

# DRAFT MINUTES OF THE SAFEGUARDING ADULTS BOARD

Thursday 20<sup>th</sup> October 2022 at 14:30-16:30

Virtual Meeting via MS Teams

## MEMBERSHIP & ATTENDANCE:

AGENCY	NAME	Initials	ATTENDANCE
<b>Safeguarding Adults Board</b>	Dr Adi Cooper, Chair	AC	✓
	Rebecca Waggott, Governance & Improvement (Minutes)	RW	✓
	Ashraf Sahebodin, Governance & Improvement	AS	✓
	Ilona Zeqiri, Team Manager, Governance & Improvement	IZ	✓
<b>Volunteer Lay Member</b>	Lauritz Hansen-Bay	LHB	-
<b>Adult Services</b>	Beverley Tarka, Director of Adults, Health and Communities	BT	✓
	Vicky Murphy, Interim Assistant Director of Adult Social Care	JP	✓
	Chris Atherton, Head of Assurance and Principal Social Worker	CA	✓
	Peter Foreman, Interim Head of Assessment and Safeguarding	PF	✓
	Marianne Ecker, Workforce Development Manager	ME	✓
<b>Commissioning</b>	Gill Taylor, Assistant Director Communities and Housing Support (Interim)	GT	Apologies
	Farzad Fazilat, Head of Brokerage and Quality Assurance	FF	✓
	Paula Rioja, Senior Performance Officer	PR	✓
	Richmond Kessie, Specialist Commissioning Officer	RK	✓
<b>Children's Services</b>	Beverley Hendricks, Assistant Director Children's Safeguarding and Social Care	BH	Apologies
<b>Public Health/ Community Safety</b>	Dr Will Maimaris Interim Director of Public Health	WM	-
	Katy Harker, Public Health Registrar	KH	Apologies
<b>Legal Services</b>	Haydee Nunes De Souza, Assistant Head of Legal	HNS	Apologies
<b>Cabinet Member for Adults and Health</b>	Councillor Lucia das Neves, Cabinet Member for Health, Social Care and Well-Being	LDN	✓
<b>North Central London ICB</b>	Deidre Malone, Interim Director of Quality	DM	✓
	Rosie Peregrine-Jones, Assistant Director of Quality	RPJ	✓

	Victor Nene, Haringey Safeguarding Adults Designated Professional	VN	✓
	Dr Lionel Sherman, Adult Safeguarding Lead	LS	✓
<b>Whittington Health</b>	Deborah Clatworthy, Interim Deputy Director of Nursing	DC	Apologies
	Theresa Renwick, Safeguarding Adults Lead	TR	✓
<b>NMUH</b>	Sarah Hayes, Chief Nurse	SH	Apologies
	Kathryne Abbott, Interim Associate Director of Safeguarding	KA	✓
	Shahida Trayling, Deputy Chief Nurse	ST	Apologies
<b>BEH-MHT</b>	Amanda Pithouse, Executive Director of Nursing, Quality and Governance	AP	Apologies
	Wayne Garner, Adult Safeguarding Lead	WG	✓
<b>Haringey Police</b>	Sebastian Adjei-Addoh, Detective Superintendent	SAA	Apologies
	Andrew Costa, Detective Chief Inspector North Area	AC	✓
<b>Housing</b>	Denise Gandy, Assistant Director of Housing Demand	DG	Apologies
<b>Housing Provider</b>	Phil Johnson, Housing Services Manager, Hornsey Housing Trust	PJ	✓
<b>London Fire Brigade</b>	Keith Wilson, Borough Commander	KW	-
	Peter Shaw, Tottenham Station Manager	PS	Apologies
<b>Healthwatch</b>	Sharon Grant, Chair	SG	-
<b>Bridge Renewal Trust</b>	Geoffrey Ocen, CEO	GO	Apologies
<b>Department for Work and Pensions</b>	Archibald Okolie, Senior Safeguarding Lead	PFe	-
<b>Probation</b>	Shirley Kennerson, Assistant Chief Officer	SK	Apologies
	Russell Symons, Deputy Head of Service	RS	✓

