Enfield Safeguarding Adults Board

Annual Report 2012/13

www.enfield.gov.uk/safeguardingadults

ENFIELD Council

Working in partnership with local people and

Enfield Clinical Commissioning Group

Message from the Chair

Marian Harrington
Independent Chair of the Enfield Safeguarding Adults Board

This report marks the end of my first year as Independent Chair of the Enfield Safeguarding Adults Board. I would like to thank Ray James for the strong position the Board was in when I took over and his support over the last year in my new role. During the year we have reviewed the way the Board operates and the membership of the Board. We established new sub groups for the Board to ensure we complete all the actions we promised in the Safeguarding Adults strategy. We have continued to emphasise the importance of all vulnerable people being treated with dignity, respect and compassion.

During the year we have consulted on and published our new three year safeguarding adults strategy. We were pleased in the interest shown by local people and made sure the comments and suggestions they made were included in our plans for future work.

This has been a very challenging year for adult safeguarding. The details of the terrible events at Winterbourne View and Mid Staffordshire Hospital which have emerged over the year have served as a clear reminder that we can never be complacent about the quality of services. This has shown so clearly how important it is to listen to the voice of people who use services and their carers.

We have worked hard over the year to continue to raise awareness around adult safeguarding. We have placed articles in local publications and have had two, specific, awareness-raising events during the year. We have seen an increase in the number of adult safeguarding referrals received by the social work teams.

This year has seen the shadow formation of Enfield Clinical Commissioning Group to commission local health services. I have been pleased to see how seriously they have taken their responsibilities around adult safeguarding. I have been pleased to be invited to speak to lead GPs and the Governing Body over the last year. I wish them well for their first year of operation and look forward to continuing to work closely with them to keep adults in Enfield safe.

There are over 160 care homes in Enfield and the Council and CCG have been keen to support them to provide the highest quality service. The My Home Life programme provides support for homes managers and helps to emphasise the positive aspects of residential and nursing care for older people. The Councils Safeguarding Adults Service and the Care Quality Commission are vigilant in following up all issues about the quality of services which are reported to them and challenging poor practice.

The Quality Checker Programme has been very successful, in its first year, with local volunteers visiting a whole range of local services and feeding back on the quality of the services they find. They have been able to establish rapport with people who use the services and provide the Council with a unique insight into their views.

I would like to thank elected Councillors in Enfield for their continued support and interest in safeguarding adults. I would also like to thank all the members of the Board and partner organisations for their enthusiastic work on all areas of safeguarding adults and to the residents of Enfield for their vigilance.

Message from Service Users, Carers and Patients on Board Sub-Group

The Service Users, Carers and Patients contribute towards actions and oversight of safeguarding adults in Enfield, and were asked about how they feel we keep people safe. This is their response.

"We hear all the time about the abuse of people and to know there are those out there who will overlook, act and stop abuse is a good thing. The group will take some time but the ideas and intentions are good."

"I think the work being done keeps people safe; more people know we are there to help them, even if they are not ready yet to take that help, its nice to know people are around. I hope we can help someone to keep safe through the work the group is doing, which is good and interesting."

"We are pleased that the Safeguarding Adults Board recognises and values the Service User, Carer and Patient Group. During the last year we have been restructured and with new members."

"We have been able to pass back information to the community, such as through the Talking Newspaper, which will help people to know what abuse is."

Glossary of Terms

Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.

Adult at risk are people over 18 years of age who are or may be in need of community care services by reason of mental health, age or illness, and who are or may be unable to take care of themselves, or protect themselves against significant harm or exploitation. The term replaces ‘vulnerable adults’.

Personalisation – the Personalisation agenda aims to ensure that everyone receiving social care support has more choice and control over how services are delivered to them.

ADASS	The Association of Directors of Adult Social Services
B&CFHT	Barnet & Chase Farm Hospitals NHS Trust
BEHMHT	Barnet, Enfield and Haringey Mental Health NHS Trust
CMHT	Community Mental Health Team
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
DH	Department of Health
DVSG	Domestic Violence Strategic Group
EDA	Enfield Disability Action
ESCB	Enfield Safeguarding Children’s Board
GP	General Practitioner
HHASC	Health, Housing and Adult Social Care
HASC	Health and Adult Social Care
HM	Her Majesty’s (Government)
IDVA	Independent Domestic Violence Advocates
ILDS	Integrated Learning Disabilities Service
DBS	Disclosure and Barring Service
LBE	London Borough of Enfield
LD	Learning Disabilities
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
MH	Mental Health
NHS	National Health Service
NMUHT	North Middlesex University Hospital NHS Trust
OP	Older Persons
OP CMHT	Older Persons Community Mental Health Team
OT	Occupational Therapy
PCT	Primary Care Trust
PD	Physical Disabilities
RSL	Registered Social Landlord
SAB	Safeguarding Adults Board
SCIE	Social Care Institute for Excellence
SSCB	Safer and Stronger Communities Board
VAWG	Violence against women and girls

Contents

1. Introduction and Strategy 5

2. Key Developments, Objective and Progress 7

3. Other achievements, challenges and opportunities 9

4. Quality assurance and organisational learning 12

5. Difference that safeguarding adults has made to those who have been harmed 14

6. Quality of Care in Provider Services 15

7. Safeguarding Adults Board Sub-Groups 17

8. Partner Statements 2012/13 19

Barnet and Chase Farm Hospitals NHS Trust 20

Barnet and Chase Farm Hospitals NHS Trust and Enfield Community Services 22

Enfield Clinical Commissioning Group 24

Enfield Homes 26

Enfield Safer and Stronger Communities Board 27

London Ambulance Service 29

London Fire Brigade – Enfield Borough 30

Enfield Borough Police 32

North Middlesex Hospital NHS Trust 34

Appendix 1: Safeguarding Adults Strategy: Action Plan 2012-2015 36

Appendix 2: Safeguarding Adults Referral Report 2012/13 41

1. Introduction and Strategy

This report sets out how Enfield has worked to safeguard adults from abuse in 2012/13 and how we intend to continue and expand upon this work in the coming year.

Keeping adults safe has always been a high priority in Enfield, which was one of the first partnerships in the country to produce a safeguarding adults strategy, in 2009. Our primary aims, since this time, have remained largely unchanged, as we want to work with local people and partners, so that adults at risk 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 to easily get the **support**, protection and services that they need.

The Safeguarding Adults Board is a partnership of statutory and non-statutory organisations, including local people and those who use services and their carers, committed to preventing and responding to the abuse of adults at risk. The Board meets every quarter and has an action plan to ensure we remain focussed on key activities to keep people safe.

Since our first strategy in 2009, we achieved many of the outcomes we set ourselves. In early 2012, we reviewed our strategy and asked local people what actions we should take to meet the priorities of the Board in the coming three years. The answers from the consultation and other activities in the community have helped to inform the action plan in the Safeguarding Adults Strategy 2012-2015. This will directly impact on and inform what we do to prevent and respond to the abuse of adults at risk.

The two main areas that respondents wanted more focus on were **raising community awareness** and **ensuring action is taken immediately** once a concern is reported.

Some of the points raised by respondents were:

- The way information is provided needs to be diverse, particularly for those who are born deaf or use British sign language.
- Immediate responses need to be ensured and service users visited in their own home.

> "Safeguarding Board should offer abused person as a first choice to be seen at their own home as they feel comfortable there."

- Advocacy services need to be provided; e.g. one respondent spoke about the needs of people that are isolated in care homes.
- Provision of help for people who are at risk but not identified or known to social services needs to be considered.

> "As a local GP, there is always a fear that vulnerable people might be left out of care, either due to not asking for help/not having (or difficulty having) access to health care and social needs. A dedicated service serving whole or part of Enfield, either to serve or co-ordinate access to service, will help."

- There was the request for more free safeguarding adults training.
- There was the call to improve the quality of care homes.
- The use of information technology was considered to be an exciting development.

We are responding to all these points through the Safeguarding Adults Strategy 2012-2015, which has been published and an action plan developed.

The ten priorities of the strategy are:

1. To continue to raise community awareness of safeguarding adults – we want the people of Enfield to be able to recognise, prevent and report abuse.

2. To work with organisations and agencies to ensure they treat people with dignity and respect – we want to make sure systems are in place to prevent the abuse of adults at risk who use support services, including dignity in care and quality improvement programmes.

3. To continue to improve our practice in responding to reports of abuse and quality assure those responses – we want to make it easier for people to report abuse and make sure they receive a good quality service, when they do so, by reviewing our safeguarding interventions and protection arrangements.

4. To listen to, and ensure people who are at risk of abuse, or have been abused, are fully involved in local safeguarding arrangements and improvements to services – we want people to feel they are listened to and, most importantly, to feel safe.

5. To support people to protect themselves from abuse – we want adults at risk to have access to advice and information to help them protect themselves from abuse and to enable them to make choices and manage risk, relevant to their own situation.

6. To support people who choose to arrange their own care to do this in a way that protects them from abuse – we want to ensure people have the opportunity to take responsibility for their own protection and are supported to manage risk.

7. To make sure adults at risk get access to the justice system – we want the police, the Crown Prosecution Service (CPS) and the courts to make sure adults at risk get equal access to the justice system.

8. To work with people to avoid situations where they may be at risk of abusing others – we want to work with people to manage risk to themselves and others.

9. To collect and analyse statistics about reports of abuse and take action to improve local safeguarding arrangements – we want to use the information we collect to improve local safeguarding arrangements by looking at trends, areas of concerns and what we can do to address them.

