglect;
- Treated fairly and with dignity and respect;
- Protected when they need to be; and
- Able easily to get the support, protection and services that they need.

Who is an 'adult at risk'?

An 'adult at risk' is someone who may be in need of help because they have care and support needs. They may be unable to stop someone else from harming or exploiting them.

Abuse happens when someone hurts you or treats you badly. It can be accidental or deliberate. Abuse can take many forms. There doesn't need to be an injury for abuse to have taken place. Neglect is when someone who is meant to look after you does not look after you properly.

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[2] https://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/haringey-safeguarding-adults-board-sab#strategicplan

What do we mean by abuse?

Abuse is described as a violation of an individual's human and civil rights by any other person or persons which results in significant harm. Abuse may consist of a single act or repeated acts. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

The aims of adult safeguarding

- Stop abuse or neglect wherever possible;
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- Safeguard adults in a way that supports them in making informed choices and having control about how they want to live;
- Promote an approach that concentrates on improving life for the adults concerned;
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- Provide information and support in accessible ways to help adults understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- Address what has caused the abuse.

About Haringey Safeguarding Adults Board

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[3] and the Human Rights Act (HRA) 1998[4].

Our Strategic Role

The HSAB provides a forum for strategic discussion and agreement on:

- areas for improvement;
- policy issues;
- guidance for practitioners, commissioners and service providers;
- approaches to self-neglect;
- preventing abuse and neglect;
- addressing antisocial behavior, hate crime and domestic abuse; and
- the respective roles of the board, other boards and partners.

[3] https://www.legislation.gov.uk/ukpga/2005/9/contents
[4] https://www.legislation.gov.uk/ukpga/1998/42/contents

Our Vision

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

Statutory Duties

The Board has three core duties defined by the Care Act 2014:

- 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 safeguarding adults' reviews where serious abuse or death has occurred, and learning can take place.

Overarching purpose of the HSAB

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-centered 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.

Governance and Membership

HSAB is chaired by its Independent Chair, Dr Adi Cooper, and meets four times a year bringing partners together from: Haringey Council, Haringey Clinical Commissioning Group (CCG), North Central London (NCL) Health Trusts, Haringey Borough Police, London Fire Brigade (LFB), London Ambulance Service (LAS), , probation services, the voluntary sector (Healthwatch and Bridge Renewal Trust (BRT)) and lay members, representing health, care and support providers and the people who use those services across Haringey.

The Chair is accountable to the Chief Executive of the Local Authority in chairing the HSAB and overseeing its work programme. However, the Chair is accountable only to the Board for the decisions taken in that role. The role of Vice-Chair is undertaken by the Director of Adults and Health.

The Board is attended by representatives of the partner agencies with a high level of engagement and has a number of subgroups chaired by senior members from across the partner agencies.

Financial Arrangements

The work of the Board is financed by contributions from partner agencies, of which currently over 60% comes from the Council. In addition to financial contributions, partner agencies contribute significant amounts of staff time to support the delivery of the board's work programme, and to support training delivery

What have we done in 2019/20 through the Haringey SAB Subgroups?

The HSAB undertook significant work to consolidate its governance and to progress our strategic plan, which has clear delegated responsibilities to roles and sub-groups to ensure clear lines of governance and accountability

The HSAB subgroups facilitate focused work in line with the objectives of the 3-year strategic work plan. Each subgroup is chaired by a member of the Board. There has been a significant amount of work undertaken and completed by the Board during the period 2019-20 some of which is detailed below. *See Appendix 1 for the HSAB annual strategic priorities progress update.*

Safeguarding Adults Reviews (SAR) Subgroup

Chair: Chair of HSAB

Purpose: The purpose of the SAR Subgroup is to consider referrals for any case which may meet the statutory criteria for a Safeguarding Adults Review (SAR) under Section 44 of the Care Act 2014[5]. The Subgroup makes decisions against the statutory criteria; make arrangements for, and oversees, all SARs; and ensures recommendations are made, messages are disseminated and that lessons are learned.

The Care Act 2014 requires SABs to arrange a SAR when a case meets the statutory criteria: that is, when an adult 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 neglect or abuse.

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 in question happening again.

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

Achievements in 2019-20:

SAR referrals

Six SAR referrals have been received for consideration during 2019-20. One referral was found to meet the SAR criteria and a SAR commenced in October 2019. A multi-agency SAR Panel was set up to oversee the review, led by an independent chair and two independent reviewers. The review has been informed by chronologies and individual management reviews completed by agencies involved in the case, a multi-agency learning event with frontline practitioners and consultation with family. The SAR is due to report in 2020 and learning will be included in next year's SAB Annual Report.

Two further SAR referrals received in 2019-20 were found to meet the SAR criteria and will be included in a thematic homelessness SAR, along with another similar case, in 2020-21. The learning from this review will be included in a future SAB Annual Report.

The remaining three referrals were found not to meet the statutory SAR criteria, but learning identified by individual agencies has been shared with the SAR Subgroup.

An analysis of the six SAR referrals received in 2019-20 shows that all referrals involved suspected neglect or self-neglect, as might be expected. 67% of referrals were for females and 33% for males. Although the number of SAR referrals is small, this is broadly similar to the pattern of Section 42 enquiries in 2019-20, of which 55% involved females, and is identical to the breakdown of SAR referrals in 2017-18 (the most recent year for which there is comparable data).

In 2017-18, 83% of SAR referrals involved people aged 65 and over whilst only 17% of referrals in 2019-20 involved people aged 65 and over. Four referrals in 2019-20 involved the deaths of people at a relatively young age, from 41 to 60 years, therefore, this will continue to be monitored to identify any emerging trends.

Two thirds of the SAR referrals received in 2019-20 involved people from a White background and one third involved people from a Black background. This compares with 47% and 27%, respectively, of safeguarding concerns in 2019-20. It is difficult to draw conclusions from the small numbers of SAR referrals received, therefore, each SAR will reflect on the implications of ethnic background within the review.

Ms. Taylor SAR

In February 2019, the SAB published its second SAR[6] since the Care Act 2014 was implemented. The SAR looked at the death of Ms Taylor who sadly died in a fire at her home in October 2017, aged 71. Alongside publication of the SAR, the SAR Subgroup disseminated a 7-minute briefing to help agencies share the learning widely across their organisations. This was followed by the development of a multi-agency action plan for improvements identified by the review. The SAR Subgroup has monitored progress against this action plan throughout 2019-20. Some of the key improvements made are:

- Training in London Fire Brigade (LFB) person-centred fire risk assessment for agencies to identify fire risks and refer people for a home fire safety visit.
- Provision of monthly data to LFB on people at risk of fire for proactive visits.
- Adult social care review and assessment documents now include consideration of fire risks.
- SAB's self-neglect policy updated in line with review findings.

In November 2019, the SAR Subgroup held a learning workshop with SAB partners and North Central London (NCL) SAB colleagues to share findings of the SAR and the improvements made as a result. All attendees found that the workshop was a good use of their time, they got what they needed from the session and were clearer about the actions taken by partners.

A multi-agency workshop was also held in 2019-20 in response to a request from SAB partners, bringing agencies together to share information about their teams and accessing support for adults at risk. Feedback was very positive about having face to face contact with colleagues from different agencies.

SAR draft strategic objectives for 2020-21

- Routine monitoring, and support of people at high risk from abuse and management of high risks;
- Develop mechanisms to provide assurance of impact of change and learning from SAR's;
- Carry out an annual review to assess the impact and effectiveness of the work of the SAR Subgroup; and
- Develop a consistent approach to conducting and sharing learning effectively for a range of serious incidents including SARs, DHRs, Coroner's inquests.

[6] https://www.haringey.gov.uk/sites/haringeygovuk/files/sar_report_ms_taylor_2019_pdf_549kb.pdf

Multi-Agency Quality Assurance Subgroup

Co-Chairs: Assistant Director Commissioning (Haringey Council)**;** and Designated Professional for Safeguarding Adults (Haringey Clinical Commissioning Group)

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

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

Achievements in 2019-20:

- Continued to refine and improve the multi-agency adult safeguarding dataset (see performance section) to enable the partnership to be informed of local adult safeguarding activity and better placed to identify trends and patterns that the intelligence may highlight**;**
- Multi-agency performance framework is in place and data analysis is provided every quarter to the HSAB;
- Continued to liaise with other subgroups and working groups to ensure a joined up and consistent approach to the work is undertaken.