**IN ATTENDANCE:**

Agency	Name	Initials	Attendance
North Central London ICB	Caroline McGirr, Quality Assurance Manager	CMG	Item 2

ITEM	SUBJECT/DECISION
	<b>WELCOME AND INTRODUCTIONS/APOLOGIES:</b> By Dr Adi Cooper (Chair) AC welcomed everyone to the meeting. Apologies for absence were received from those listed above and accepted by the meeting.
1.	<b>MINUTES OF LAST MEETING AND MATTERS ARISING</b> The minutes of the July meeting were reviewed and agreed as an accurate reflection of the meeting.

Actions 3, 4 and 5: AC has written to BEHMHT concerning representation at the MASP and received a positive response. Other improvements to the effectiveness of the MASP to be presented back to the SAB in the MASP's July 2023 update report.

Action 8: PR has completed a deep dive looking at reasons for increasing safeguarding concerns amongst the 18-64 age group. To be circulated with the minutes.

PR noted that a meeting had recently been held with the LFB Borough Commander concerning GDPR and the consent to share data of people identified as living at risk of fire. It was acknowledged that the people on the list have consented for their data to be shared appropriately during the care assessment. The performance team will now provide details of people who are bedbound, heavy smokers and where there is an issue of hoarding. The LFB have agreed to return data on the date of the completed home fire safety visit and the outcome. These clients will be flagged as high risk on Liquid Logic going forward.

**ACTION:**

1. RW/AS to circulate 18-64 age category deep dive with the SAB minutes.

**BRIEFINGS AND PRESENTATIONS**

2.

**LeDeR Annual Report 2021/2022**

Caroline McGirr presented the North Central London CCG Learning from lives and deaths - People with a learning disability and autistic people (LeDeR) annual report for 2021/2022.

She noted that there had been some changes to the LeDeR review process, including introduction of a two-stage review system where most cases receive a basic review, with only a proportion of cases moving to a full review where required or where families request this. LeDeR reviewers no longer make recommendations for each review, instead they present areas of learning, good practice and areas of concern to the panel. A new IT platform went live in June 2021 and reviews of the lives and deaths of people with a diagnosis of autism without a learning disability were introduced in January 2022.

Out of 40 relevant deaths notified across the NCL sub-region in 2021/22, 4 cases were reported in Haringey. There were no new or emerging themes from the subsequent LeDeR reviews. Annual Health Checks, Mental Capacity Act assessments, early warning signs of deterioration, reasonable adjustments and respiratory causes of death continue to be the main areas of learning identified in reviews across the NCL area.

Within NCL the 60+ age group accounted for 34% of the deaths, which is a slight decrease of 2% in comparison to 2020/21 data. Notably there has been increase in the 40-49 age group, with a 9% increase. NCL has diverse communities across all its boroughs. Ethnicity for 2021/2022 is consistent with 2019/2020 and 2020/2021 reporting.

Respiratory related illnesses and COVID-19 were the most frequently listed cause of death across NCL as was reported in 2020/21. Cancer, cardiovascular related causes of death and sepsis have all increased in 2021/22. No reviews highlighted a late diagnosis of cancer however, one particular review did highlight a delay in a scan referral which was pursued by a GP leading to a 2 week wait referral where the diagnosis was promptly made. The review concluded this delay would not have changed the outcome or progression of disease. Identified service improvements are included in the full LeDeR report.

The ICS is currently considering how to form the required LeDeR Panel. The local governance group/panel will consist of people from across the ICS who have responsibility for the quality of services and can take action to improve services. LeDeR governance must not sit separate to and remote from the wider ICS quality governance. NHS England regional teams will hold ICSs to account assuring that the actions are robust, address the issues identified and will achieve the objectives required. There is a requirement to report quarterly on performance against the actions agreed for all reviews completed.