10. To promote and implement the use of Information Technology for safeguarding adults – for example, using appropriate surveillance technology to detect or identify abuse of adults at risk.

2. Key Developments, Objective and Progress

The key objective of the Safeguarding Adults Board has continued to be the raising of awareness of abuse and how we work to prevent it. We believe safeguarding adults is everyone's business – it is an issue that can affect any one of us and together we can stop it.

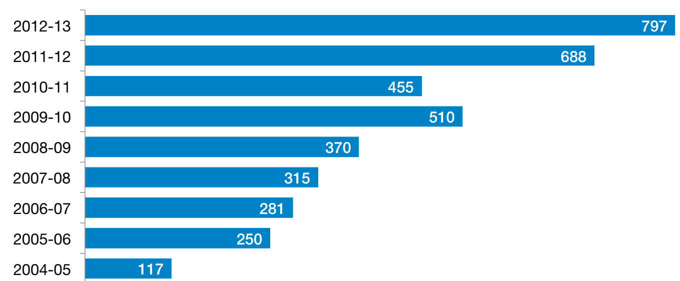
We have continued to see the number of safeguarding adults referrals received by adult social care increase; this year we saw 797 referrals made- an increase of 14%. In spite of this increase in reporting, the abuse of adults at risk continues to be under-reported and under-represented in some of the communities in Enfield. The Board has continued with efforts to raise awareness and the profile of safeguarding adults, so that more people understand what abuse is and how to seek support.

Two, successful, week-long, event programmes were held, one during October 2012 and one during March 2013. In conjunction with the Enfield Safeguarding Children's Board, these events aimed to bring together information on how to keep oneself safe and prevent abuse. Partners, such as the London Fire Brigade, Safer Neighbourhood Team, Trading Standards and the North Middlesex Hospital NHS Trust, took part.

We also saw the re-launch of the Community Help Point Scheme in March 2013. Originally set up in 2007 to provide places of support to enable young people to safely navigate the borough, this scheme has now been extended to cover adults at risk. Businesses and organisations nominate themselves to act as help points for people who are lost, frightened or afraid and in need of assistance. At the re-launch event, volunteers from One to One Enfield did a short play on hate crime and how it impacts on people with learning disabilities, while Face Front Inclusive Theatre acted out scenarios of people who may need to access, for assistance, the Community Help Point Scheme.

The Board continued to raise awareness through the many mechanisms available, including articles in Our Enfield, Enfield Homes magazine and the Essential Guide for 2012-2014. With the support of a member of our Service User, Carer and Patient Group, we also had information on safeguarding adults in the Talking Newspaper.

The following graph displays the number of referrals received since the local multi-agency policy was launched in 2003 and until March 2013. The date indicates that the result of heightened awareness, following community events and other actions having been undertaken by Board partners, has been effective.



Key themes from the safeguarding adults referrals, include (for further information, please see Appendix B):

- April 2012 to March 2013 there were 797 referrals (alerts) received. This is an increase of 14% from the previous year.
- There has been a 31% increase in alerts related to people over 65 years of age.
- Most alerts relate to multiple abuse (29%) or neglect (26%).
- 40% of the referrals are in relation to alleged abuse in the Adult at Risk's own home and 30% are in a residential/nursing home.
- Hospital staff made the most referrals, at 18%.
- 36% of alerts relate to adults aged 18-64 while 64% to adults aged over 65 years.
- There is an increase in referrals from Black and Ethnic Minority communities.
- For the person alleged to have caused harm, 243 (31%) are family/friends/neighbours of the adult at risk and 245 (31%) are formal social carers.
- Of the 797 safeguarding adults referrals (alerts) received, 660 proceeded to the safeguarding adults process.
- 33% of cases had a nominated advocate involved, which may be both paid or a family or friend.
- 88% of the strategies agreed were within the target of five working days from the alert.
- In 87% of cases, the alerter was informed of the strategy on the same day it was agreed, if considered appropriate. This is an improvement from 38% in 2011/12.

Relating to the cases which are now closed:

- Of the 170 cases that have an outcome following investigation, 35% of them were substantiated or partially substantiated (34% in 2011/12).
- 63% of eligible cases had a review.
- Some of the outcomes for adults at risk included: supporting individuals to move away from the property or service causing them harm in seven cases, and in 48 cases we increased monitoring to contribute towards protection planning and safety.
- In 19% of closed cases, the outcome for the person alleged to have caused harm was 'continued monitoring', whilst in 11 cases there was disciplinary action recorded.

In addition to raising awareness, a range of actions took place across the partnership to prevent abuse and keep people safe. The Police Community Safety Unit meet regularly with the Council's Safeguarding Adults Service to review that all referrals being made are progressing appropriately; access to the justice system is important for adults at risk. The Police have also internally audited and reported on how safeguarding adults is flagged, recorded and addressed within their organisation. From this data a range of proactive recommendations has been made, to ensure equality of service for adults at risk.

The Enfield Clinical Commissioning Group (CCG) officially begun its role from April 1, 2013. The CCG is led by local GPs and will commission the majority of health services, giving the opportunity for health-related services to be arranged and delivered which are responsive to local need. Over 2012/13, much work was done to ensure responsibilities were transferred to the CCG, which includes how it will safeguard adults at risk. The CCG have set out their policy on safeguarding adults, in terms of what it will expect from the services it commissions and a number of groups have been set up, including one which focuses on quality and safety. Members of the CCG Board have also had training in relation to their safeguarding adults responsibilities.

Training and development opportunities are important for staff who work with adults at risk. Enfield Council has continued to open up its e-learning and classroom-based training session to partners, focusing on areas such as investigators training. In addition, the Enfield Safeguarding Adults Service delivered safeguarding adults training to all General Practitioners, in early 2013.

At the centre of everything we do is the experience of and contribution from adults at risk; this includes learning from the experiences of such adults. To improve safeguarding, all of our Board partners include the participation of people who use their services. Examples of where this takes place, include:

- Barnet and Chase Farm Hospital Trust have a patient and carers advisory group with an action plan; they also arrange audits of wards by service users with questionnaires.
- In the Barnet Enfield and Haringey Mental Health Trust they have a dignity audit, completed by service users who go out to the ward and ask questions about people's experiences. There are carers on management group meetings and a service user representative on a clinical governance group.
- Patient story and learning experience is brought to the North Middlesex Hospital NHS Trust senior management group. There are also service users and carers on the Patient and Quality Group.

We know that unpaid carers, such as family or friends, are often under pressure with the level of care they provide. This can lead to carers putting at risk of abuse the person they care for and there are also cases of the cared for being the abuser. In response, the carers' commissioner for adult social care has worked to set up targeted events for carers, in conjunction with the Carers Centre. A leaflet is also being developed to help carers keep themselves, and the person they care for, safe and well. Information, such as this, will help to prevent abuse from happening, in the first place.

3. Other achievements, challenges and opportunities

In addition to the above, a number of achievements have been demonstrated by the Board and across the partner agencies. We have:

- Ensured adult social care has practice-based forums, to focus on sharing good learning examples and how we continue to keep adults at risk in the centre of the process.
- Developed an electronic newsletter for professionals in Health, Housing and Adult Social Care, promoting information on safeguarding adults, including changes that occur at national and local levels.
- Demonstrated analysis of reports of abuse and learned from trends, in such areas as advocacy and protection planning.
- Delivered information sessions to carers, on safeguarding adults, alongside colleagues in the Brokerage service, which focused on personalisation.

The Central Safeguarding Adults Service is working with the Council's Drug and Alcohol Action Team (DAAT) to ensure that adults at risk, living with substance misuse, are safeguarded from potential or actual abuse, as well as against posing a risk to others. The DAAT has contributed to the development of an action plan and is attending practice forums. The Central Safeguarding Adults Service is currently promoting awareness of safeguarding procedures, amongst DAAT staff and their managers, and developing safeguarding practices to promote identification of drug and alcohol users at risk, preventative actions and risk minimisation.

We saw an increase in requests for Deprivation of Liberty Safeguards (DoLS) authorisations in 2012/13. The DoLS are for people who lack mental capacity and may require care or treatment in a hospital or care home, where their freedom may need to be restricted to the point of depriving them of their liberty. This can only be done lawfully if appropriate authorisation for a Deprivation of Liberty Safeguard has been sought. There were **36 DoLS requests made**, of which 33 related to people in residential or nursing homes and 3 related to people in hospital. Of these, 28 were authorised and 8 were declined. There were also 3 DoLS reviews conducted, all of which resulted in the authorisation being ceased.

Personalisation is about ensuring that everyone who receives social care support has more choice and control over how services are delivered to them. We have helped to develop the local personalisation arrangements, across adult social care, by working to balance increasing choice for people, while keeping them safe. An example of this is our contribution to how the Social Care Market Place has developed, including planning for how services will be vetted, in the future. The market place will enable you to view services and providers and purchase services, with a personal budget or by using your own money. We believe clear and transparent information about the types of services and support available will enable safer and more informed choices.

The voluntary sector in Enfield has continued to show a high level of commitment and drive to keep people safe from harm. Over the last year, we have had three voluntary sector organisations supporting the work of the Board and sharing information across partners; these are: Age UK Enfield, One-to-One Enfield and Enfield Disability Action. These partners have provided support to raise awareness of abuse, to target information for service users who use their services and also to raise reports on abuse, when they have concern.

