DRAFT MINUTES OF THE SAFEGUARDING ADULTS BOARD

Wednesday 20th October 2021 at 14:30-16:30
Virtual Meeting via MS Teams

MEMBERSHIP & ATTENDANCE:

AGENCY	NAME	Initials	ATTENDANCE
Safeguarding Adults Board	Dr Adi Cooper, Chair	AC	✓
	Rebecca Waggott, Governance & Improvement (Minutes)	RW	✓
	Ashraf Sahebdin, Governance & Improvement	AS	✓
Volunteer Lay Member	Lauritz Hansen-Bay	LHB	Apologies
Adult Services	Beverley Tarka, Director of Adult Services	BT	✓
	Jeni Plummer, Interim Assistant Director of Adult Social Services	JP	✓
	Chris Atherton, Head of Assurance and Principal Social Worker	CA	✓
	Peter Foreman, Interim Head of Assessment and Safeguarding	PFo	✓
	Grace McHenry, Safeguarding Team Manager	GMcH	✓
	Dianna StHilaire, Interim Workforce Development Manager	DSH	✓
Commissioning	Charlotte Pomery, AD for Commissioning	CP	Apologies
	Gill Taylor, Strategic Lead – Single Homelessness & Vulnerable Adults	GT	Apologies
	Paula Rioja, Senior Performance Officer	PR	✓
	Margaret Gallagher, Performance Manager	MG	Apologies
	Farzad Fazilat, Head of Brokerage and Quality Assurance	FF	✓
Children's Services	Beverley Hendricks, Assistant Director Children's Safeguarding and Social Care	BH	Apologies
Public Health/ Community Safety	Dr Will Maimaris Interim Director of Public Health	WM	Apologies
	Manju Lukhman VAWG Strategic Lead and Commissioner	ML	Apologies
Legal Services	Stephen Lawrence-Orumwense, Assistant Head of Legal	SLO	Apologies
Cabinet Member for Adults and Health	Councillor Lucia das Neves, Cabinet Member for Health, Social Care and Well-Being	LDN	Apologies
North Central London Clinical Commissioning Group	Jenny Goodridge, Strategic Adult Safeguarding Lead	JG	Apologies
	Rosie Peregrine-Jones, Assistant Director of Quality	RPJ	✓

CONFIDENTIAL

	Victor Nene, Haringey Safeguarding Adults Designated Professional	VN	✓
	Dr Lionel Sherman, Adult Safeguarding Lead	LS	✓
Whittington Health	Breeda McManus, Interim Deputy Director of Nursing	BM	Apologies
	Theresa Renwick, Safeguarding Adults Lead	TR	✓
NMUH	Sarah Hayes, Chief Nurse	SH	Apologies
	Celia Jeffreys, Associate Director of Safeguarding	CJ	Apologies
	Shahida Trayling, Deputy Chief Nurse	ST	✓
	Rita Kyambadde, Lead Nurse for Adult Safeguarding	RK	✓
BEH-MHT	Amanda Pithouse, Executive Director of Nursing, Quality and Governance	AP	Apologies
	Sian Carter-Jones, Head of Safeguarding	SCJ	Apologies
Haringey Police	Sebastian Adjei-Addoh, Detective Superintendent	SAA	Apologies
	Paul Ridley, A/Detective Chief Inspector North Area	PRi	Apologies
	Sam Rigby, Detective Chief Inspector, Public Protection, North Area	SR	✓
Neighbourhood Policing	Imran Asghar, Inspector	IA	Apologies
Homes for Haringey	Denise Gandy, Director of Housing Demand	DG	✓
Housing Provider	Phil Johnson, Housing Services Manager, Hornsey Housing Trust	PJ	✓
London Fire Brigade	Claiton Murray, Borough Commander	CM	Apologies
London Ambulance Service	Sophie Hill, Quality, Governance and Assurance Manager	SHi	Apologies
Healthwatch	Sharon Grant, Chair	SG	Apologies
Bridge Renewal Trust	Geoffrey Ocen, CEO	GO	Apologies
Department for Work and Pensions	Phyllis Fealy, Haringey Relationship Manager	PF	Apologies
Probation	Shirley Kennerson, Assistant Chief Officer	SK	✓
Community Rehabilitation Company	Mathieu Bergeal – Area Manager	MB	Apologies