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

- The subgroup continued its cycle of policy development and review, and has worked to update and review a range of multi-agency policies and procedures including:

    - QA subgroup terms of reference
    - Quality Assurance Framework
    - Safeguarding adult's multi-agency self-neglect and hoarding protocol
    - Prevention strategy and delivery plan
    - HSAB Risk register

Safeguarding Multi-Agency Self-Neglect and Hoarding Procedure 2019-22

The Self-Neglect and Hoarding Procedure was jointly reviewed by Adult Social Services and the LFB, following the recommendations of the Ms Taylor SAR. The LFB's person-centred fire risk assessment is now embedded in the procedure and information around case-coordination and management of mental capacity has been strengthened. The HSAB agreed to the revised updated procedure.

Haringey Multi-Agency Section 42 (s42) Enquiry Framework and Guidance

The local s42 Enquiry Framework was updated in line with the London Associate Directors for Adult Social Care (ADASS) guidance. The document represents collaboration between the agencies on behalf of HSAB to provide a joint s42 Enquiry Framework by which we work in partnership to safeguard vulnerable adults from abuse. The guidance is for use by staff that manage or undertake a Statutory Safeguarding Adult Enquiry under s42 of the Care Act 2014.

Haringey Multi-Agency Quality Assurance Framework

The Mult-Agency Quality Assurance Framework (QAF) was revised and presented to the HSAB for agreement. The QAF evidences whether the right things are being done for the right reasons in the right way and enables the use of information to secure greater impact and effectiveness.

QA Subgroup draft strategic objectives for 2020-21:

- Collaborate and conduct deep-dives on areas of practice, use of MCA for the victim and survivor's journey;
- Ensure MSP is embedded in safeguarding practice across the partnership;
- Improve understanding of and responses to older people at risk of or experiencing domestic abuse across the partnership and make links to the Violence Against Women and Girls (VAWG) strategy; and
- Embed multi-agency case file audit to ensure learning from safeguarding cases is embedded in practice.

Prevention and Learning Subgroup

Co-Chairs: Workforce Development Change Manager (Haringey Council), and Haringey Borough Metropolitan Police Service

Remit: Oversee the delivery of the Haringey Safeguarding Adults Prevention Strategy 2017-20[7], and development and coordination of multi-agency safeguarding adults training provision.

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

Achievements in 2019-20:

- The subgroup continued to monitor safeguarding performance data produced by the council and followed up with a number of deep dives to understand the local picture better. This included investigation of community backgrounds of those facing safeguarding issues and where they may be under-reporting. Links were made with Haringey Multi-Faith forum, Neighborhood Watch and the Bridge Renewal Trust to improve understanding of safeguarding and encourage reporting of concerns in hard to reach parts of the borough's diverse communities.
- In addition to on-going safeguarding staff training used by all partner organisations, partners also developed and ran a number of multi-agency events. Follow- up evaluation identified actions staff were putting in place to improve their practice. The *'Why MCA simulation training'* was run over 10 sessions with 330 attendees and was shortlisted for a national NHS training award.
- Changes were made to council processes to ensure staff took the time to find out what people wanted a safeguarding investigation to achieve. Recording on council systems improved. Statutory partners ensured MSP were embedded in their inhouse training and staff understood their responsibilities. For e.g., LFB rolled out a new training package, Police included themes of MSP in their PDD development days. Work carried out in BEH mental health trust saw links made between training and staff practice with patients. A special mini workshop was held for SAB members in January 2020 charting progress to date and outlining key actions to further embed MSP for the coming year.

[7] https://www.haringey.gov.uk/sites/haringeygovuk/files/haringey_adult_safeguarding_prevention_strategy_2017-2020.pdf

- The previous basic awareness e-learning material was replaced by 5 short animated videos and a quiz to test understanding. The videos are on the Council's Fuse learning portal for staff, and freely available on the council's website, as well as on the website of Bridge Renewal Trust for the voluntary sector and on YouTube where there have been over 19,000 views.

Understanding safeguarding videos

We have produced a series of short videos to help you understand what safeguarding is, how to recognise the signs of abuse and what to do to report it.

The videos are particularly designed for people who work within an organisation as a paid or voluntary worker but could be of interest to others too.
https://vimeo.com/showcase/6206013

- LFB continued to run fire safety checks across the borough in people's homes and responded to about 15 referrals per month. A number of visits and sessions were run in the community to raise staff awareness of fire safety. These were run in care homes, on location in home care provider locations and in Haringey Civic Centre.
- Awareness raising about different safeguarding themes and leafleting were carried out a Wood Green Customer Service centre, Marcus Garvey Library and a range of GP surgeries across the borough.
- The 2017-2020 Haringey Adult Safeguarding Prevention Strategy continues the ongoing commitment of different agencies and partners involved with adults to promote safety, prevent abuse and protect vulnerable adults, whilst promoting an approach to enable adults to protect themselves; living their own lives and making their own decisions. The Strategy sets the strategic direction for prevention in adult safeguarding and the main priority areas of work for the different agencies and partners that care and support vulnerable adults in our community. It represents an ongoing collaboration between these partners using the Strategy as a framework for the partnership work in safeguarding adults at risk from abuse.

<u>Prevention and learning subgroup draft strategic objectives for 2020-21:</u>

- Ensure engagement of service users, carers and community and voluntary sector to ensure current concerns and trends are captured
- Use intelligence to identify key themes and raise awareness of abuse and neglect with staff, partners and the public through improved communications and campaigns

- People who are homeless are appropriately safeguarded and mechanisms are established to improve professional awareness and response around the complexity of health & care needs within the homeless cohort.
- People who are homeless are appropriately safeguarded and mechanisms are established to improve professional awareness and response around the complexity of health & care needs within the homeless cohort.
- Improve understanding of and responses to older people at risk of or experiencing domestic abuse across the partnership and make links to the VAWG strategy.
- Implement multiagency refresher training on understanding mental capacity and conducting mental capacity assessments, to include evidence from SARs on the significance of mental capacity in cases of self-neglect/service refusal/high risk.
- Deliver a programme of fire safety training in the use of person-centred fire risk assessment across all agencies
- Develop a consistent approach to conducting and sharing learning effectively for a range of serious incidents including SARs, DHRs, Coroner's inquests.

Some other key work from the HSAB and its partner organisations during 2019/20

Barnet, Enfield, Haringey Mental Health Trust
Review of the Mental Health Act

In October 2017, the government announced an independent review of the 1983 Mental Health Act (MHA). The review was tasked with making recommendations for improvements "in relation to rising detention rates, racial disparities in detention, and concerns that the act is out of step with a modern mental health system".

One of the recommendations from the review states more needs to be done to ensure safeguarding of patients to protect them from abuse. One of the lessons of incidents such as Winterbourne View is that local authorities have not always been involved to the extent that they should, and that the hospital has not engaged with the safeguarding process. This is despite the fact local authorities have a responsibility under section 42 of the Care Act to investigate any safeguarding issues, including those in private and mental health units in their area and that Trusts have a duty to co-operate with local authorities on safeguarding issues.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH) have strong working links with all three Safeguarding Adult Boards. Over the last four years, BEH have built on and developed a Safeguarding Strategy and associated work plan. Part

of this has been to build on the existing strong partnership working with a clear vision of ensuring there is a shared understanding of safeguarding process and responsibilities. This is particularly true of Haringey where we do not work under a Section 75 agreement. This mean there needs to be open and effective communication pathways with a clear understanding of responsibilities.

The HSAB was assured that the safeguarding arrangements support organisations discharge their safeguarding duties and that there are effective processes in place to identify, investigate and take action on safeguarding issues.

Fire Prevention Task and Finish Group

The HSAB agreed to set up a Fire Prevention Task and Finish Subgroup to deliver Objective P6 of the HSAB Strategic Plan 2018-21 to 'Establish routine monitoring and management of clients at high risk of domestic fires', considering links to the High Risk Panel (HRP) and providing assurance to the HSAB that a robust mechanism is in place to manage and monitor clients at a high risk of fire.

Much work has been done in learning from fire deaths and creating the Haringey Borough Community Fire Safety Strategy, which we expect to continue to develop as time passes.