Safeguarding adults is very much about how people are treated with **dignity and respect**. We believe in promoting the Dignity Standards, which are:

1. To have a zero tolerance of all forms of abuse
2. To support people with the same respect you would want for yourself or a member of your family
3. To treat each person as an individual, by offering a personalised service
4. To enable people to maintain the maximum possible level of independence, choice and control
5. To listen and support people to express their needs and wants
6. To respect people's right to privacy
7. To ensure people feel able to complain, without fear of retribution
8. To engage with family members and carers, as care partners
9. To assist people to maintain confidence and a positive self-esteem
10. To act to alleviate people's loneliness and isolation

We have written to all residential and nursing homes, to challenge them to meet these standards and display the Dignity Challenge Poster. Our local hospitals have also shown a commitment to the dignity standards. A range of actions and activities, to ensure that their patients are treated well, have taken place, such as the Butterfly Scheme in Barnet and Chase Farm Hospital, in which care to patients with dementia has been supported.

The Safeguarding Adults Board works within a challenging area, and despite the evidence of good work being undertaken and positive outcomes for adults at risk, there is always much more to do.

Keeping safe adults at risk is receiving increased focus in the media, following high profile cases such as 'Winterbourne View Hospital' and the public enquiry into events at Mid Staffordshire Hospital. Events at Winterbourne View Hospital, a facility for people with learning disabilities, were uncovered by BBC Panorama and evidenced the most appalling abuse and violence against adults at risk. The use of covert surveillance by the BBC has demonstrated the effectiveness of surveillance in uncovering inappropriate and, indeed, violent behaviour towards vulnerable individuals. In the coming year, we will consult on a policy for Health, Housing and Adult Social Care on the use of overt and covert surveillance to deter and detect abuse, seeking feedback from residents and key stakeholder on its implementation.

Changes in health will have a big impact on how we keep people safe. Clinical Commissioning Groups will have responsibility for identifying the needs of the local population and commissioning health services to meet these needs. This is a real opportunity for the Board to work with Enfield CCG, to ensure that these services are safe and do not cause harm. The Enfield CCG has already joined up with the Local Authority to fund a safeguarding adults nurse assessor, which provides invaluable clinical input into high risk cases and developing network of health investigators for safeguarding adults; this post will continue during the coming year.

The Care and Support Bill has set out its intention for **Safeguarding Adults Boards to become statutory**. We are well placed in Enfield to deal with this challenge and see this as a great opportunity to strengthen the existing partnership.

Nationally, we are also seeing major changes in the political and economic context in which services and activities are planned and provided. We have the impact of the national and internal budget deficits, coupled with the impact of poverty and health inequalities faced by some groups. All of this will affect the capacity of individuals and whole communities to care well for themselves and the more vulnerable residents. The Board will face these challenges to ensure those most vulnerable are kept safe from harm and that the routine analysis of abuse takes into consideration trends associated with these political and economic changes.

The above national changes may also impact on carers and families, so we need to improve out understanding of the stress faced by families, in order to be able to take a holistic approach to care and risk planning. By improving our understanding and working across adult and children's services, where necessary, we can help alleviate the strain placed on families and the potential for harm.

Our work with the Safeguarding Children's Board is an important part of how we keep everyone safe. In addition to joint events, the two Boards will need to consider how we can join up projects and initiatives which keep all communities safe. The extension of the Community Help Point Scheme, in March 2013, was an example of this and further projects will be considered in 2013/14.

During 2012/13 we saw the number of referrals for safeguarding adults increase to 797, which of these 660 proceeded to the safeguarding adults process. The coming year will also see the Police use Merlins, which are a reporting system for adults coming to the notice of police personnel. This may result in a higher number of referrals to adult social care, which need to be screened and assessed to ensure the safety of individuals and to determine whether they require progression under safeguarding adults procedures. In response to these two factors, the Council's Safeguarding Adults Service are working with Adult Social Care Teams, to review the resources needed to effectively and safely manage safeguarding alerts.

The safeguarding adults process is aimed at ensuring that the outcomes identified by the adult at risk are achieved; its about asking their views on whether risk has reduced without compromising the other things that are important to them. To ensure we keep people central to the safeguarding adults process, where their views and experience drive practice, the Enfield Safeguarding Adults Service are developing methods for feedback which can be translated into service improvement.

We know from our data that reports of abuse involving older adults continues to increase in Enfield. There were 38,880 people aged over 65 years in Enfield in 2011, with 5,345 aged 85+ years (ONS Census). Of these individuals, around 7,200 have two or more problems with daily living, such as washing and getting around and about their home, due to an underlying health problem. As a result of their circumstances, such individuals are some of the most vulnerable older people living in Enfield, and are therefore at risk of harm, abuse and/or neglect. Our awareness events will shift to target this area and work towards a more preventative model in care homes with our health partners and commissioners in the Clinical Commissioning Group. We will also continue to work with **Trading Standards** to raise awareness of rogue traders and scams, particularly against older people.

One group of older people, especially at risk because of their condition, are those with **dementia**. It was estimated 2,700 people in Enfield suffer from the condition, with 1,225 of these having advanced dementia. Households living with dementia can be doubly at risk because, even at any early stage, such individuals can begin to lose contact with friends and family, leading to social isolation. The Board will continue to ensure that issues of **mental capacity**, prevention of abuse and providing information to help people make informed decisions continues in the coming year.

Learning from events at Winterbourne View Hospital and Care Quality Commission reports into the application of the Deprivation of Liberty Safeguards has highlighted the need to continue to raise awareness of this area. The Enfield DoLS Office has responded proactively by setting up targeted training with the care homes and hospitals most in need of support, including a programme of 'train the trainer' courses. In this coming year we will focus on setting out a **Deprivation of Liberty Safeguards and Mental Capacity Action Plan**. Only 4 DoLS cases of 2012/13 related to people in hospitals. NHS trusts have been prompted to commission more training for their staff to ensure there are no unauthorised deprivations of liberty occurring and we will continue to support NHS Trusts to improve in this area.

The personalisation agenda in Enfield remains a priority for the coming year, so that adults at risk and their carers are empowered to take a lead role in how they are cared for and supported. This will include helping them to manage risk and protect themselves from harm. We also saw from our data that advocates, both paid and informal, were recorded in 33% of cases. **Advocacy** is particularly important for adults at risk to support their voice to be heard and identify those outcomes which will improve their quality of life; the Service User, Carer and Patient sub group of the Board is very passionate about challenging and improving this area in the coming year.

4. Quality assurance and organisational learning

The Safeguarding Adults Board has a range of activities which aims to ensure the high quality of our responses to reports of abuse and that learning from these activities is embedded in our future practice. The Quality Checker Programme, in Adult Social Care, is an example of how service users and carers directly impact on how care is provided.

The Council's Health, Housing and Adult Social Care department commissioned an external safeguarding adults case audit, where an independent consultant reviewed a number of safeguarding adults cases, selected at random. The aim of this review is to look at case practice, against a standard of excellence, and identify where there have been improvements, in previous years, and where further work needs to be done.

The audit found that the following had changed for the better:

- There is better recording and follow-through action, in relation to individuals or organisations that have caused harm.
- More staff and managers are following the principles of keeping adults at risk as central to the safeguarding adults process and to participation and are maintaining a record of this.
- There has been some improvement in protection planning, but more needs to be done for the medium-to-long term.

The areas of good practice noted, in some cases, were:

- The clarity, relevance and timeliness of **recording**.
- The **Timeliness** of safeguarding actions taken.
- The quality of **risk assessment**.
- The quality of the **investigations** which were held.
- The quality and wide use of **protection planning**, in some form.
- The **person-centred** approaches to adults at risk.
- An increasingly sophisticated use of the **Mental Capacity Act**.
- The effective **chairing of safeguarding meetings**.
- The recording of episode **closures and outcomes**.
- Where **a child** is linked to a Safeguarding Adults case, there is excellent, pro-active liaison with Children's Services.

Areas identified for focus, in the coming year, include:

- Due rigor, care and probity should be ensured when working with all organisations alleged to have caused harm.
- More adults at risk or their representatives should be invited to and actively supported to attend safeguarding meetings (or parts of these).
- Ensuring that recording-related improvements, such as managers' decisions, sending of minutes and sign-off of safeguarding templates, occur in a timely manner.

In addition to the external audit, the Central Safeguarding Adults Service complete quarterly case file audits with managers or staff who worked on a case. This helps to ensure that any learning can be done from the ground up and continuous improvement is put into practice. The Central Safeguarding Adults Service want to ensure that practice **reflects the achievement of outcomes that the adult at risk identifies**; to achieve this, the audit form will be amended and an emphasis placed in practice recording which accurately portrays how the safeguarding process has improved safety and well-being of the adult at risk.

Managers working in Barnet, Enfield and Haringey Mental Health Trust also have an audit process, which helps to assure case practice for adults at risk that have mental health needs. This is done on a monthly basis and promotes best practice.

Quality assurance activities must have those who use services as key participants. Enfield's Quality Checker Programme exemplifies the commitment to include those who are services users and carers to directly influence how care is provided. Quality Checkers are service user and carers who have provided feedback and insights that have helped improve our day centres, residential units, extra-care sheltered housing units, private care homes and equipment retailers. We are currently working on pilot projects for home care and, following the recent Winterbourne View Report, hospital wards for learning disability service users.

> "Learning from the personal experiences of people who receive care services, I believe is the best way to improve care services and drive up quality."
>
> *Bindi Nagra, Joint Chief Commissioning Officer*

By the end of March 2013:

- We have recruited and trained 50 Quality Checkers
- We have sent 22 Quality Checkers out on visits. 11 of these Quality Checkers are now 'buddies', which means they will visit services in pairs. This means that we usually have carers, service users and different client groups represented on each visit, resulting in excellent and balanced feedback.
- We have completed 57 Quality Checker 'mystery shopper' visits.
- In addition, there has also been one 'mystery shopper' call to Brokerage.