IN ATTENDANCE:

Agency	Name	Initials	Attendance
Caroline McGirr	NCL LeDeR Coordinator, Learning Disabilities & Autism Transformation Programme	CMG	Item 3

CONFIDENTIAL

ITEM	SUBJECT/DECISION
1.	**WELCOME AND INTRODUCTIONS/APOLOGIES:** By Dr Adi Cooper (Chair) AC welcomed everyone to the virtual meeting. Apologies for absence were received from those listed above and accepted by the meeting.
2.	**MINUTES OF LAST MEETING AND MATTERS ARISING** The minutes of the July meeting were reviewed and agreed as an accurate reflection of the meeting. Action 3: TR confirmed that a meeting has been arranged with GT in November concerning the issues raised regarding hospital discharge arrangements and supporting those with complex needs and substance misuse issues. Action 13: AC noted that is expected to be a government consultation on the forthcoming inspection regime for adult social care, including adult safeguarding, in November, which the Board may want to consider.
	BRIEFINGS AND PRESENTATIONS
3.	**LeDeR Annual Report Presentation** CMG and VN gave a presentation on the Learning from Lives & Deaths- People with a Learning Disability (LeDeR) Haringey Programme update for 2020/21. CMG explained that the LeDeR Programme was established in 2016 to support local areas in reviewing the deaths of people with learning disabilities. It was rolled out in Haringey in 2018, and since then there have been 23 reviews completed. The aims of the LeDeR programme are to identify learning from these deaths and to ensure service improvement. LeDeR is not an investigation process, nor is it a statutory process. In 2020/21, there were 7 deaths reported in Haringey with 4 reviews completed. Three of the 7 deaths resulted from Covid-19 and respiratory related illness. Across the NCL area, Covid-19 accounted for 52% of learning disability deaths. Service improvements identified through the Haringey LeDeR reviews are: • Discharge planning meeting takes place weekly with learning disability nurse at North Middlesex and Whittington hospitals to ensure all relevant information is communicated upon hospital discharge; • Complex Physical Health Pathway (ComPHy) protocol and 'at risk' register has been developed; • Dysphagia training- Haringey SaLT team have adapted their training to deliver this online; • Patient experience- Whittington Health & NMH have introduced sensory equipment; VN noted that three of the LeDeR reviews had prompted referrals for consideration of a Safeguarding Adults Review, however, the referrals were not found to meet the SAR criteria. The reviews highlighted learning themes around: • Lack of advocacy and involvement of advocate • Evidence of diagnostic overshadowing • Lack of care coordination • Lack of annual health check • Self-neglect A learning event is being planned for partners looking at the themes arising from these reviews, and the input of SAB partners is welcomed.

CONFIDENTIAL

	Since VN has been in post, improvements have been made to: • Improve the interface between the LeDeR steering group and the SAR Subgroup; • Renew the LeDeR steering group terms of reference; • Report into newly formed Learning Disability Joint Quality Group Haringey; • Establish a working group to allocate service improvement actions with clear tasks to achieve these and how these will be evidenced. CMG noted that there will be changes to the LeDeR Programme from Spring 2022: • New LeDeR policy will review deaths of those with learning disabilities and autism; • Different approach to reviews including those deaths with no concerns having a rapid review; • Policy has a stronger emphasis on the delivery of the actions coming out of reviews and holding local systems to account for that delivery. AC thanked CMG and VN for the presentation and asked if there were any questions. BT asked whether any gaps had been established relating to cultural considerations around advocacy for people with learning disabilities. VN explained that an audit of advocacy is currently being undertaken and this should provide information on any gaps and learning. AC asked whether the SAB can support the LeDeR Steering Group any further than promoting the forthcoming learning event and facilitating an annual discussion on the LeDeR annual report findings. VN suggested that it may be useful to bring back the findings of the advocacy audit. AC agreed that the LeDeR Steering Group is welcome to report back to the SAB in six months' time, or sooner, if required. TR asked whether any gaps had been identified around the skillset of practitioners to carry out LeDeR reviews for people with autism, when this is included in the programme's remit. VN explained that he was in the process of establishing the training needs relating to autism so that this could be addressed before Spring 2022. **ACTIONS:** **1. AS/RW to circulate LeDeR Programme 2020/21 Update Presentation.** **2. VN to contact AC if a further update to SAB is required before next year's annual report presentation.**
	BUSINESS ITEMS
4.	**SAB Escalation Policy** CA presented the revised SAB Escalation Policy, which has been updated for 2021-2024. It focuses on the positive resolution of professional differences around adult safeguarding, setting out a four-stage process to be followed. Key contacts are included in the policy and can be updated if there are changes before the next review of the document. BT asked whether the policy was based on learning from previous cases. CA noted that he was not aware that the policy had been used in the last three years, so the policy is not based on actual cases. BT suggested that SAB partners promote the revised policy to key staff within their organisations when the revised policy is launched. AC asked CA to ensure that the policy is worded appropriately so that voluntary sector workers are able to utilise it.