The task and finish group has largely delivered its intended aims, with one action being monitored through the Ms Taylor SAR action plan and other actions to be picked up in the HRP annual report to SAB.

Public Health
Suicide Prevention in Haringey

The Haringey Suicide Prevention Group (HSPG) is an inter-agency partnership that has been established to guide the Borough's Suicide Prevention Plan. A new plan is due to be developed in 2020. It aims to shape and strengthen community-based suicide prevention planning and implementation.

The HSPG is coordinating local action planning to reduce deaths from suicide and supporting those affected by suicide, as well as ensuring that data and intelligence on suicide is collected and shared across agencies.

A local strategy can strengthen suicide prevention potential within existing work. The HSAB agreed to contribute to the development of the Prevention Plan and is committed to actions within the Suicide Prevention Plan.

London Safeguarding Adult Partnership Audit Tool

The HSAB agreed to pilot the first draft of the London Safeguarding Adult Partnership Audit Tool (SAPAT) which was developed at the request of the London Safeguarding Adults Board (LSAB) network.

The focus of the new audit process is to provide evidence of partners' contribution to the HSAB, evidence of partnership working to deliver the aims and objectives of the SAB, and for the SAB to be able to assess how effective it is as a partnership.

The new process aims to do something different, which is more focused on the partnership and the effectiveness of partnership working. It focuses on what agencies do in partnership, rather than what they are doing within their own organisation, unless it contributes to the partnership.

All statutory partner agencies including a number of non-statutory partners completed the toolkit which focused around 4 core areas:

i. Making Safeguarding Personal (MSP)
ii. Mental Capacity Act (MCA) application.
iii. Preparation for implementation of Liberty Protection Safeguards.
iv. SARs and Learning Reviews.

Areas of good practice identified across all partners and areas for improvement have been imbedded within the HSAB draft priorities for next year and in partner organisations action plans.

Haringey Safeguarding Adults Activity 2019/20[8]

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

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

The safeguarding statistics over the past three years are fairly consistent:

- mainly occurring in the adult at risk's own home;
- mainly older people (about half are aged 65+ years);
- with an over-representation of black minority ethnic groups; and
- the most common abuse types are neglect, psychological/emotional, physical abuse and financial abuse.

Adult Safeguarding Performance Summary

Number of safeguarding concerns and Section 42 Enquiries.

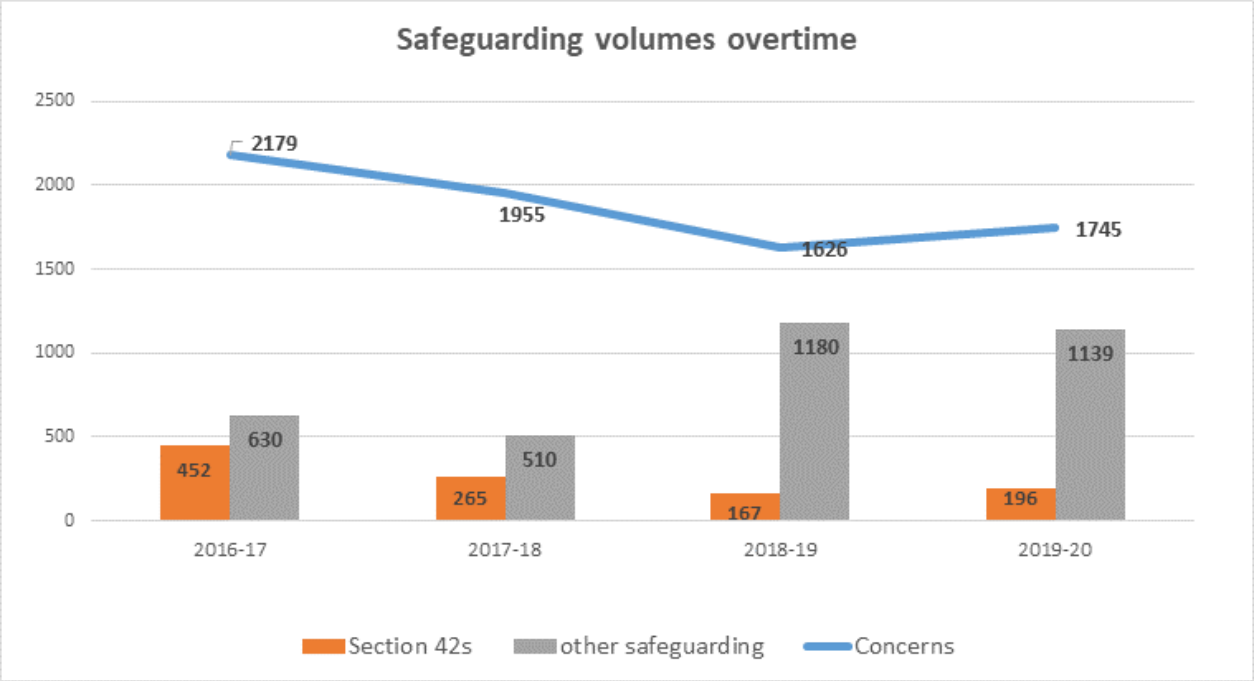
The Care Act 2014 sets out the statutory duties and responsibilities for safeguarding, including the requirement to undertake enquiries under Section 42 (s42) of the Care Act to safeguard people. Below and on the next page is a summary of safeguarding activity recorded during 2019/20 for both safeguarding concerns raised, and s42 enquiries undertaken.

There have been **1,745** concerns raised during the year 2019/20 of which only **194** went on to a s42 Enquiry. In comparison to last year, safeguarding concerns have has increased by approximately 7% and the number of s42's has also increased by **17%** from last year. **The s42 rate has increased from 79 per 100,000 ppn to 93.06 in 2019-20.** The number of s42's although is higher than

[8] Provisional data subject to SAT validation

last year, when compared to the rest of London (2018-19 data), we are below the statistical neighbours average.

The number of 'other safeguarding' (see definition of 'other' below) decreased by 3.5% last year from 1180 in 2018/19 to 1139 in 2019/20.



What do we mean when we say 'Concern'?

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

What do we mean when we say a Section 42 Enquiry?

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

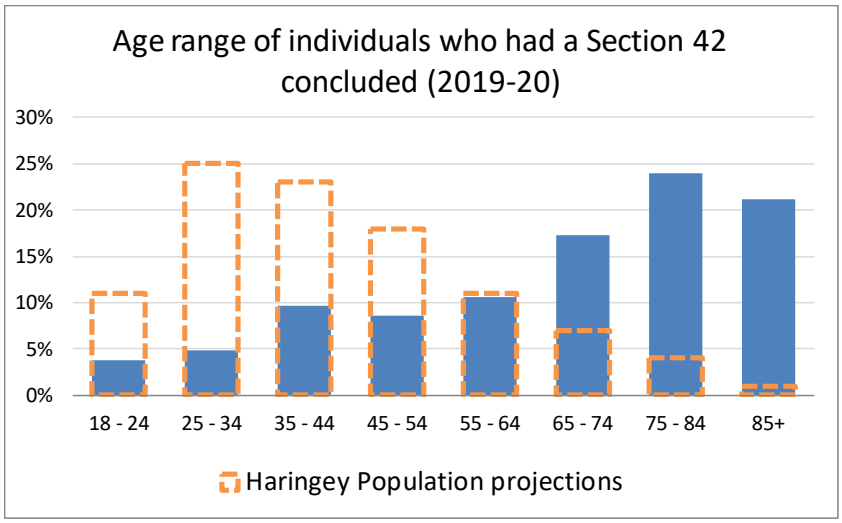
The number of referrals that are assessed as not meeting the criteria for s42 are still significant, they are known as 'Other' safeguarding concerns. The safeguarding service performs an important role in identifying safeguarding concerns that should progress to a s42 enquiry, undertaking these enquiries and

ensuring that any further actions required are progressed, such as referral for a Safeguarding Adult Review (SAR).
The service also takes responsibility for significant preventative action, such as a referral to other services or support, where a s42 Enquiry is not required, so that Other safeguarding concerns are managed appropriately.