So there are now 58 pieces of Quality Checker feedback/ improvement plans being processed, currently.

Some examples of the difference the Quality Checkers have made to services include:

Day centre to social club

After two Quality Checker visits to different older persons' day centres, a common theme emerged: Our Quality Checkers felt that the day centres should feel like social clubs and that this was not found in these centres. Managers were made aware of this, with the suggestion that re-organising the chairs so that they were in smaller circles, rather than in one big circle or against walls, would help make conversations between service users easier. This is something that all Enfield Council-run, older persons' day centres are now doing.

100%

One of our day centres for adults with learning disabilities achieved a perfect score – all of the Quality Checkers' feedback fell into the "Things that impressed" category. This was very satisfying for the day centre staff. The feedback also highlighted a difference in cultures between the older persons' and learning disabilities services. To help address this issue the Quality Assurance Team is organising Improvement Hub meetings for the day centre managers.

How do I get in?

On a visit to one of our larger equipment retailers, the Quality Checkers felt the signage identifying the store and how to get into the building was an area that needed to be improved. Their concern was that once on the industrial estate where the retailer is based, service users or carers would not be able to find their way in to the retailer and might feel unsafe on the estate. This has been fed back to the store manager, who is organising new signs.

No price tags, no receipt, no chance!

On a visit to a smaller equipment retailer, the Quality Checkers found that the price of equipment for self-funders was not clearly displayed. They also found that the retailer did not provide a receipt after a transaction had been made. These practices have led to the retailer being issued with a warning. If such practices are still evident on future visits, the retailer will be removed from our retailers list.

5. Difference that safeguarding adults has made to those who have been harmed

The Care Management Service received a safeguarding alert from a home care agency stating that **Mr. and Mrs. A** seemed to have money missing from their account. The Care Management Service spoke to Mr. and Mrs. A and then contacted the police, following which an investigation was opened.

It transpired that the money had been taken from a cash machine, by a member of the home care agency's staff, and the member of staff was suspended immediately. Because of the prompt communication with the police, CCTV evidence was discovered and the member of staff was charged and eventually found guilty of fraud. Mr. and Mrs. A received compensation from the court and the member of staff has received a Community Order and is registered with the Disclosure and Barring Scheme, so they will not be able to work with other vulnerable people, in future.

Mr. and Mrs. A also had their care needs reassessed, as part of the process, and they are now supported to manage their finances, through the London Borough of Enfield. This should protect them from further financial abuse, in the future. They have reported that they have found the professionals that they worked with to be caring and are happy with the result.

Ms. B is a younger woman, with a diagnosed Mental Health condition, who works with the Community Rehabilitation Team. During her work with the team, it emerged that her accommodation was in desperate need of improvement and that the manager of her supported tenancy was alleged to have been verbally abusive to her.

The team worked with Ms. B to establish that her wishes and that she had capacity to make her own decisions about her accommodation. They investigated and insisted that improvements be made. As a consequence, Ms. B's accommodation is now properly ventilated and the bathroom is fixed. The manager apologised to her and they have a more positive working relationship. Most importantly, Ms. B says she now knows who to call if she has a problem and that she will be listened to and treated with respect.

Mrs. C is an older woman who suffers from dementia and is cared for by her husband, Mr. C. The London Ambulance Service visited the home and were concerned that Mr. C might be being emotionally abusive to his wife.

A social worker visited Mrs. C at her day service and spoke to other professionals who knew the couple. She was able to determine that Mr. C was a loving husband who was struggling to care for Mrs. C and was very isolated. She conducted a Carer's Assessment. He didn't want extra practical help as he wanted to do this himself but the social worker arranged for Mr. C to make contact with both the Carer's Centre and Age UK so that he could make connections with others in the same situation. He said that he was grateful to be talked to as an individual and to have everything that he did to help his wife recognised.

Miss D is a woman with learning disabilities who lives in a care home in Enfield. She told a friend that she had been assaulted by another resident. The Integrated Learning Disabilities team visited her the day that they received the report, in order to see that she was safe. The person alleged to have caused harm was found alternative accommodation and Miss D was supported to report to the Police.

Miss D's capacity was assessed in accordance with Mental Capacity Act (2005) and she had an advocate working with her throughout the process. The Integrated Learning Disabilities team also worked closely with the residential home and the CQC in order to make sure that all residents were safe and that the risks had been properly assessed.

Miss D has been given support from the Occupational Therapy team around how she might keep herself safe, in future.

6. Quality of Care in Provider Services

People who use care services have an expectation that they will be safe, that the service which is delivered has quality embedded in all aspects and that these care services will be delivered with dignity and respect. Enfield is committed to ensuring that those, who receive a service, are kept safe and have a number of processes in place to achieve this.

The events at Winterbourne View Hospital awakened many people to a reality that care is not always synonymous with quality and that abuse can and does happen within provider services. They showed that how services are provided encompasses a complex web of multiple partners and that multi-agency working has to be key, if we are to uncover failings in the system.

Abuse was revealed at Winterbourne View Hospital by the BBC in Panorama Undercover Care: the Abuse Exposed, in May 2011. Winterbourne View was a private hospital for adults with learning disabilities and autism and, following the exposure of widespread, institutional abuse, was closed on 24th June 2011. Many of the conditions which allowed the abuse to occur were present from 2008, which included the use of restraint by untrained staff, the lack of a registered manager in post, poor oversight of patients and a lack of patient advocacy. The environment created was one in which "patients lived in circumstances which raised the continuous possibility of harm and degradation" (Flynn, 2012, SCR).

Partners on the Safeguarding Adults Board reported in December 2012 and March 2013 how their organisations have learned from the events at Winterbourne View, in order to prevent and put in place systems which will assure that people are kept safe. This includes, for example, changing how we commission services and review placements at hospitals, our advocacy service and ensuring we monitor trends and numbers in alerts, complaints and other factors which can highlight a failing care provider.

This year we also saw the Francis Report in response to the care provided by Mid Staffordshire NHS Foundation Trust. The Inquiry Chairman, Robert Francis QC, concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care. Robert Francis QC has made 18 recommendations for both the Trust and Government. His final report is based on evidence from over 900 patients and families who contacted the Inquiry with their views.

How Enfield has responded to concerns about the quality of care delivered by local providers, including hospitals, has developed in line with a number of factors. The emphasis on prevention, as set out by the Safeguarding Adults Board's first strategy, in 2009, shifted the focus to stopping abuse in the first place. There is recognition that taking reasonable steps to improve the quality of care, before significant failings or a detrimental impact on residents well-being takes place, as opposed to responding when harm has occurred, will always be the preferred option. Furthermore, the fostering of relationships between the local authority, as lead for safeguarding adults, and organisations, such as the Care Quality Commission, Clinical Commissioning Group and the police, has created a strong partnership, committed to responding robustly to concerns raised within provider organisations.

The Safeguarding Information Panel (SIP) was created, stemming from a partnership of the Councils Central Safeguarding Adults Service and the Care Quality Commission. The panel brings together information from the Council, such as safeguarding, health and safety and information held by commissioning staff, with that of partner organisations. The panel is instrumental in helping partners share information and in identifying common areas of concern. Some of the outcomes from these meetings, include:

- To ensure that care homes, where the provider concerns process is needed, are identified
- To link homes with specific audits. These will be undertaken by pharmacists, to improve medication management
- To co-ordinate joined-up interventions, such as work by the Local Authority and the Clinical Commissioning Group
- To set out a work plan for a policy on pressure care.

The Panel has also successfully identified a complex theme, involving risk assessment in care plans meeting Health and Safety guidelines. This was then implemented at the Quality Improvement Board, which manages projects with service users and carers.

The Central Safeguarding Adults Service in Enfield Council manages the provider concerns process. This process is put in place in response to concerns or information which highlights that a care provider is failing to meet the reasonable expectations in terms of quality, safety and dignity in care. We will work with our partners to support provider of care services to implement improvement plans, which will increase the standard of care for all residents. Service users and their families and friends play a big part in providing feedback on their experiences of the provider and letting us know when they are happy with the quality of the care and the dignity upheld by it.

> As someone with a loved one in a nursing home, I have to thank the Central Safeguarding Adults Service for their quick action in sorting out problems within the home and, by doing so, ensuring a safe environment for elderly and often extremely vulnerable people; some without a voice of their own. It is vitally important for close relatives to have someone to contact at Enfield Council, when they have serious concerns about a home, and to be able to do so with confidence.
>
> *Relative*

In 2012/13 we had 22 providers under our concerns process.

Nursing Home C had undergone a previous improvement plan to look at issues regarding quality of care. Concerns still existed and some residents, their families and visiting professionals raised further issues with staffing levels, quality of care and safety of residents. A range of partners worked together, such as the Central Safeguarding Adults Service, Care Quality Commission and NHS Enfield/Shadow CCG.

An improvement plan was put in place, along with a range of protective measures, to assure us that all current residents were safe to remain in the home.