TR noted that although there may not be many local deaths as a result of choking, there is a need to raise awareness of the risk of choking for people with learning disabilities.

CMG noted that there was a choking death in Barnet three years ago and the lead of that review has been contacted to establish how learning can be shared. VN noted that the new LeDeR Panel arrangements will enable learning to be shared across the ICS.

KA noted that there she was aware of national and regional learning around choking deaths and asked to be linked into the LeDeR programme. CMG to contact KA.

ME noted that she has been liaising with Haringey Learning Disability Partnership carers and Carer First to provide first aid training around choking for family carers.

AC noted that she welcomed the shift from recommendations being made by individual reviewers to the LeDeR Panel taking on improvement work across the sub-region. She highlighted the importance of opportunities to disseminate improvement work via the SAB's SAR Subgroup so that themes are picked up and reflected in the work across the SAB partnership.

TR noted that the LeDeR report was a thorough report and that it was helpful to see NCL data presented in one report.

**ACTION:**

2. **CMG to contact KA regarding LeDeR review learning (deaths from choking).**

**STANDING ITEMS**

3.

**COVID-19 Safeguarding Concerns**

CA explained that it had been highlighted at a previous SAB meeting that there are significant waiting lists for adult social care assessments and reviews due to the pandemic, which may have implications for adult safeguarding. CA noted that there had been improvements to case allocation within Adult Social Care, which meant that a backlog of around 900 cases had been reduced to around 300 across the service. He noted that in some cases, services had been utilised from other organisations to move the case forward. PF noted that there had been improvements also in the safeguarding team, with a current caseload of 29 safeguarding concerns to be screened. He noted that the improvements had been achieved by recruiting new staff; a more robust front end into the service; a social worker acting up as a senior practitioner; weekly virtual hub meetings with non-statutory partners, regular catch ups with team managers and the appointment of a new service manager to directly line manage the team.

AC noted the positive improvements that had been made. BT thanked the teams for their hard work in reducing the backlog and noted that the significant challenges following the pandemic had been noted as a national issue by ADASS. She therefore suggested that a written report is provided to the SAB on the approach taken to

quickly cut waiting lists, so that the learning may be shared nationally. AC also noted that this may be useful for the upcoming CQC assessment and would provide assurance to the SAB of the impact of this work on adult safeguarding. VM to provide a written briefing to the SAB meeting in January 2023.

AC noted that the impact of COVID-19 is no longer the only external threat to adult safeguarding and suggested that partners are invited to give verbal updates on the impact of the cost of living and fuel and food poverty as well as COVID-19 for this item going forward. AS to amend agenda item on forward plan.

VM noted that there had been a significant increase in COVID-19 cases across the NCL area and suggested that any increase in hospital admissions may put pressure on hospital discharge and step-down facilities. TR noted that the spike at the Whittington had reduced and did not appear to be causing issues for hospital discharge. She explained that the Trust is now rolling out COVID-19 booster and flu vaccinations via clinics and district nursing. FF noted that the impact of COVID-19 was being monitored alongside care providers and no concerns had been raised. AC noted the importance of keeping this as a standing item to monitor the impact of any spike on service provision and adult safeguarding.

**ACTIONS:**

3. **VM to bring a written update to the next SAB meeting regarding the approach to ongoing pressures in Adult Social Care.**
4. **AS to revise agenda item on SAB forward plan regarding cost of living impact.**

4.