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

Age of individuals involved in safeguarding concerns and s42 Enquiries

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

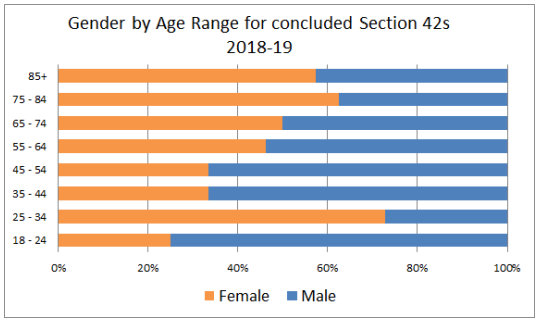


63% of individuals with a S42 enquiry are aged 65 and over, over-represented when compared to the age structure of Haringey's adult population. The largest percentage of s42's (24%) are from individuals aged 75-84. The national data

published in November 2018 notes that the majority of concerns raised in England as a whole relate mostly to those aged 85+.

Gender of individuals involved in s42 Enquiries.

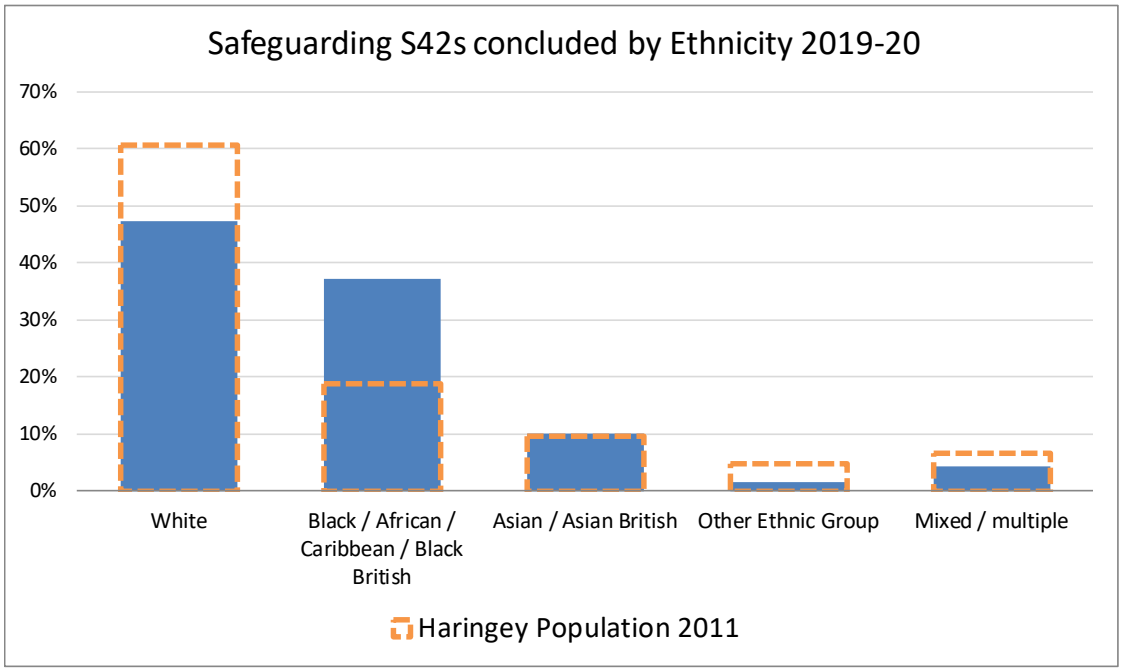
50% of individuals who had a s42 concluded are females, a 3% decrease from the previous year. The highest proportion of females who had a s42 concluded were aged between 75+. For concluded cases approx. 75% (6 cases) were from males aged 18-24.



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

Ethnicity of individuals involved in s42 Enquiries

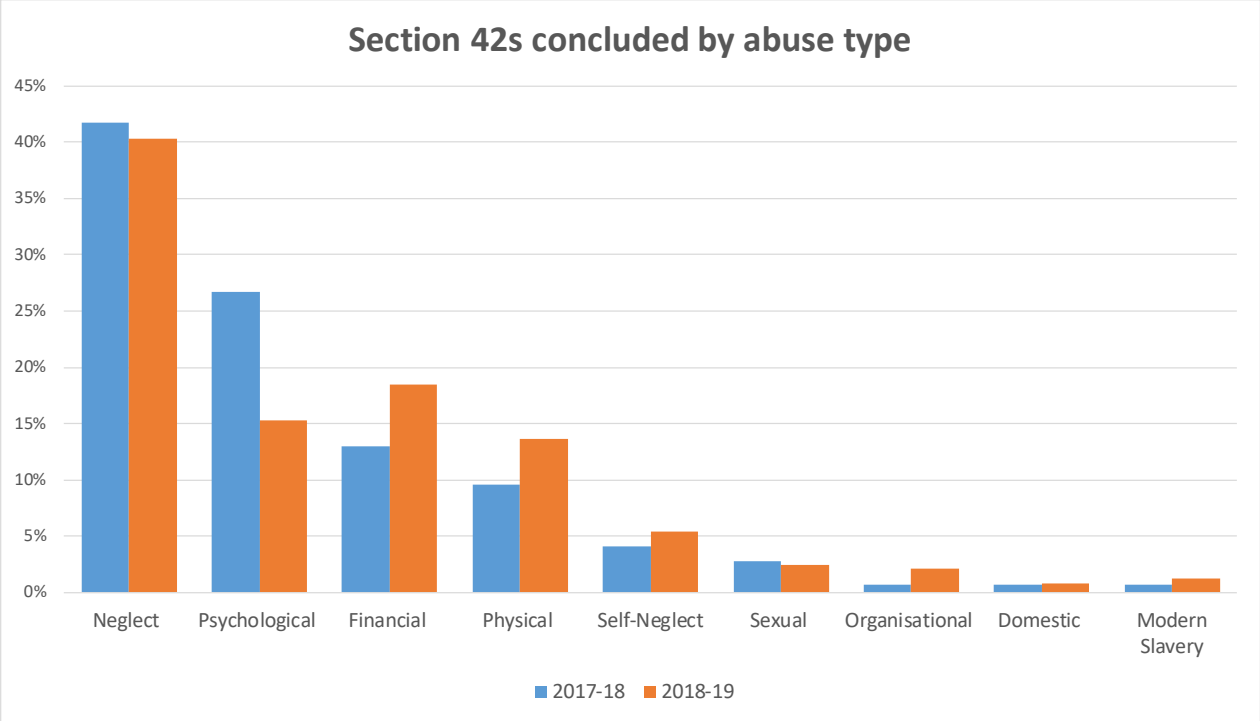
Year on year the ethnic background of people for whom a safeguarding concern has been raised remains similar, with the two main ethnic groups being White and Black/African/ Caribbean/Black British



47% of individuals who had s42 concluded are White, a 14% decrease compared to the previous year, underrepresented compared to Haringey's population. 37% are Black, an increase of 10% from previous year but over-represented when compared to the Haringey population 19%.

Safeguarding Concerns by abuse type

Proportionately, Neglect and Acts of Omission account for the majority of risk types, accounting for 26% of all risk types in 2019-20, down from 40% in the previous year. This is in line with the 2017-18 national data.



There has been a decrease in financial abuse cases (7%) and an increase in self-neglect cases (7%), followed by an increase in emotional/ psychological cases by 6% and an increase in domestic abuse cases (6%) when compared to previous year. Only 9% of the safeguarding concerns were related to domestic abuse, similar to 2017-18 reporting.

Hate crime is monitored through our safeguarding process however small numbers have been reported in 2019-20.