Because this home had been through the provider concerns process before, everyone wanted to learn from this process and see how concerns of this nature can be prevented in the future. A learning event was held with a range of professionals and many staff from the nursing home, itself. This event identified some areas where improvements can be made, in future, including:

- Improving and setting out our communication strategy for sharing information
- Introducing a risk evaluation process to establish levels of risk and proportionate action
- Establishing greater liaison with families and friends, at an early stage; including their involvement in devising relevant policies and procedures
- Giving greater choice and control to residents
- Introducing into the process timescales for service improvement

The improvement plan was implemented and results were achieved. Subsequently, residents and their families were very happy with the running of the home and felt that the culture of the home had changed completely. Those friends and families that felt disengaged said they really felt that they were being listened to, when they commented on the home. The home is now regarded as a place of excellence.

7. Safeguarding Adults Board Sub-Groups

During 2012/13, we reviewed the sub-groups which support the work of the Safeguarding Adults Board. The Board agreed for there to be four groups, which would be chaired by members of the Board.

The four groups agreed were:

- **Service User, Carers and Patients Group** (co-chaired by Age UK and Over 50's Forum)
- **Quality, Performance and Safety Group** (co-chaired by the police and Clinical Commissioning Group)
- **Learning and Development Group** (co-chaired by Barnet, Enfield and Haringey Mental Health Trust and London Borough of Enfield)
- **Policy, Procedures and Practice Group** (co-chaired by North Middlesex Hospital NHS Trust and London Borough of Enfield)

Service User, Carers and Patient Group

This group, that was previously called the Safeguarding Adults Reference Group and consisted of service users, carers and local residents, was revised. The changes included that the Group would consist primarily of those who use services and their carers (including patients).This acknowledges the health element and input of health-related services in keeping people safe.

The Group currently consists of three service users, one carer and three patients. There is an active drive to recruit new members onto the Group, which can include up to twelve individuals. Support for those needing assistance to attend will be given. The Group is aware of the need to be inclusive and representative of the population of Enfield.

The Group has been meeting, monthly, since January 2013 and, since this time, a number of actions have been taken to contribute to the safety of adults at risk. The Carers Commissioner presented a leaflet that is being developed on supporting carers to remain healthy and well. This will include advice on how to report abuse if they are being harmed or feel at risk of harming the person for which they care. The Group has provided feedback on all areas, including suggesting information which needs to be included to keep carers safe and to enable them to access appropriate support.

Group members have also received information on advocacy. This is currently being reviewed by the Commissioning Service for Health, Housing and Adult Social Care. Members brought external challenges to how commissioning of advocacy will develop and its accessibility to those who need it. The Group will also be reviewing the service specification, in order to provide feedback and comments.

In March, the Group reviewed the safeguarding adults literature and publicity used by the partnership. Feedback was provided, which was shared with partners.

The Group would like to develop a DVD on the different types of abuse, in an effort to increase the understanding of service users, carers and local people. It is felt that a DVD could also include translating and signing for the deaf community, which is a focus of the Safeguarding Adults Strategy Action Plan for 2013/14.

The Group will continue to challenge and review developments in safeguarding, such as how service users are supported to participate in safeguarding adults. This is currently being done through review of case audits.

Policy, Procedure and Practice Group

The Policy, Procedure and Practice Group will focus on ensuring guidance to staff in line with national and local changes, including multi-agency working to ensure best outcomes for adults at risk. Practice will be reviewed to ensure lessons learnt can be embedded and inform how we safeguard adults at risk.

To date, the group has set out and agreed the terms of reference and membership requirement; as the policies and procedures are multi-agency in nature and require sign-up from partners, it is important for a range of professionals and local people to take part.

The Group reviewed a Safeguarding and Serious Incidents Policy which had been submitted for consideration. Members approved the policy, which aims to provide clarity on how the two processes should run, while reducing the risk of duplication.

The Group is currently writing a multi-agency Hoarders protocol, to ensure joined-up working.

The Group will continue to review policies put forward for consideration and lead on any new policies, in line with national or local guidance. In addition, the Group has led for practice developments and, therefore, will consider how multi-agency sharing of lessons learnt can improve how we safeguard adults at risk.

Learning and Development Group

Learning for adults is a diverse activity and spans a range of activities, including formal training sessions, e-learning, group activities and one-to-one reflective practice, to name a few.

The Learning and Development Group is tasked with supporting those in Enfield who both work and support adults at risk to gain a minimum basic competency set, with commissioning training courses and embedding organisational learning, that arises from the many activities we do.

The following training is mandatory, where relevant, for staff whose organisations are represented on the Safeguarding Adults Board:

- Basic Awareness
- Investigators
- Managers Introduction
- Managing from referral to closure
- Chairing Strategy Meetings
- Refresher course

The multi-agency training programme is currently managed and administered by the Learning and Development Team of the Council's Health, Housing and Adult Social Care department.

The organisations represented on and numbers of people attending multi-agency training courses are as follows:

Course	HHASC	BEH MHT	Police	Private & Voluntary	Totals
Alerters	93	7	0	36	**136**
Investigators	16	6	6	0	**28**
Financial Abuse: Stage 1	10	3	0	0	**13**
Financial Abuse: Stage 2	4	3	0	0	**7**
Legal Context	4	2	0	1	**7**
Managers of staff who raise alerts	10	0	0	9	**19**
Chairing Strategy Meetings	9	2	0	0	**11**
Referral to Closure	6	1	0	0	**7**
Total	**152**	**24**	**6**	**46**	**226**

The courses being run, in 2013/14, include:

- Basic Awareness (e-learning)
- Alerters
- Investigators
- Financial Abuse: stage 1 and stage 2
- The Legal Context
- Managers Introduction
- Managing from referral to closure
- Working with domestic violence and safeguarding adults: Practitioners Course
- Safeguarding Adults and Domestic Violence for Managers

The Learning and Development Group is planning to review the safeguarding adults learning strategy over the coming year, which will include how safeguarding learning is planned, commissioned, delivered and evaluated. The Group will also ensure that all organisations have learning opportunities for their staff, so that everyone will have the knowledge and skills to understand, identify, respond to and report abuse.

Quality, Performance and Safety Group

The Board's Quality, Performance and Safety Group has been set up to ensure oversight of the quality and care of providers and internal processes of partners; this will include audits of case practice and the Board's quality assurance activities.

The tasks that the Group intends to undertake over the coming year, include:

- To scope audits completed across the partnership and provide a quality assessment and gap analysis. This will include referring organisational learning points back to the Safeguarding Adults Board.

- To inform the Board of the effectiveness of partner commissioning functions, to be able to integrate safeguarding adults into its cycle.

- To review and advise partner organisations on how contractual arrangements safeguard adults at risk. To review two partners on an annual basis.

- To advise the Board on the effectiveness of local data collection; including its consistency, timeliness and reliability and its ability to meet national requirements.

- To secure reasonable assurance on safe employment practice; including effectiveness of policies and procedures for recruitment, supervision of people working with adults at risk and compliance with Disclosure and Barring Service (DBS).

8. Partner Statements 2012/13

- Barnet and Chase Farm Hospitals NHS Trust
- Barnet and Chase Farm Hospitals NHS Trust and Enfield Community Services
- Enfield Clinical Commissioning Group
- Enfield Homes
- Enfield Safer and Stronger Communities Board
- London Ambulance Service
- London Fire Brigade – Enfield Borough
- Enfield Borough Police
- North Middlesex Hospital NHS Trust

Barnet and Chase Farm Hospitals NHS Trust

Internal arrangements for governance regarding Safeguarding adults:

- The Director of Nursing is the director responsible for Safeguarding.
- One of the Deputy Director of Nursing acts as the corporate lead for Vulnerable Adults.
- A Medical Matron on each site acts as an operational lead, providing advice and support to staff on adult protection policies and procedures.
- The Trust has a vulnerable adult's board which meets quarterly and has a safeguarding strategy group, to ensure that learning from both children's and adults' safeguarding are taken forward within the organisation.
- An Annual Report which includes the Annual Reports from both the London Borough of Barnet and London Borough of Enfield is taken to the Trust Board.
- A quarterly report, which includes the number of safeguarding alerts/investigations and the numbers of staff who have attended safeguarding training, is taken to the Quality and Safety Committee.

Internal arrangements for training regarding Safeguarding adults:

- There is a session on induction for all staff.
- Additional training has been provided by an external trainer.
- The Trust has e-learning packages for all statutory and mandatory training including Safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguards and Dementia.
- 85% of staff have safeguarding training as of March 2013.
- The Trust solicitor provides training on the Mental Capacity Act.
- Training has been provided on caring for patients with dementia in an acute setting as part of the Trust's Dementia Strategy.

Work undertaken/planned and achievements/ progress in 2012/13:

- As part of safeguarding awareness week and Nurses day the Trust had information stalls on both sites.
- The "We Care" campaign introduced the Quality of Interaction Observational Tool (QUIS) to improve the quality of interaction and communication between staff and patients.
- QUIS audits are undertaken monthly and staff are using this tool to reflect on how they care and to agree actions as a team to continue to improve care and communication. The results of the QUIS audits are reported on as part of performance review.
- The Trust has a Patients and Relatives Group and members of this group undertake QUIS audits.
- The Trust is making environmental changes within the ward areas, to improve the facilities for patients with dementia; this includes the use of symbols and colours to identify key areas within the wards.
- The Trust continues its ongoing commitment to reducing the inequalities experienced by people with learning disabilities, when accessing healthcare environments.
- Training in Learning Disability awareness is provided in a number of formal and informal sessions.
- The Acute Liaison Nurse has provided training to specific wards and departments and has supported the Day Surgery Unit to identify reasonable adjustments they can make to their pathways.
- The Acute Liaison Nurse for patients with a learning disability undertakes sessions on recognizing the needs of people with a learning disability as part of the student nurse induction.
- The Trust has revamped its safeguarding pages on the intranet and has a combined safeguarding page for children and adults, with signposts to relevant sections.
- The Trust implemented the dementia pathway as part of its dementia strategy. As part of this, a range of information and advice sheets are available to patients, staff and their relatives.
- The Trust has implemented the 'green cup' scheme for patients, with dementia, to prevent dehydration.
- Distraction boxes have been implemented for patients with dementia.
- The Trust has implemented a 'carers' badge' scheme.