**Performance Safeguarding Data**

PR presented the SAB performance data for April to September 2022, highlighting:

- Safeguarding concerns have decreased by 35% since April 2022.
- However, Section 42 enquiries have increased by 90% since April 2022.
- 58% of victims were female.
- 46% of abuse victims were people from White ethnic backgrounds and 26% were from Black ethnic backgrounds.
- 62% of abuse victims were aged 18-64.
- Neglect accounted for 26% of all abuse types. Emotional/Psychological abuse is the second highest abuse type overall at 24%.
- The victim's own home accounts for the location of the majority of safeguarding concerns (68%). Cases in Supported Living (including sheltered, extra care housing) increased by 63% compared to previous month (from 16 to 26 cases) and 13% when compared to the same period last year.
- Haringey has the 4th highest rate of safeguarding concerns when compared to statistical neighbours.
- Haringey has the 8th lowest rate of section 42 enquiries when compared to statistical neighbours.
- Haringey has the 2<sup>nd</sup> highest rate of other safeguarding enquiries when compared to statistical neighbours.
- In September 2022, 96% of people had their risk removed or reduced at the end of the safeguarding case. This is above the 95% target set.
- There has been a 1% increase in the proportion of people asked about their desired outcome in September 2022 (84%).
- In September 2022, 96% individuals had their desired outcomes met or partly met.

VM commented on the large proportion of safeguarding concerns raised for people aged 18-64. PR noted that this was a recent trend since April 2022. AC suggested that this may be due to the demographic profile of the borough and the fact that there

are not many care homes for older people in the borough. TR noted that this trend is apparent at the Whittington also. PR explained that Section 42 enquiries are more likely to be undertaken for this age group, whereas there are very few for people in residential care.

AC highlighted that the high rate of safeguarding concerns compared to statistical neighbours is a positive finding and suggests that there is a high level of adult safeguarding awareness amongst the community and partner agencies. The relatively high rate of other safeguarding work/enquiries is also a positive indication that different pathways are being used for safeguarding prevention for cases that do not meet the Section 42 criteria. BT and PF noted their agreement with this analysis.

AC highlighted the recent significant increase in Section 42 enquiries and suggested that the SAB continues to monitor this to establish if the trend continues.

AC noted some concern about the increase in safeguarding concerns from people in supported living. PF noted that joint work is being undertaken between adult social care and brokerage to move some provider quality issues into adult safeguarding. AC asked that this is reported on in the January 2023 provider monitoring report if it continues to be a concern.

AC commended the significant improvement in the outcomes of safeguarding intervention.

PR presented the findings of the deep dive into self-neglect cases. Out of 794 safeguarding concerns, 73 related to self-neglect and 8 section 42 enquiries were carried out. Seven of the cases involved self-neglect and one involved hoarding.

Of those 8 enquiries, 4 related to substance misuse followed by missed medication, 2 related to missed mental health medication, 1 concerned a missing person and 1 involved personal care. The outcomes were:

- Referral to Police
- Referral to HAGA alcohol service
- Enquiry cancelled by victim
- Increase in care package
- Referral to community Mental Health Team.

FF noted that this had been discussed at the Quality Assurance Subgroup and Public Health had been asked to consider a piece of work to understand why trends identified in the community may not be reflected in Council data. AC agreed that this would be an interesting piece of work and noted that similar issues have been identified in a SAR which is currently under way, which has highlighted the importance of flagging safeguarding cases from community organisations and other partners on a multi-agency basis.

PR noted that this would be her last SAB meeting as she will be moving to another role outside of Haringey. AC thanked PR for consistently providing clear and useful information to the Board over the years that she has worked with the SAB.

**ACTION:**

- 5. PF/FF to report any ongoing provider concerns in supported living in the January 2023 provider monitoring report.**

5.

### **HSAB Management Report**

AC presented the Board Managers report, noting the updates from the SAR Subgroup Prevention and Learning Subgroup, Quality Assurance Subgroup and the Chairs Executive Subgroup.

The Quality Assurance Subgroup recently discussed the revised Self-Neglect and Hoarding Protocol. It was felt that hoarding is an issue that would benefit from a focused discussion, as it is impacting a surprisingly large number of residents with consequences for their mental health and safety for themselves and others. The subgroup agreed that it would be helpful to quantify the scale of the problem and as a starting point, it was suggested that the HSAB should ask Homes for Haringey to prepare a report on the number of tenants they are aware of who have a hoarding problem and those whose tenancies are currently at risk for this reason. Public Voice Community Connectors also offered to provide a report on clients they see who have hoarding problems and provide some case studies. The Director of Public Health has also initiated an evidence gathering exercise at the request of Healthwatch.