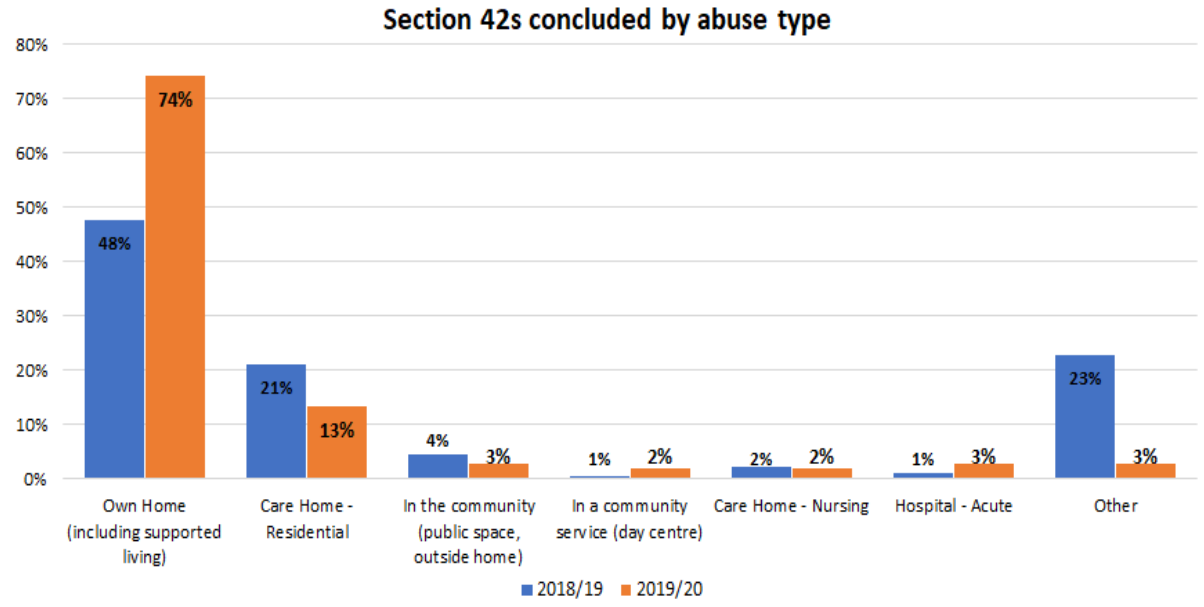
The number of organisational abuse cases has decreased, this is due to the increased scrutiny of care homes from the Commissioning arm of the Local Authority and the Clinical Commissioning Group (CCG) Quality Assurance nurses which is monitored by the multi-agency Quality Assurance subgroup.

Section 42s concluded by location of abuse

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

The abuse location profile remains similar for the last two years, with abuse most commonly occurring in the person's own home.

The home of the adult at risk accounted for 74% of the risk locations in 2019-20, an increase of 26% to the previous year. This is in line with the 2017-18 national data. Abuse location in residential care homes decreased by 8% this year.

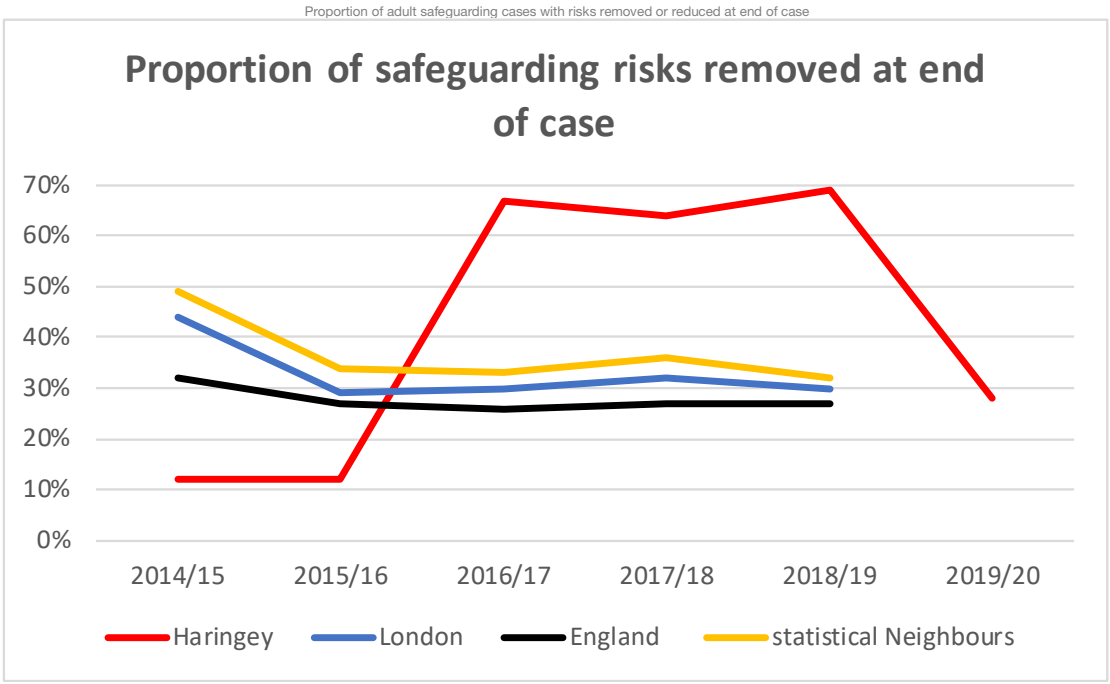


National and Regional data show a similar pattern within the home being the most likely area that abuse occurs, followed by care homes, community and then hospital.

In 'other' abuse location decreased by **20%** from previous year, this is due to better recording.

Risk outcomes

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



The proportion safeguarding cases where the risks were removed decreased by 41% since 2019-20. Despite the decline, Haringey is in line with the regional and national average.

The proportion of safeguarding cases where the risks were increased by 43% compared to previous year and is above the regional and national average.

Making Safeguarding Personal

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

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

The use of the Mental Capacity Act has been a feature in a number of safeguarding adult reviews and has formed part of the agenda at learning forums. Also, many safeguarding situations are complex, often involving the actions of friends or relatives, and the problems created are seldom easy to resolve.

The person's desired outcome may not always be achievable. During 2019/20 we recorded these outcomes for the **93%** of enquiries undertaken (see breakdown below of those that expressed their outcomes and those that did not). This is an increase compared to last year where **68%** of s42 enquiries were asked to express their outcomes. Breakdown of individuals who expressed an outcome and those that did not:

- **80%** of individuals who had a s42 concluded were asked and their outcomes were expressed; and
- **13%** of individuals who had a s42 concluded were asked but did not express their outcomes.

For those individuals who expressed their desired outcomes, **93%** had their outcomes fully or partly met in in 2019-20.

A combination of learning and process development has been put in place to ensure that all people with a safeguarding concern are asked about their desired outcomes, including the following:

- Improvements to the safeguarding reporting process and workflow;
- Importance of recording (I.e. good practice, empowering for Adult, accountability) reiterated to team in huddles
- Where discussions with Adult/family clearly not documented, work returned by management and triaging Officer asked to demonstrate discussion or attempts to have discussion undertaken and outcomes recorded.

Appendix 1 – Strategic Priorities update 2018/19

Many of our partner organisations have been involved in the front-line response to the Covid-19 pandemic. Some of the objectives and actions have not been achievable this year while the partnership focus on their front-line response. As a result, a number of actions have been carried forward into next year's priorities yet to be agreed. The focus on next years priorities may be amended during the year to reflect shifting priorities and risks as they develop.

ASSURE PRACTICE – We are assured that safeguarding practice is person-centred and outcomes focused

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
A1	Collaborate and conduct deep-dives on areas of practice, such as MSP, DoLS, use of MCA or the victim and survivor's journey	Protection Proportionality Prevention	Assurance that partner organisations are working to best practice and working to improve any areas of concern.	Quality Assurance Subgroup	Monitor the effectiveness of the application of mental capacity assessments through multi-agency case file audits.	March 2020	Multi-agency Audit discussed at QA subgroup; responses received from the audit was not enough to base any learning from. If the audits will not work, will need to think of other ways to meet the objective of monitoring the effectiveness of the application of mental capacity assessments and implementation of MSP. We are clear that lessons have been learnt so that criteria for the next audits will ensure a more in-depth analysis. Principal Social Worker working with safeguarding team and performance to identify cohort for next round of audits.
					Monitor implementation of MSP through multi-agency case file audits.	Dec 2019	Partners do not monitor MSP implementation. HSAB hosting an MSP Workshop put on hold. Was scheduled for January 2020 with 3 case studies identified (hoarding, hospital discharge, and risk).
					Undertake multi-agency MCA Audits to provide assurance to the Board that partner agencies are identifying and delivering training	Ongoing	Impact assessment of MCA training form community matters completed, and included in report to SAB. The audit document was circulated to partners. Information returned will be evaluated.

					on MCA, and that MCA assessments are being completed as required; and that practice is being impacted as a result. This will also include the opportunity for partners to provide examples of exemplary practice in the area of mental capacity and share any tools.		
					Support delivery of the proposed changes in Liberty Protection Safeguards legislation (due to come into force in 2020.	TBC (expected mid-2020)	Agreed to run LPS workshop in May 2020 to look at the changes and implications of the introduction of the LPS. This has been put on hold.
				Prevention and Learning Subgroup	Increase MCA awareness and plan training of MCA following MCA new code of Practice being published.	March 2020	Council MCA training will run again from April 2020- in discussion with Legal services. Any further multi-agency training needs funding.
A2	Ensure MSP is embedded in safeguarding practice across the partnership	Prevention Empowerment	The Board is assured that the safeguarding workforce is person-centred and understands MSP; and the system is focused on prevention.	Performance Team Safeguarding Adults Team	Local authority to carry out minimum of 5 surveys quarterly and analyse outcomes and trends.	Quarterly	Principal Social Worker working in conjunction with Performance team and Safeguarding team to deliver. To date 5 interviews have been undertaken although only 2 have provided enough information that can be used. We will wait for further information from other interviews to be gathered before providing some structured feedback as to findings so far.