CONFIDENTIAL

	VN highlighted the need to share the policy with the Children's Safeguarding Partnership and GPs once it is ready for circulation. **ACTIONS:** **3. CA to review the revised SAB Escalation Policy to include access by the voluntary sector.** **4. CA to circulate the finalised SAB Escalation Policy to SAB members for the onward sharing with relevant key staff within agencies.**
5.	**HSAB Safeguarding Performance Data (as at end of September 2021)** PR presented the SAB performance data for July to September, highlighting: • 137 safeguarding concerns were raised from July to September 2021, with 50 leading to Section 42 enquiries. This is an increase of 27% in concerns, but a 12% decrease in Section 42 enquiries. • Emotional and psychological abuse remained consistently high at 30% of concerns. • Concerns about neglect have increased by 23% compared to the previous month. • Financial abuse cases remain low, at 30 cases in September, 21% lower than the same period last year. • The victim's own home account for the majority of safeguarding concerns raised (64%). • 55% of people were asked and expressed their desired safeguarding outcomes, a 17% decline since July 2021. • But 89% of those asked had their desired outcomes met or partially met. • A pressure sore deep dive was conducted in response to concerns raised at a previous SAB meeting. Of the 858 concerns raised since April 2021, 25 related to pressure sores. An audit was carried out for 10 of the 25 cases. • 60% of the sample involved women and 67% of the cases were for people aged 65+. The victim's own home accounts for the majority of pressure sore cases. There was only one residential care case. • The key findings were: unavoidable pressure sore; service user discharged from hospital to care home with grade 4 pressure sore; neglect by care provider agency; act of omission by district nurse. • The outcomes were: staff training; support plan put in place; Care Act Assessment; handover sheet for care staff implemented; moved to residential care. TR asked whether any particular issues had been picked up concerning pressure sores amongst people who are Black Caribbean, as this appeared to have been a particular issue at the Whittington. PR explained that no issues had been identified in this audit and that 50% of cases involved people who were White British and 50% were from Black / African / Caribbean / Black British backgrounds. TR noted that there appears to be an increase in safeguarding referrals for pressure ulcers where domiciliary care agencies are involved. She explained that district nurses provide training to care agency staff to prevent pressure ulcers (e.g. repositioning, using equipment) and to escalate concerns about any signs of deterioration but there are reported instances where care agency staff do not want to sign the client's care plan in case they become liable for deterioration of a pressure ulcer. TR also noted that there appears to be a correlation between cases of self-neglect and pressure ulcers. PR highlighted that links between self-neglect and pressure sores had been noted in a previous audit of self-neglect.