BT noted that the tenancy management and repairs services sit within the Placemaking & Housing Directorate under Judith During and Judith Page. She noted that feedback suggested that reports are made by tenancy management and repairs staff but there are gaps in acknowledging the report and providing feedback to the referrer.

AC suggested that other social housing landlords are involved in this piece of work to provide a wider understanding of the issues and risks around hoarding in the borough. She therefore suggested that VM and VN, as chairs of the Quality Assurance Subgroup, initiate a conversation around the scale of hoarding in social housing in the borough with Judith During, Judith Page, and a representative of local social housing providers for a possible report to the SAB.

It was noted that Sharon Grant had offered at the Quality Assurance Subgroup meeting for Public Voice Community Connectors to provide a report on clients they see who have hoarding problems and provide some case studies.

AC explained that plans are underway to start the consultation process on the new HSAB Strategic Plan 2023-28, working jointly and closely with members of the HSAB and the Joint Partnership Board (JPB) to ensure that we have set a suitably ambitious but achievable plan, which meets the needs and expectations of Haringey residents and promotes a partnership approach to the delivery of the Plan. AC will be attending meetings with the JPB starting in November 2022 and January 2023 with the intention of co-producing the strategy. All board members were asked to note this and to attend the 'shaping of the HSAB Strategic Plan 2023-28' meeting currently scheduled for 15th November 2022.

VN to send AS the ICB annual report so that ICB safeguarding priorities to inform the HSAB Strategic Plan.

AC noted that all partners who contribute to the SAB's budget are kindly requested to send Purchase Order details for any outstanding HSAB budget contributions. Details to be sent to [raquel.pinadelgado@haringey.gov.uk](mailto:raquel.pinadelgado@haringey.gov.uk) and copy [ashraf.sahebodin@haringey.gov.uk](mailto:ashraf.sahebodin@haringey.gov.uk). AS noted that financial contributions for 2021/22 are outstanding from NCL ICB, Whittington Health and North Middlesex University Hospital.

AC highlighted that SAB partners should note the HSAB Annual Report 2021/22 in Appendix B. AC noted her thanks to AS for pulling together a comprehensive Annual Report, which will be presented to the Council's Overview and Scrutiny Panel for

information. She asked partners to circulate or present the HSAB Annual Report 2021/22 within their own organisations.

**ACTIONS:**

6. VM and VN to initiate a conversation around the scale of hoarding in social housing in the borough with Judith During, Judith Page, and a representative of local social housing providers for a possible report to the SAB.
7. VM and VN to liaise with SG for Public Voice Community Connectors to provide a report on clients they see who have hoarding problems and provide some case studies.
8. VN to send AS the ICB annual report so that ICB safeguarding priorities to inform the HSAB Strategic Plan.
9. All partners who contribute to the SAB's budget to send Purchase Order details for any outstanding HSAB budget contributions. Details to be sent to raquel.pinadelgado@haringey.gov.uk and copy ashraf.sahebodin@haringey.gov.uk.
10. All SAB partners to circulate or present the HSAB Annual Report 2021/22 within their own organisations.

6.

**Joint Providers Monitoring Report**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

7.

**LIN/LPS Update**

PF noted that the first meeting of the local implementation group for the Liberty Protection Standards had been arranged for early November and will be chaired by PF. The first meeting will look at the terms of reference, membership, meeting frequency and quoracy, etc.

AC noted that it is still unclear when the LPS will be implemented but it is important for the SAB to have reassurance that the current DoLS and MCA processes are working effectively, and that the partnership is prepared for implementation of the LPS. AC asked for updates to be provided by the LIN within the Board Management report going forward and for PF's replacement to chair the group.

TR noted the importance of involving children's services in the group.