			The principles of MSP are at the heart of the organisation's safeguarding practice by threading MSP across all SAB's subgroup activity, including communications, community engagement, quality assurance, learning and development, and workforce development	Quality Assurance Subgroup	Using the MSP outcomes framework to provide a means of promoting and measuring practice that supports an outcomes focus for safeguarding adults work.	March 2020	To be discussed at a future QA Subgroup meeting.
				Quality Assurance Subgroup	Ensure that all staff/professionals from all organisations ask people about outcomes at the point of concern; that this is recorded and analysed so that SAB can see the extent of partner engagement in MSP.	March 2020	Changes have been made to the ASC system to ensure that the MSP can be effectively monitored in regard to the requested outcome of individuals and therefore assurance that MSP is a priority. Other organisations do not monitor MSP. Practice ascertained through agency training examples and case file audits
				HSAB	Seek assurance on the impact of MSP through the annual London Safeguarding Adult Partnership Audit Tool	Dec 2019	The HSAB piloted the new draft London Safeguarding Adult Partnership Audit Tool. Section 1 of the toolkit is on MSP. Findings from the toolkit presented to the HSAB meeting in January 2020. Any actions/recommendations arising from the SAPAT with regard to MSP will feed into the MSP planned workshop in January 2020.
				Prevention and Learning Subgroup	MSP is integral in all training commissioned by the board and partner organisations; which staff are trained and areas of staff development	March 2020	Partners have shared examples of training content. ME working with JD around Police training. Contact to be made with Tower Hamlets/Hackney Police re MSP briefing for frontline practitioners.

				HSAB	Consider an MSP workshop at a future SAB meeting, working around case studies across the partnership.	March 2020	Discussed at Haringey Chairs Exec subgroup and the QA subgroup. Proposal for workshop in January 2020 put on hold.
				Bridge Renewal Trust/	The Bridge Renewal Trust to assist VCS organisation to understand their roles in MSP through attendance at VCS forums and regular e-bulletins.	Dec 2019	Reworded in 2020-21 strategic plan.
A3	Embed multi-agency case file audit to ensure learning from safeguarding cases is embedded in practice	Protection Prevention	The Board is assured that learning from case file audits is embedded and leads to improved safeguarding practice Regular cycle of audits planned	Quality Assurance Subgroup Multi-Agency Case File Audit T&F Group:	Monitor the effectiveness of practice and learning from SARs through multi-agency case file audits.	March 2020	Multiagency Audit discussed at QA subgroup; responses received from the audit was not enough to base any learning from. If the audits will not work, will need to think of other ways to meet the objective of monitoring the effectiveness of the application of mental capacity assessments and implementation of MSP. Principal Social Worker working with safeguarding team and performance to identify cohort for next round of audits. This is also embedded in the Safeguarding Adult Partnership Audit Tool and the MCA case file audit.

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
P1	Ensure engagement of service users, carers and community and voluntary sector	Prevention	The Board is assured that the engagement of service users and the voluntary community sector	Bridge Renewal Trust (BRT)	Focus on underreporting within specific communities through the BRT and the Adults Joint Partnership Board	March 2020	Reworded in 2020-21 strategic plan.

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
	to ensure current concerns and trends are captured		and their priorities is feedback to the Board	HSAB Prevention and Learning Subgroup	Establish and maintain a feedback mechanism for priorities to/from Joint Partnership Board	Ongoing	The Joint Partnership Board presented a paper to the HSAB in May on a number of safeguarding issues and how best to utilise local networks to promote awareness of safeguarding issues in the Borough. The HSAB has provided a FAQ on the concerns and the HSAB Chair, along with other officers attended the JPB in September to address the safeguarding questions raised by JPB members and to raise awareness of adults safeguarding. The meeting provided a helpful opportunity for dialogue between the HSAB, JPB members, and the community groups that they represent. Following presentation and mini-training sessions to the multi faith forum over the summer there are now contacts in place to share issues connected to adult safeguarding.
P2	Use intelligence to identify key themes and raise awareness of abuse and neglect with staff, partners and the public through improved communications and campaigns	Prevention Empowerment	The Board is assured that there is a cycle of well-informed public campaign and communications in place with evaluation criteria that includes measuring access and impact.	HSAB/ Bridge Renewal Trust	Support development of capacity in the community and voluntary sector to raise awareness of adult safeguarding and working with risk.	March 2020	BRT has now completed all 6 of its face to face safeguarding awareness training sessions to VCS organisations. A total of 66 people has been trained over the past 12 months. In addition, a new online training portal was launched via BRT's new website on 1 September 2019. This links to Haringey's new safeguarding training videos. Quizzes have been embedded after each video to check for understanding and upon completion; users receive a certificate and feedback on their responses. To date, 69 people have completed the online training. An evaluation of the face to face training found that 83% of respondents rated the training as excellent and 17% rated it good.
				Prevention and Learning Subgroup	Disseminate campaign/information and posters (easy read) to raise awareness of safeguarding issues in	Ongoing	The 5 short videos are now available on the council website, BRT website and the council learning portal. There is also a quiz to test understanding. The videos replace the e-learning course. Very positive feedback received. **Council** monitoring take up through corporate induction

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
					wider public and make easily accessible. Producing and promoting safeguarding animated videos.		Review included in annual training report P&L Subgroup will work to make best use of posters produced during 2018 & 19 on self-neglect & hoarding, financial abuse and modern slavery. Leaflets made available at events such as VCS Expo 2019, Quarterly Neighbourhood watch coordinator meetings
					Undertake impact assessment of public awareness material	Dec 2019	Ongoing work with CCG on visits to GPs & leaflets to pharmacists, BRT links to website use and follow up with others receiving e-posters.
							2 Briefing sessions on using High Risk Panel (HRP) during Adults Safeguarding Week. **COMPLETED**
					Continue cycle of awareness raising campaigns for safeguarding adults informed by statistical data	From June 2020	Will be informed by ongoing statistical monitoring, deep dives and comparative work with Met data.
P3	Routine monitoring and management of clients at high risk of domestic fires	Prevention Protection	The Board is assured that a mechanism to monitor and manage high fire risk clients (smokers, hoarders, bed bound, etc.) has been embedded in practice.	SAR Subgroup	Provision of monthly data relating to clients at risk of domestic fire to LFB.	Ongoing	Since February 2019, monthly data has been shared by the LBH Performance Team with the LFB. The data provides details of clients who are bedbound, heavy smokers, and/or those who have requested a home fire safety visit.
					LFB to undertake Home Fire Safety Visits at clients' homes.	Ongoing	LFB continue to undertake home fire safety visits clients' homes. In total last year LFB in Haringey carried out over 2000 home fire safety visits in the Borough. LFB staff have delivered fire safety information and ensured that identified risks have been managed through suitable means (such as provision of fire-retardant bedding, testing and fitting of detection and alerting systems and safeguarding referrals where appropriate). LFB staff are

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
							provided with continuous training to ensure they understand how to carry out a fire risk assessment and employ suitable control measures.
					Promote updated multi-agency Self Neglect & Hoarding procedure and develop briefings and awareness training to support	Dec 2019	Revised Hoarding Protocol agreed by the HSAB in October 2019. Design work begun to undertake multi agency needs analysis for procedure implementation. Survey conducted, results to be fed into plans for 2020 training offer and information to partners.
					High Risk Annual Report to SAR Subgroup/SAB	July 2019	The HRP was set up in response to a fire death a few years ago. All partner agencies need to take the advantage that there is a mechanism in place in Haringey to discuss and have conversations across the partnership on how to support people in these circumstances. High risk panel continues to meet in its current format. In conjunction with ongoing meetings there is also work being carried out by a core group of managers to develop and improve the offer. Two meetings were undertaken in November 18th and 20th with staff from multiple agencies and organisations to understand knowledge of views of how panel currently operates and improvements that could be made. It should be noted that professionals will attend the Community MARAC event (21/11/20) to avoid any duplication between the two offers.
P4	People who are homeless are appropriately safeguarded and	Prevention Partnership	The Board is assured that people who are homeless are	Prevention and Learning Subgroup	Develop & deliver awareness training for staff and partners	Dec 2019	3 multi-agency awareness briefings running in Sept, Oct & Nov. More specialist topics to be developed from Dec onwards and rolled out in early 2020. Briefings well received.