CONFIDENTIAL

	VN added that it would be helpful to establish how domiciliary care agencies are contract monitored with respect to pressure ulcers, as there appears to be continuing issues despite the provision of training to care agency staff. FF suggested that the Brokerage and Quality Assurance Team carries out an audit to establish the level of training and any gaps among domiciliary care agencies around pressure sore prevention and escalation, so that providers can be appropriately supported. AC raised a concern about the deteriorating level of people asked about their desired safeguarding outcomes. PR explained that this had been scrutinised at the performance call over and it was identified that in many cases it had been recorded that the desired outcomes were not sought, however, the person involved did not have mental capacity and therefore their family representative was consulted. AC noted that this data would therefore need to be cleansed and asked PR to do this before the next SAB meeting in January. **ACTIONS:** **5. FF to conduct an audit into domiciliary care agency training and support required around pressure sore prevention and escalation.** **6. PR to cleanse MSP data in advance of the January SAB meeting and provide an update.**
6.	**HSAB Strategic Plan** AS presented the HSAB Strategic Plan. Most areas have been updated as of 30th September 2021. The areas still pending were discussed; L1: VN and CA are meeting this week to progress this. VN to contact Barnet SAB who have already completed an audit on the refusal of medical treatment. N2: VN explained that a NCL Safeguarding Forum now meets every two weeks, which is currently combining safeguarding policies across CCGs. A forum for all safeguarding leads is also being developed. There is a commitment to maintaining safeguarding on a borough basis within the ICS restructure. BT noted that it would be useful to confirm timescales of the restructure as soon as possible and to provide the SAB assurance that partners, including community representatives, will be engaged in the quality assurance framework for safeguarding as the ICS is developed. RPJ suggested that she prepares a report about the impact and timescale of the ICS development on adult safeguarding in Haringey. She suggested that it would be useful for her and VN to meet with BT and other local authority representatives to establish the scope of the report. AC asked that RPJ confirms when this report could come to the SAB once this meeting has taken place. **ACTIONS:** **7. VN to contact Barnet SAB regarding their refusal of medical treatment audit.** **8. RPJ/VN to meet with BT and prepare a report for SAB on the impact of the ICS development on adult safeguarding and plans for engagement of the SAB and communities.**
7.	**Safeguarding Adults Week** DSH presented a report on the arrangements for the national Safeguarding Adults Week, which is running during the week commencing 15th November. The aim is to highlight key safeguarding issues, facilitate conversations and raise awareness of safeguarding best practice so we can all be better together.

CONFIDENTIAL

	At the time of writing the report, no in-house events/webinars have been planned. However, the Council does provide a wealth of information on Safeguarding Adults including a series of short videos to improve understanding of what is safeguarding, and advice on how to recognise the signs of abuse and what to do to report it. There is also an 'Understanding safeguarding online quiz'. A meeting was held with the Haringey Safeguarding Adults Manager and the Head of Safeguarding and Welfare at Tottenham Hotspur Foundation to plan a joint event for Haringey partners as part of Safeguarding Adults Week to look at areas of raising awareness, what safeguarding is, how to raise a referral, and celebrating success stories, etc. Unfortunately, the Tottenham Hotspur Foundation are not able to host the event during November due to event fixtures. Also, the majority of agencies are not able to commit to facilitating sessions due to other commitments and lack of resources. The safeguarding networking event is now planned for early 2022 to give agencies more time to plan and enable a more inclusive approach. Throughout national Safeguarding Adults Week, we will be taking to social media (Twitter/Facebook) to highlight important adult safeguarding messages. We will also promote the Ann Craft Trust's webinars taking place throughout the week on the Haringey SAB safeguarding adults webpage. Other events, including Derby SAB's self-neglect webinar, will also be advertised on the webpage. DSH asked SAB partners if they could share any adult safeguarding events or resources that they have available, so that these can also be promoted on the Haringey SAB webpage as part of national Safeguarding Adults Week. DG noted that Haringey will be marking each day of the 16 Days of Activism against Gender-Based Violence campaign from 25th November to 10th December with a different activity, workshop, training session, partner event or social media campaign. DG to provide details to DSH. AC also highlighted that there is a London SAB event on November 16th with lunchtime webinars all week. AS/RW to circulate information to SAB partners. The Board agreed to the recommendations outlined above and in the report: a. Partner agencies to share information with the HSAB on any events/videos planned for Safeguarding Adults Week b. Partner agencies to promote Safeguarding Adults Week on websites and social media platforms. Remember to use hashtag any time you talk about the week on social media: #SafeguardingAdultsWeek as well as a few variations: #SafeguardingWeek; #NationalSafeguardingAdultsWeek and #NationalSafeguardingWeek. c. Partner agencies to register with Ann Crafts for resources to use during Safeguarding Adults Week d. Any feedback/reports/pictures following Safeguarding Adults week to be shared with the HSAB to include in the HSAB Annual Report 2021/22. **ACTIONS:** **9. SAB partners to send DSH details of any adult safeguarding events or resources that they have available, so that these can also be promoted on the Haringey SAB webpage as part of national Safeguarding Adults Week.** **10. AS/RW to circulate details of the London SAB event on 16th November.**
8.	**Joint Providers Monitoring Report** *(Parts exempt from publishing due to data confidentiality)*