	<p><b>ACTION:</b>  <b>12. PF to ensure LIN updates are provided in the Board Management report from January 2023 and that his replacement chairs the group.</b></p>
<p><b>BUSINESS ITEMS</b></p>	
<p><b>8.</b></p>	<p><b>Joint S42 Safeguarding Adults Enquiry Framework and Incident/Alert Form</b>  PF presented the updated Enquiry Framework, noting that the language in the document had been updated and extra emphasis put on establishing the person's desired outcomes at the referral stage, in line with Making Safeguarding Personal. Where shift workers are making a report, the Framework now requests the contact details of a named worker to contact during normal working hours. The updated document has been circulated to partners for comments.</p> <p>TR asked if the document could clarify that where the local authority causes another agency to undertake an enquiry, that there should be a strategy meeting first. PF agreed that the Framework would be edited to reflect that a strategy discussion should take place, as a meeting would be expected for more complex cases.</p> <p>The Enquiry Framework was agreed by the Board subject to this amendment by PF.</p> <p><b>ACTION:</b>  <b>13. PF to update document to highlight the requirement for strategy discussions when causing another agency to undertake an enquiry.</b></p>
<p><b>9.</b></p>	<p><b>Multi-Agency Quality Assurance Framework</b>  FF presented the Multi-Agency Quality Assurance Framework which has been reviewed. He noted that the NCL ICB restructure will be reflected in the document, but the framework is otherwise working well. The new ICB safeguarding structures will not impact on the framework, but the changes to personnel will be updated in the document.</p> <p>The Framework was agreed by the Board subject to this amendment by FF.</p> <p><b>ACTION:</b>  <b>14. FF to update Framework to reflect change to personnel in NCL ICB.</b></p>
<p><b>10.</b></p>	<p><b>Safeguarding Adults Multi Agency Self-Neglect and Hoarding Procedure</b>  CA presented the reviewed Multi Agency Self-Neglect and Hoarding Procedure, which has been in place since 2016. He noted that there were no major changes to the procedure, but staff contact details had been updated and links made to the Multi-Agency Solutions Panel. He noted that this is a robust procedure, which appears to be under-used, and he asked SAB partners to circulate the document within their organisations.</p> <p>AC suggested that a 7-minute briefing should be developed about what the procedure contains and that this is promoted during National Adults Safeguarding Week in November 2022 as well as the planned promotion in multi-agency safeguarding training from January 2023.</p> <p>TR to consider if the Procedure could be used as a model during Mental Capacity Act session during National Adults Safeguarding Week.</p> <p>The revised procedure was agreed by the Board.</p>

	<p><b>ACTIONS:</b></p> <p><b>15. All agencies to circulate the Safeguarding Adults Multi Agency Self-Neglect and Hoarding Procedure within their organisations.</b></p> <p><b>16. CA to develop a 7-minute briefing summarising the Procedure for promotion during National Safeguarding Adults Week in November 2022 and multi-agency safeguarding training from January 2023.</b></p> <p><b>17. TR to consider if the Procedure could be used as a model during Mental Capacity Act session during National Adults Safeguarding Week.</b></p>
<p><b>11.</b></p>	<p><b>Any Other Business</b></p> <p>VN noted that details of the ICB safeguarding conference have been circulated to the SAB. He explained that partners can attend virtually if they wish.</p> <p>AS noted that Beverley Hendricks (Assistant Director for Safeguarding and Social Care (Children’s Services)) and Vicky Murphy (Assistant Director for Adults) will be hosting three engagement sessions for the opportunity to share ideas, learn and participate in the development of the Transitional Safeguarding action plan. The plan is to have the final draft of the action plan in place by the new year and presented to the joint board on 26th January 2023. Invitations to HSAB and HSCP members were sent out today. Please RSVP (ashraf.sahebodin@haringey.gov.uk) with the date you would like to attend, and we will add you to the invitation list 18.11.22 (15:00-16:15), 29.11.22 (13:00-14:15), 14.12.22 (09.00 – 10:15).</p>

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