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
	mechanisms are established to improve professional awareness and response around the complexity of health & care needs within the homeless cohort.		appropriately safeguarded. Develop links with the Homelessness/ Rough Sleepers Strategy.		Embed learning from Homelessness Fatality Review process into safeguarding practice	March 2020	Several meetings have taken place to discuss this. A process for submitting-processing-collaborating around homelessness safeguarding alerts is now going to be worked up between First Response Team (FRT) /Safeguarding and Rough Sleeping Teams.
					Widen the scope & membership of the High-Risk Panel to include people who can advise on homelessness and include cases where people are homeless or rough sleeping and awareness	March 2020	Safeguarding lead for BEHMHT has now been invited to sit on the HRP membership. Report on how the panel can be more effective and a review of it terms of reference to be presented to the HSAB meeting in January 2020. In conjunction with ongoing meetings there is also work being carried out by a core group of managers to develop and improve the offer. Two meetings were undertaken in November 18th and 20th with staff from multiple agencies and organisations to understand knowledge of views of how panel currently operates and improvements that could be made. Subject to this feedback core members of the existing panel met 23/12 15/11 to action the amendments this includes representation from the Single Homelessness & Vulnerable Adults team.
				Homelessness lead	Homelessness and Rough Sleeping Annual Report to SAB	March 2020	The Homelessness and Rough Sleeping Annual Report will be presented to the next Board meeting.
					Develop a toolkit for safeguarding and social care practitioners working with homeless people	March 2020	A number of local learning events and workshops was delivered in Sept-Dec 19 and feedback informed the toolkit development. The toolkit developed by Barnet SAB Chair Fiona Bateman and Voices, from the national safeguarding conference series (led by Adi Cooper) has been adopted.

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
P5	Undertake preventative and proactive work to support those subjected to modern slavery/ human trafficking /forced labour/criminal exploitation/domestic servitude and continue to raise public awareness	Empowerment Partnership Prevention Protection	The Board is assured that there is a cycle of well-informed campaigns and communications to raise public awareness	Prevention and Learning Subgroup/ Public Health	Monitor effectiveness of awareness briefing sessions run in 2017/18.	Dec 2019	Future training and briefings will be linked to the new Policy.
					Develop Multi-Agency options training in line with the new Modern Slavery Policy.	TBC following publication of policy	Public Health working with Hestia (an organisation supporting people in crisis across London) to provide targeted training for Trading standards, Housing etc. Community training also planned.
					Modern Slavery awareness raising and financial exploitation.	TBC following publication of policy	Community awareness campaign lead by Public Health
			Local services will gather evidence, analyse risk, design interventions, and evaluate results. The Local Authority's anti-slavery strategy will be built on partnerships across the borough and with North Central London.		Link: Outcome 3 (Exploitation) of Haringey's Community Safety Strategy 2019 - 2023		The Community Safety Strategy presents the Haringey Community Safety Partnership's approach and priorities to achieving a reduction in crime and anti-social behaviour in Haringey up to 2023. A Community Safety Action Plan sets out the specific actions that community safety partners will take forward in order to address the issues identified in the strategy corresponding to the six outcome areas. Colleagues from within Community Safety are part of the strategic and operational group for modern slavery and have been involved in discussions to shape the developing strategy. The development of the modern slavery strategy will be mindful of Haringey's Community Safety Strategy 2019-2023. **COMPLETED**
				ASS Lead	Agree the inclusion of the following	TBC	To support the joined up development and implementation a Multi-agency modern slavery strategic group for Haringey

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
					associated milestone actions, timelines for delivery and action owners, into the delivery plan of Haringey's Community Safety Strategy 2019 – 2023: • Monitor effectiveness of awareness briefing sessions developed & delivered • Develop Multi-Agency options for stage 2 training • Modern Slavery awareness raising • The council will work to build a formal partnership across on modern slavery. This will set joint outcomes, progress monitoring and lines of accountability • The council will connect survivors to mental health		has been set up, chaired by the Director of Public Health. The objectives of the group are: • Overseeing and developing a modern slavery strategy for Haringey • Develop a clear protocol and pathway for referral of potential modern slavery victims across partners • Sharing and collecting data across partners • Raising awareness of modern slavery in partners and residents and taking action to prevent modern slavery and increase identification

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
					and trauma services as quickly as possible, following the guidance set out in the Human Trafficking Foundation's Slavery and Trafficking Survivor Care Standards		
				ASS lead	Agree twice yearly reporting to HSAB progress with the Community Safety Partnership (CSP) lead. The development and delivery of all actions will be monitored and managed by the CSP.	May 2020 and Sept 2020	The newly formed Multi-agency modern slavery strategic group will provide the leadership and coordination of this work going forward. Progress updates to the HSAB will be provided through this group going forward.
P6	Development of partnership wide transitional safeguarding response	Partnership Protection	The Board is assured of a more effective use of resources and the development of a Think Family approach to safeguarding. Improved approach and early help to	ASS lead and Children's lead	Joint CYPS & Adult Social Services to agree actions to progress start-up of joint working.	May 2019	Meeting held and agreed actions defined. **COMPLETED**
					Develop evidence-based summary paper that outlines the vison and purpose of the approach.	January 2020	AD Adults and CYPS Safeguarding Lead attended a Transitional Safeguarding Training event in September to inform and support developments. The target completion date of the summary paper deferred until March 2020 to allow additional evidence gathering/ analysis over 2 years.

PREVENT – We prevent abuse and neglect where possible

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
			safeguarding during transitional period		Develop and agree key milestones & success factors to deliver against vision and purpose.	March 2020	The milestones and success factors will be agreed following completion of summary paper in March 2020.

RESPOND – We respond to abuse and neglect in timely and proportionate way

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
R1	Develop a consistent approach to conducting and sharing learning effectively across the NCL area for a range of serious incidents including SARs, DHRs, Coroner's inquests	Prevention	The Board is assured that all deaths and other incidents involving serious abuse or neglect are assessed within the protocol and the process managed well with the focus from a range of experiences.	VAWG lead	Domestic Homicide Review Annual Report to SAB	Oct 2019	Deferred to present in 2020
				SAR Subgroup	Provide HSAB assurance that key findings from the SARs have been effectively incorporated into organisations' culture	March 2020	SAR Robert and SAR Ms Taylor action plans monitored by SAR Subgroup to ensure that improvements are made as a result of SAR recommendations. SAB partners have reported back on progress in delivering and embedding improvements at SAR learning events.
				SAR Subgroup	Commissioners are assured that providers are meeting their responsibilities in relation to the SARs	March 2020	Commissioning are currently working with the LFB to deliver briefing sessions to providers around fire risk and assessment. The quarterly provider monitoring report to SAB has also been expanded to include information about out of borough placements.
					Share 7-minute Ms Taylor briefing to the NCL.	Dec 2019	**COMPLETED**