Work planned for 2012/13:

- As part of Nurses Day, the Trust intends to continue holding safeguarding awareness stalls.
- The Trust is planning further environmental changes, as part of its dementia strategy, and extending the use of colour and symbols to identify specific areas.
- The Trust has trained key staff as dementia trainers and will continue its dementia training programme.
- The Learning Disability Liaison Nurse will continue to work with the communications department to develop patient information leaflets in an accessible form.
- The ALN is also looking at ways our cancer services and pre-admission clinics can be improved to take into consideration the unique needs of some of our patients with learning disabilities.
- The Trusts will revise its Patient Experience Strategy in line with the Chief Nursing Officers '6 C's' and will incorporate the recommendations from the government's response to the Francis Enquiry.

Statement written by:

Teresa McHugh
Deputy Director of Nursing
Enfield Safeguarding Adults Board representative

Barnet and Chase Farm Hospitals NHS Trust and Enfield Community Services

Internal arrangements for governance regarding Safeguarding Adults

As part of the governance structure in Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) and Enfield Community Services (ECS) the Safeguarding Adult Committee meets on a quarterly basis. The Safeguarding Adults Committee meeting is chaired by the Executive Director of Nursing, Quality and Governance. Other members of the committee are assistant directors from each service line or their representatives and safeguarding leads from the local authority. This meeting affords for the discussion and follow up on actions from both internal and external issues regarding safeguarding adults. A Safeguarding Annual Report and work plan continues to be developed on a yearly basis, for presentation at the Governance and Risk Management Committee (GRMC) and the Trust Board. The executive lead and assistant directors represent the Trust at the three Safeguarding Adults Boards.

The Executive Director of Nursing, Quality and Governance is the Board Lead for Safeguarding Adults in the Trust. The Trust has a specific post of Assistant Director for Safeguarding Adults who reports to the Executive Director of Nursing, Quality and Governance.

The management of safeguarding cases is co-ordinated by the Community Mental Health Team Managers and Team Managers in integrated teams. This arrangement has been reached with Barnet and Enfield local authorities. The process for Enfield Community Services is different as all safeguarding alerts are sent to and managed by the London Borough of Enfield.

The Trust participates in the bi-monthly practice development group, co-ordinated by the Enfield Safeguarding Adults Team.

Work undertaken/planned and achievements/progress in 2012/13

During 2012/13, the practice in safeguarding adults has continued to ensure the best outcomes for the service user, if they have been subject to a type of abuse. To ensure compliance with “Protecting Adults at Risk: London multi-agency policy and procedures to safeguard adults from abuse” (Pan-London Procedures) case file audits on Meridian have been carried out as part of a quality assurance measure.

The Trust has achieved the following in terms of learning and development:

- Development of safeguarding adults’ e-Learning refresher level 1 training.
- Level I training has continued to be delivered in the Trust, on mandatory training days.
- Bespoke Safeguarding Adults training was undertaken and delivered to managers and staff in the Forensic service.

In total, **2,203 staff attended level 1 safeguarding adults training during 2012/13.** This training is offered as part of the mandatory training day.

Additional achievements across the Trust include:

- The Self-Assessment Assurance Framework was reviewed and signed off by the Enfield Safeguarding Adults Board, in November 2012.
- A Domestic Violence and abuse protocol has been developed jointly with Safeguarding Children, in the Trust.
- Compliance inspections against the criteria in Outcome 7 (safeguarding) of the CQC’s regulatory framework on all inpatient units and Community Teams.
- A Domestic Violence factsheet and flowchart have been developed for each borough in the Trust.
- Safeguarding Adults updated information on the new Trust website.
- A Safeguarding Adults Flowchart/Poster has been developed for Enfield Community Services.

Work planned for 2013/14

The Trust will incorporate the following elements into its safeguarding adults work programme for 2012/13:

- Continue to raise awareness among staff, in the practice of Safeguarding Adults.
- Continue to ensure that the Trust deliver a safe, friendly and caring environment where people are treated with respect, courtesy and dignity.
- Learning from Safeguarding cases to be embedded in the Trust and across the partnership.
- Quality of care on secure wards to be maintained.
- Ensure appropriate referrals are sent to the Disclosure and Barring Service.
- Safeguard adults by ensuring that any case of abuse is reported and managed though the London Multi-agency policy and procedure.
- Have a continued programme of level 1 Safeguarding Adults training with 85% compliance achieved.
- With the increased activity in the number of referrals being reported, services to ensure that adequate resources are available to support and respond to alerts in a timely way.
- Staff to access domestic violence and abuse training through the local authority or in the Trust, in order to improve awareness and gain further understanding of the referral process and support available to victims.
- Raise awareness in the use of the Domestic Violence and Abuse protocol.
- As part of a quality measure, team managers to audit one case file per month on Meridian.
- Maintenance of the Trust-wide Safeguarding Adults Database.
- Review of the Trust Self-Assessment using the Safeguarding Adults Assurance Framework for Healthcare Services.
- A planned programme of compliance inspections against the criteria in Outcome 7 of the CQC regulatory Framework to be carried out as part of the Trust peer review process.
- As part of the implementation the Bournemouth Competency Tool, to work with the local authorities training sub-group to ensure competences are linked to safeguarding adult training and to afford consistency in the Trust.

Statement written by:

Mary Sexton
Executive Director of Nursing, Quality and Governance
Enfield Safeguarding Adults Board representative

Enfield Clinical Commissioning Group

Introduction

Keeping "adults at risk" safe whilst they are receiving health care in Enfield remains at the heart of all NHS Enfield Clinical Commissioning Group (CCG) planning and decision-making. The CCG has continued to work in partnership with all agencies to achieve this and to ensure all providers understand their role in the health and wellbeing of "adults at risk".

The Commissioning Strategy for Safeguarding Adults 2012/13 sets out the CCG's plan to improve its systems and processes to deliver high standards of safeguarding adults practice, via our commissioning responsibilities, during a time of significant organisational change.

At the time of transition, the CCG assured the Department of Health, NHS England (London) and Enfield Safeguarding Adults Board (SAB) that its statutory obligations in relation to safeguarding adults are being followed and strengthened, through on-going developments.

Key Achievements

There have been several notable achievements in the safeguarding function in NHS Enfield Clinical Commissioning Group, between 2012/13, including:

An authorisation process that demonstrated the CCG had appropriate systems in place, in respect of safeguarding adults, when discharging their responsibilities:

- The CCG staff were trained in recognising and reporting safeguarding issues. Additionally all GPs across Enfield were trained in the recognition and reporting of adults at risk.
- There is a clear line of accountability for safeguarding adults, clearly reflected in the CCG's governance arrangements.
- Appropriate arrangements to co-operate with local authorities in the operation of the Enfield Safeguarding Adults Board.
- A safeguarding adults lead, a Mental Capacity Act lead and a PREVENT lead are in place, supported by the relevant policies and procedures.
- A comprehensive Safeguarding adults commissioning policy, in relation to safeguarding concerns and developments identifying adult individuals at risk, is in place, ratified by the local Safeguarding Adult Board (SAB).
- Links with Enfield SAB support a consistent partnership approach to interagency working to promote a multi-agency process of managing Safeguarding Alerts is in place.
- Annual Self-Declaration of Assurance which is the Safeguarding Adults Assurance Framework (SAAF) against specified safeguarding adults standards was completed and passed by NHS London, in 2012.
- We have recruited to the Nurse Assessor's post which is jointly funded between the Local Authority and the CCG.
- The CCG continue to contribute to the Domestic Violence Strategy, which includes the commissioning of a project to aid General Practice staff in the Identification and Referral to Improve Safety (IRIS). The CCG co-ordinated a Master class on Domestic Violence for both GPs and local community staff, including Health Visitors. The organisation has contributed to a number of Domestic Homicide Reviews. The CCG will continue to work with partners across the health economy to ensure that suitable processes are implemented so that effective and meaningful Domestic Homicide Reviews are produced.
- The CCG work to ensure that the safeguarding recommendations from the Winterbourne review are fully implemented in health commissioning and health services in Enfield.

The CCG has been committed to sharing, receiving and using information from other agencies and organisations, where this is relevant to the performance management of a provider in relation to safeguarding adults. This may include exchanging information with:

- Safeguarding Adults Department in the Local Authority
- Safeguarding Adults Board
- Police
- NHS providers and contractors
- Care Quality Commission
- Care Homes
- Provider concerns meetings

Governance Arrangements and Next Steps for 2013/14

The CCG will comply with its governance arrangements and move forward in the following way:

- There is now a GP and a Head of Safeguarding in place for safeguarding adults who as part of their portfolio will ensure strategic ownership of safeguarding adults at Board level. These officers' will champion the organisation's vision and responses and provide high level support for staff in leadership positions related to safeguarding adult issues.
- A safeguarding committee is in place and is chaired by the Director of Service Quality and Integrated Governance from April 2013; meetings will be quarterly to oversee compliance for safeguarding all adults who access provider services. The CCG is committed to developing robust arrangements to ensure that safeguarding becomes fully integrated into provider services systems, which will create greater openness and transparency about clinical incidents and learning from safeguarding concerns with partner agencies.
- Dedicated links to PREVENT will be established and joint working arrangements will be developed in order to achieve effective multi-agency working across the health economy in conjunction with local authority and the police.
- Seek assurance from providers that staffs are knowledgeable about the Mental Capacity Act and are applying the principles of the Act in everyday practice.
- The CCG will design a Quality Assurance Tool that will be sent out to all Nursing Homes twice a year.
- The CCG will be working towards safeguarding adults as integral part of their commissioning cycle in:
  - planning services with patients to address the needs of patients at greatest risk of neglect and abuse
  - securing contracts with services that set clear standards for safeguarding adults
  - monitoring services through a comprehensive assurance framework that support improvements and address concerns.