CONFIDENTIAL

	AC thanked FF for the report and the inclusion of monitoring information for out of borough placements, as its importance had been highlighted by the findings of Safeguarding Adults Reviews. VN noted that the CCG also undertakes significant quality assurance of providers outside of the borough. VN to link in with FF to share information. RPJ thanked the Commissioning Service for their support in looking at provider concerns jointly with the CCG. FF noted that there has been investment in the Quality Assurance and Contract Team and a new structure would be in place in April. **ACTION:** **11. VN to liaise with FF around quality assurance of out of borough placements.**
9.	**HSAB Board Managers Report** AS presented the Board Managers report, noting the updates from the Safeguarding Covid Task and Finish Subgroup, SAR Subgroup, Prevention and Learning Subgroup, and the Quality Assurance Subgroup AS highlighted that there was a previous proposal to hold a virtual event to complete the Safeguarding Adult Partnership Audit Toolkit (SAPAT) in November 2021. The previous Chairs Executive subgroup agreed to delay the completion of the audit toolkit for 2020/2021, taking into consideration the current impact on workloads for partners as a result of the COVID-19 pandemic. The HSAB has agreed with the Board Manager and Chair of Enfield Safeguarding Adults Board to provide mutual support through virtual challenge events, this will give Board partners the opportunity to collaboratively respond to the SAPAT and to help reduce the workloads for partners. The Chairs Executive agreed to hold the SAPAT event (2 hour session) in January 2022 and to consider a workshop mid-December to discuss the toolkit methodology with HSAB partners. The Board agreed to defer completion of the SAPAT to early 2022 to inform next year's Strategic Plan. Claire Bland provided an update on the Liberty Protection Standards (LPS). To date, neither the Code nor Regulations have been published. The Government had committed to 12 weeks consultation, parliamentary time, followed by 6 months implementation. This timeframe puts an April 2022 implementation in doubt as there will be no time to consider the consultation and make adjustments. The Government may, of course, decide to shorten the consultation and implementation timeframe. The national implementation group cannot progress implementation of the LPS until the guidance is published. AC thanked CB for the update and noted that the lack of national progress was disappointing. She asked partners if there were any other networks that could be utilised to escalate the SAB's concerns. TR noted that the LPS author is on the implementation group for London and it had been noted that the position is the same across the country. She noted that Islington SAB had developed some awareness slides around Deprivation of Liberty Standards and the proposal for new Liberty Protection Standards. TR to provide presentation slides to AS/RW for circulation to SAB partners. VN highlighted that since organisations are not able to progress implementation of the LPS, other boroughs are focusing on ensuring that mental capacity training is embedded, so that practitioners are confident in applying the Mental Capacity Act 2005.

CONFIDENTIAL

	ACTION: **12. TR to send Islington DoLS/LPS slides to AS/RW for circulation.**
	INFORMATION ITEMS
10.	**HSAB Risk Register** The Risk Register was noted for information.
11.	**HSAB Forward Plan** VN noted that the Multi-Agency Pressure Ulcer Protocol and Decision Pathway is due to be reviewed by him and TR in time for the January SAB meeting, however, input is required from the local authority. GMcH offered to support this. VN to contact GMcH. The remaining items for January's SAB meeting were noted. **ACTION:** **13. VN/TR to liaise with GMcH around the input required to review Multi-Agency Pressure Ulcer Protocol and Decision Pathway.**
12.	**Any Other Business** PR provided some information on a new Multi-Agency Safeguarding Tracker (MAST) that has been developed, which pulls together data about clients' contacts with various agencies, e.g. Adult Services, Police, Fire Brigade, hospitals. The cost is £14K per partner per annum and the aim is that the tracker provides instant access to partner data which may inform adult safeguarding knowledge and approaches. AC thanked PR for the information. BT noted that it would be useful to look at the information available on the MAST outside of the meeting to understand the added value of the tracker. GMcH noted concerns around partners having to input data into the MAST as well as current IT systems. VN also noted that the data sharing framework for the MAST would need to be considered. **ACTIONS:** **14. PR to arrange conversation about the MAST with key SAB partners.**

CONFIDENTIAL