RESPOND – We respond to abuse and neglect in timely and proportionate way

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2020
				Prevention and Learning Subgroup	LeDeR Annual Report to Prevention and Learning Subgroup and the HSAB	March 2020	The Learning Disabilities Mortality Review (LeDeR) Programme was established in response to the recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPOLD). The Haringey's Learning and Disabilities Mortality Review (LeDeR) annual report provides an update on the work undertaken by the LeDeR steering group since the programme started in May 2017, reporting to the HSAB in January 2020.
				SAR Subgroup and Prevention and Learning Subgroup	Deliver SAR learning workshops (open to NCL) in 2019 looking at service thresholds and Ms Taylor Taking forward SAR learning across NCL and continue to disseminate lessons learnt from SARs.	March 2020	Safeguarding service threshold workshop held in May 2019 with staff across the partnership. SAR learning workshop held in November 2019 to share findings of Ms Taylor SAR. Over 40 people attended from across agencies and feedback about the event was very positive. The event was attended by two other NCL SAB representatives. Informal feedback from other NCL SAB managers and the workshop facilitator was also very positive, noting the active involvement of partner agencies, interesting group discussions and the importance of holding a closing event for SARs.
					Assurance that learning from the SARs has been disseminated to staff	March 2020	Findings of Ms Taylor SAR incorporated in a 7-minute briefing disseminated to SAB agencies alongside SAR report. Agency feedback suggests this was a very successful way of communicating with staff in partner organisations. SAR learning workshop held in November 2019 to share findings of Ms Taylor SAR. Discussions built into Prevention subgroup meetings. Will build into case study template for annual training plan
R2	Review and improve the transition pathway	Prevention Protection Empowerment Partnership Accountability	The SAB and LSCB is assured of a more effective plan and approach for	SAR Subgroup	Consider implications for Haringey of Colin SAR and Enfield SAR into the care and risk management of P.	March 2020	Awaiting notification from Enfield SAB that SAR WK has commenced.

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	for CYP with care and support needs in conjunction with Children's Services to ensure the safeguarding needs of those transitioning to adulthood are addressed [There is a link with P6]		those transitioning to adulthood; and the independence of young adults is promoted to reduce long term needs for care and support.	Adults and Children's lead	1. Transitions Steering Group and SEND Improvement Group responsible for oversight and tracking of development and actions 2. Co- design joint response for people who have safeguarding/ welfare needs but may not be Care Act eligible. Vulnerable People's Policy to be shared for consultation	August 2019	1. The terms of reference and action plan agreed across Adults and Children. Multi agency pathways established for people with learning disability including a clear response that addresses safeguarding needs for LD and MH support needs. Job description endorsed and recruitment on track to better enable the early identification and tracking of a wider cohort of young people. AD's will move to co-chair the Transition Panel. **COMPLETED** – work monitored through Transitions Panel and outcome report to be made available 6 monthly from 1st April 2020 2. Further work required to design joint response for people who have safeguarding needs but may not be Care Act eligible. Adult's and Children's Principal Social Workers to jointly work on developing Vulnerable People's Policy
R3	Improve understanding of and responses to older people at risk of or experiencing domestic abuse across the partnership and make links to the Violence Against Women	Protection Prevention Empowerment Partnership	The Board is assured through improved reporting of domestic abuse	Quality Assurance Subgroup	Identify patterns in data for targeting intervention	Ongoing	
			Training on domestic abuse to identify and inform risk assessment(s)	Prevention and Learning Subgroup/ VAWG Lead	Maintain a strategic link with Haringey VAWG Strategy Priorities through presenting the VAWG annual report to the HSAB	March 2020	The VAWG Annual report was circulated for the meeting in January 2020 for information only. **COMPLETED**

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	and Girls (VAWG) strategy				Plan and deliver joint training for staff in domestic abuse and VAWG.	March 2020	VAWG Practitioners' Forum - Supporting survivors experiencing multiple disadvantage took place in September across agencies working in adults and children's services. VAWG team provided multi-agency events reported in annual safeguarding training plan. New team now in place and planning for 2020.

LEARN – We are committed to learning and improving

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L1*	NCL to undertake case audits	Partnership Accountability Protection	Safeguarding Adult Boards across the NCL is assured that practitioners have the confidence when applying responsibilities under the MCA 2005. And opportunities for early intervention for adults at risk who refuse medical treatment.	LB Barnet	NCL to undertake case audits regarding refusal of medical treatment and Mental Capacity; and Fire Safety	**March 2020**	The 'Refusal of Medical Treatment' audit was undertaken in November 2019 to explore what practice change has occurred in respect of supporting adults at risk who refuse medical treatment following the implementation of actions plans arising from the recommendations from Safeguarding Adults Reviews completed in the last 2 years by Camden and Barnet SABs. The audit was conducted across the NCL area and was chaired by Fiona Bateman, Independent Chair, Barnet Safeguarding Adults Board. A number of recommendations have been suggested and HSAB with the NCL will follow this through.
L2*	Develop mechanisms to provide	Partnership Accountability	**TBC**	LB Barnet (Fiona Bateman)	Barnet to set up a Task and Finish Group to develop	**TBC**	**To be reviewed**

LEARN – We are committed to learning and improving

	Objective/aim	Key Principle	Success Criteria	Lead	Actions to ensure achievement of aim?	By when	Update as at 31st March 2019
	assurance of impact of change and learning from SAR's				mechanisms to provide assurance of impact of change and learning from SAR's		
			The SAB is assured that issues identified in the learning log are followed through and are not repeated in practice.	SAR Subgroup	Consider pilot for a learning log to be monitored by the SAR Subgroup.	March 2020	Learning log considered by SAR Subgroup and decision taken that this would not provide improved assurance of the impact of change and learning from SARs. Agreed to continue to use learning events and SAB meetings to require partner agencies to feedback on how SAR improvements have been delivered and impact of change. It was agreed that high-level recurring issues should be included and monitored through the SAB's Strategic Plan going forward.
L3	Improve multi-agency knowledge and awareness of mental health including Mental Capacity.	Empowerment Protection	The Board is assured that practice has improved through auditing of the quality of assessments and increased use of advocates. Evidence around audits, practitioner clinics to ensure documentation identifies issues of capacity and self-neglect Positive feedback from briefing sessions.	Quality Assurance Subgroup	Evidence from audits, and practitioner clinics demonstrates issues of capacity and self-neglect are being identified and addressed by practitioners, and the audits to inform workforce development across the partnership	March 2020	Results of audits to be shared with the Adults Workforce Development Manager to inform staff development. Refresher training will be run for ASC to pick up on learning from audit results.
				Prevention and Learning Subgroup	Support multi-agency MCA training and look for flexible funding options. Continue to use multi-agency offer of MH awareness training.	Dec 2019	Health partners conducting follow up survey of 300 participants to draw out implementation of learning. This will inform single agency training going forward. Funding for multi-agency training coming to an end
					Commission in-house training around MCA	Nov 2019	Sessions took place during September and November 2019. **COMPLETED**

LEARN – We are committed to learning and improving

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					in conjunction with Adult SS and Legal services.		
L4	Carry out an annual review to assess the impact and effectiveness of the work of the SAR Subgroup	Partnership Accountability	The Board is assured that the SAR subgroup and chair is delivering its objectives and priorities as outlined in its Terms of Reference. Demonstrate that HSAB partners have applied the learning from SARs to practice	SAR Subgroup	Evaluate impact and delivery of action plan. Review actions and areas of improvements from the Safeguarding Adults Partnership Audit Tool).	March 2020	Review of SAR Subgroup effectiveness completed, including analysis of areas for improvement from the SAPAT (SAR section). The review provides assurance that that the SAR Subgroup is delivering its objectives and priorities as outlined in its Terms of Reference and highlights the ongoing need for partners to demonstrate how SAR learning has been implemented. The SAB will continue to use SAR learning workshops and SAB meetings to request assurance from partners.
					Seek feedback from partners on effectiveness of Ms Taylor SAR briefing.	March 2020	**COMPLETED**
				Prevention and Learning Subgroup	Evaluate dissemination of learning from SARs.	March 2020	Feedback from SAB partners on the Ms Taylor SAR 7-minute briefing was generally very positive, with partners considering it a concise and useful way to brief staff who may not have time to read the full report. Most agencies disseminated the briefing through a combination of email/intranet and face to face briefings.
					Evaluate the learning impact of SAR workshops.	March 2020	40 people attended the Ms Taylor SAR learning workshop in November 2019. 100% of attendees found that the workshop was a good use of their time, got what they needed from the session and were clearer about the actions taken by partners.