Statement written by:

Carole Bruce-Gordon
Head of Safeguarding for Enfield CCG
Enfield Safeguarding Adults Board representative

Enfield Homes

Commitments to Safeguarding Adults at Risk

Enfield Homes is committed to work in partnership with all organisations to prevent adults at risk from being abused in the first place and reduce the suffering caused by abuse in Enfield.

Enfield Homes is an ambitious organisation that believes quality, affordable housing is crucial to help shape vibrant, cohesive and social inclusive local communities, making the borough a safer place to live. Having gone live as an Arms Length Management Organisation on 1st April 2008, it has an easily understood mission – to deliver quality homes, excellent services and successful communities.

The primary focus for Enfield Homes is the delivery of high quality services to its customers and maintenance/ repair of their property to be a good standard. However, the organisation's objectives also embrace community development and improvement, working in partnership with the Council, community groups and other agencies and developing staff to achieve their own and the organisations aspirations.

One part of delivering a successful community is through our aim to help prevent abuse, making sure our tenants, leaseholders and staff know what to look out for and who to contact for advice and support.

Ensuring safeguarding adults remains a strategic priority is driven by representation on the Safeguarding Adults Board by a member of Enfield Homes and will continue to be driven for 2013/14.

Key achievements

Enfield Council's Safeguarding Adults Team attended the Enfield Homes Tenants Conference in 2012 and spoke about how Enfield safeguards its residents.

The Sheltered Housing Service achieved in August 2011 the Centre for Housing and Support's Code of Practice for Housing Related Support. This included submitting evidence substantiating that our staff are aware of the policies and procedures and their practice safeguards our residents, they understand their professional boundaries and that we are committed to participating in a multi-agency approach to safeguarding. It was also evidenced that our residents understand what abuse is and know how to report concerns. Working within the Code of Practice ensures that there is continuous improvement within the service.

We have promoted awareness within Enfield Homes and all staff who regular come into contact with adults at risk, to ensure they can access advice and support and know how to report their concerns.

An article about 'Preventing Abuse' was included in our March 2012 and edition of our quarterly newsletter 'Housing News' to enable our tenants and leaseholders to recognise, prevent and report abuse. The Adult Abuse Line telephone number is again in the March 2013 edition.

Priorities for 2013/14

The article about 'Preventing Abuse' is due to be included in our June 2013 edition of Housing News and will continue to be a regular feature every six months.

All staff within Enfield Homes are now required to undertake the London Borough of Enfield Safeguarding Adults Awareness e-learning module this is due to be rolled out within the next couple of months, with a completion target of the end of October 2013 for all staff.

Work with the local authority to ensure the implementation of the Pan London Safeguarding Policy and Procedures raise staff awareness and make sure the procedures and guidance are easily accessible on our internal directory on 'Staffnet' for staff.

For Enfield Homes to include Safeguarding Adults in its Business Plan and Delivery Plan for 2013/14 as part as our commitment to prevent adults at risk being abused.

Enfield Homes works to an internal Hoarder's Protocol, which seeks to engage multi-agency partners in supporting those who are at risk. This model has been recognised by other partners in Enfield and during 2013/14, we will work with a sub-group of the Safeguarding Adults Board to develop a multi-agency protocol.

Statement written by:

Jan Goodkind
Principle Housing Manager
Enfield Safeguarding Adults Board representative

Enfield Safer and Stronger Communities Board

The Enfield Safer and Stronger Communities Board (SSCB) is the statutory Community Safety Partnership locally and has responsibility to maintain an understanding of crime and anti-social behaviour, develop and consult on a strategy to bring about improvements and drive forward the delivery of a Partnership Plan.

The Partnership has an excellent reputation for innovative and effective joint working, delivery and value for money. There is a strong emphasis on performance management and a programme of continuous improvement.

Current position

The Safer and Stronger Communities Board comprises of the local authority, the police, the fire and rescue service, the probation trust and health agencies. Senior officers from these agencies promote the activity of the Safer and Stronger Communities Board within their own agencies.

They work in partnership with the Mayors Office for Policing and Crime and with representatives from the local Youth Offending Team, other criminal justice agencies such as the Crown Prosecution Office and the Courts, Housing Providers, Elected Members and voluntary organisations.

The partnership receives support from the Council's Community Safety Team which sits within the Environment Department. The Assistant Director for Community Safety and Environment is a member of the Safeguarding Adults Board and is responsible for ensuring support is provided to the Board.

There are considerable changes underway in the landscape of community safety, including the introduction of the Local Policing Model and the selling of parts of the police estate. Probation Trusts are unlikely to manage offenders in the same way, following the introduction of Ministry of Justice reforms and the other parts of the Criminal Justice System, such as the Courts and the Crown Prosecution Services are also undergoing major change.

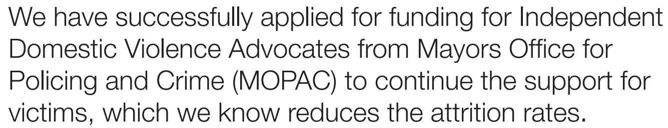
These changes to how offenders and victims are dealt with in general will have obvious implications for dealing with complex cases, aggravated offences and vulnerable victims. We also know that in the current climate, more offenders than ever are citing financial pressure as a reason for offending.

Key achievements of 2012 to 2013 and how we will deliver improvements in the following year

In the last 12 months the SSCB focussed on the following priorities:

- Working with young people as victims and offenders
- Tackling violence against women and girls
- Reducing serious acquisitive crime
- Tackling anti-social behaviour (including improving offender management)
- Improving community engagement
- Ensuring local community safety during the Olympic Games 2012.

We have made progress in the area of tackling violence against women and girls and are reviewing cases through the Multi-agency Risk Assessment Conference (MARAC) and the Domestic Violence Steering group, in order to shape services and support cases through the criminal justice system. Examples of this include the provision of cameras and video cameras for the police who attend incidents. In this way we have already seen an improvement in the number of early guilty pleas, which in turn reduces further stress on the victim.



We have successfully applied for funding for Independent Domestic Violence Advocates from Mayors Office for Policing and Crime (MOPAC) to continue the support for victims, which we know reduces the attrition rates.

Although the number of domestic violence cases has increased, the number of repeat offences is starting to reduce; this would indicate that there is greater confidence in the services and that we are working with those cases of highest risk.

There is acceptance however that we can still improve the confidence of those who fall outside the definition of “intimate partner” perpetrated violence and are victims of familial violence. This may be more prevalent in some communities and the same is true of those with Learning Disabilities or who are otherwise vulnerable. The new performance framework has the ability to highlight gaps and focus attention of partners.

We are currently conducting a Domestic Violence Homicide Review following a fatal attack on a young woman in the borough. The lessons learned from this will inform services about how better to engage with communities to reduce the risks to others.

The Hate Crime Case Management Panel continues to discuss specific cases and determine whether all appropriate action has been taken. Our Integrated Offender management process now coordinates activity to tackle perpetrators of domestic violence and some other violent crimes, excluding Multi-agency Public Protection Arrangement (MAPPA) cases. Previously this has only focussed on property crimes.

We have continued to fund target hardening for homes in cases where the victim is vulnerable. This service is provided free of charge to those who qualify.

The SSCB is working with the Health and Wellbeing Board to ensure that investment is made in preventative work. This includes the introduction of the IRIS project where GPs are trained to safely discuss domestic violence with patients who appear at risk.

Statement written by:

Andrea Clemons
Head of Enfield Council Community Safety Unit
Enfield Safeguarding Adults Board representative

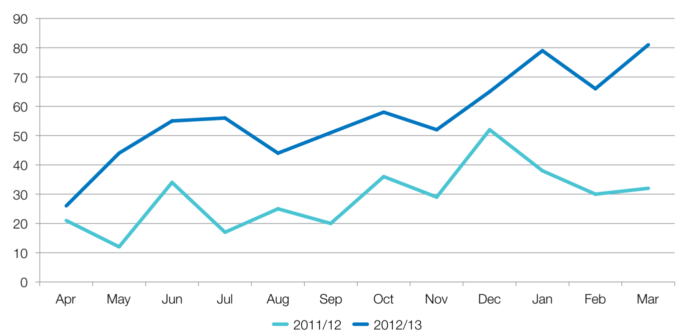
London Ambulance Service

The London Ambulance Service NHS Trust has been working hard over the past year to ensure that we can keep the people we have come into contact with safe.

- In November 2012 we appointed a Head of & Named Professional for Safeguarding Adults in line with the Children's Named Professional.
- We reviewed our Adults at Risk policy and this is currently undertaking an Equality Impact Assessment and will be published on our safeguarding web pages.
- We now have named local leads for all safeguarding boards, although it is recognised that it is not always possible for us to attend all meetings.
- We have reviewed our training and deliver both child and adult at risk training together for all clinical staff.
- We provided safeguarding training for the LAS Trust Board and are due to present to them again at the end of 2013.
- We reviewed our contracts with private providers and ensured safeguarding training is undertaken and to the required standard.
- We have undertaken Prevent training for our officers.
- We reviewed the recommendations from Winterbourne View and have written to Safeguarding Chairs to outline our response and actions.
- We have produced safeguarding easy read materials for the public.
- We have updated our web pages and included an easy read section.
- We have produced a safeguarding pocket book for staff which is being issued in June.
- We are holding a safeguarding conference on 5th June for 100 LAS staff plus 6 national leads.
- We are undertaking a review of our referral system and processes.
- We are meeting the Chairs group this month to discuss how best we can engage with adult safeguarding.

Our referrals continue to rise month on month pan London we now make 2,300 referrals a month for children and adults. For Enfield figure please see below.

As a Pan-London it is not possible for us to write 32 reports for the safeguarding boards. We complete a Trust report annually which is published on our website and covers safeguarding. Likewise we have provided a response to the Winterbourne View Report and recommendations which is being given to the chairs group.



Statement written by:

John Carmichael
Enfield Borough, London Ambulance Service
Enfield Safeguarding Adults Board representative

London Fire Brigade – Enfield Borough

The London Fire Brigade has a strong commitment to safeguarding adults at risk and continues to work to develop service delivery by focusing preventative work streams to better identify at risk individuals as well as responding appropriately following referral through links with inter professional groups. We recognise that robust safeguarding arrangements are essential to managing risk. We believe that all residents have the right to be treated fairly and with dignity and respect.

The London Fire Brigade has a good reputation for working closely with and supporting multi-agency teams to deliver adult safeguarding services in accordance with the pan London 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse ' framework.

Current position

As part of the London Fire Brigade's adult safeguarding responsibilities, it is required to provide a representative as board members on the local multi-agency safeguarding adult board. The Borough Commander Enfield Borough is currently on Enfield Safeguarding Adults Boards and is an integral decision maker in the development and progression of the local safeguarding agendas. The London Fire Brigade has maintained an active participation in the Safeguarding Adults Board, undertaking work streams as required throughout the year.

The Borough Senior Officer for Community and Fire Safety has also been nominated to attend Enfield Safeguarding Adults Board subgroup for the multi-agency Safeguarding Adults Policies, Procedures and Practice Group.

Key Achievements 2012/13

Last year London Fire Brigade Enfield Borough planned the following activities and achieved the following outcomes:

- Raise awareness of partners, organisation and agencies of risks to adults from fire in particular dangers of hoarding and provision of arson proof letter boxes.
  - Outcome: Partners were invited to 2 seminars hosted by London Fire Brigade in relation to the identification of repeat callers to London Fire Brigade, recommending future practise and the availability and provision of domestic fire suppression systems.
  - Work commenced on the development of a Multi-agency Hoarding Protocol through the Policies, Practices and Protocols sub group of the Adults Safeguarding Adults Board.
  - Attended a number of Community based events to promote home fire safety and raise awareness of the provision of arson proof letter boxes.
- Work with partners to ensure a robust information sharing process is established that sits within data protection act.
  - Incorporated data sharing provision within Multi-agency Hoarding Protocol which is currently being drafted.
  - Maintained current information sharing provision within current Safeguarding Adults procedures.
- To develop protocol between LFB and adult social services reporting referral outcomes in relation to safeguarding.
  - Local systems within London Fire Brigade Enfield have been developed to ensure follow up calls are made with Adult Social Services following referral.
  - Following a fatal fire, an internal review recommended considerations for serious case review where appropriate.
  - Through joint working with Enfield Adult Social Services and Enfield Borough Council Safeguarding Adults Service identified and offered a free home fire safety risk assessment to adults vulnerable to fire incidents in the home.
- Raising awareness of fire crews as to what other services are available for adults at risk.
  - A training programme is incorporated into each Fire Stations training plan in relation to Safeguarding policy and procedure for both Children and Adults.
- Monitor outcome reports.
  - Standing agenda item on all Borough management meetings to monitor and evaluate/quality assure previous 28 days safeguarding issues and referrals.

- Working with at risk groups such a the deaf community to improve services, involving the provision of free smoke detectors for the deaf and provision of information about home fire safety and calling the emergency services.
  - London Fire Brigade have made excellent links with the local drop in services and received a number of referrals from the deaf community for home fire safety visits. This has been delivered by fire fighters with British Sign Language level 2 proficiency.
- Officers to refer to appropriate agency through Safeguarding protocol where evidence suggest this is necessary.
  - London Fire Brigade Watch officers have made a number of referrals throughout the year in accordance with Brigade Policy. Of these only a small number have been referred through the urgent referral agreement. The remainder have been referred to appropriate services and agencies.
- Work with partners to address vulnerable adults at risk from exploitation by unscrupulous land lords to receive support through implementation of statutory enforcement.
  - London Fire Brigade Regulatory Fire Safety Team have worked with Enfield Council to raise awareness of these issues and offer assistance and advise when necessary.
- Officers to identify evidence of abuse, preserve scene and early passing of information to the Police as possible crime scene.
  - London Fire Brigade Officers have received awareness training and referred cases to Police where appropriate.
- Support partners by providing advice in relation to fire safety in the home when requested.
  - Senior Officers attended a seminar hosted by Enfield Borough Council Safeguarding Adults Services, for Residential Social Landlords, to raise awareness of home fire safety and regulatory fire safety matters.
- A centrally held safeguarding referral database to identify safeguarding adults trends pan London, by developing LFB policy and outcomes shared with partners is ongoing.

Staff Training in Safeguarding Adults

Safeguarding adults training is mandatory for all staff. The training is provided internally by the Watch based managers. This is programmed for refresher training at least twice per year per member of staff.

As Safeguarding encompasses a wide range of legal responsibilities the training sessions include coverage of:

- Policy Statement
- Definition of Adults at risk
- Disclosure and Barring Service (previously Independent Safeguarding Authority)
- Recognising harm to adults
- Reporting procedures
- Information sharing and data protection.

Priorities for 2013/14

- Raising staff awareness of domestic violence.
- Focusing our prevention and protection activities on ensuring that older people living in care home and in sheltered housing are as safe as possible.
- Developing further local recording and quality assurance programmes.
- Continue to raise awareness of partners, organisation and agencies of risks to adults from fire, in particular dangers of hoarding and provision of arson proof letter boxes and fire retardant bedding.
- Continue to raise awareness of the availability and provision of domestic sprinklers for very high risk adults.
- Continue to develop protocol between LFB and adult social services reporting referral outcomes in relation to safeguarding adults or otherwise.
- Support partners by providing advice in relation to fire safety in the home when requested.
- Regular analysis of centrally held safeguarding referral database and other incident related databases, to identify safeguarding adults trends pan London to develop LFB policy and outcomes shared with partners.

Statement written by:

Les Bowman
Enfield Borough Commander, London Fire Brigade
Enfield Safeguarding Adults Board representative

Enfield Borough Police

Enfield Borough Police are committed to safeguarding adults at risk, previously known as vulnerable adults, and are setting out work to improve performance in this area. Full details of all proposed activity for Enfield Police are recorded in the Safeguarding Adults Board Action Plan for 2012-2015. All police actions in relation to the plan were updated and reviewed in April 2013.

Achievements over 2012/13

In February 2013 DCI Mark Rochester conducted a review of the way in which Safeguarding Adult investigations were handled by the Borough. This review looked at the processes used to identify and prioritize risk, together with the outcomes of investigations into safeguarding adult matters. This review has been presented to the Safeguarding Adults Board and the recommendations from the review will form the basis for future activity.

In addition to the above, the Police took forward a number of actions to keep adults at risk safe, including:

- Continued meetings with the Councils Safeguarding Adults Service on a frequent basis, in order to ensure all alerts which may be a crime are reviewed and progressed
- Joint investigators training with the Council
- Review of domestic violence processes and support
- Co-chairing of the Quality, Performance and Safety Group of the Safeguarding Adults Board.

Activities planned for 2013/14

The review process identified a number of areas where safeguarding adult matters could be more effectively addressed. On a national level guidance around safeguarding adults investigations is limited and the lack of clear solvability factors make achieving judicial outcomes challenging. The following proposed changes were identified as being necessary to improve the Borough's handling of vulnerable adult investigations and to ensure that wherever possible risks are identified and addressed.

Proposed activity relating to Training:

- Detective Sergeant (DS) with safeguarding adults responsibility to provide training to frontline officers regarding actions at the scene of a possible offence and appropriate referral.
- Detective Chief Inspector (DCI) for Public Protection to provide training to Acting Inspectors in role of Duty Officer to emphasize risk-management and the need for intrusive supervision around the initial response to Safeguarding incidents.
- Frontline officers to be briefed regarding the use of appropriate flags for adults at risk, as these appear to be underused at present; clarification will be sought from the Territorial Police on flagging process and policy.

Proposed activity relating to Processes:

- Relevant departments within Enfield Police to conduct daily review of all crimes recorded in the previous 24 hours, to ensure that all crimes are flagged appropriately.
- Safeguarding Adults Supervisor role to be created within the Community Safety Unit. This supervisor will deal exclusively with safeguarding adults and matters referred to the Multi-Agency Risk Assessment Conference (deals with high risk domestic violence). This Detective Sergeant will be responsible for the supervision and standards of investigation for all safeguarding adults offences.
- Dedicated Detective Constable (DC) to work under Safeguarding Adults Supervisor – this DC will investigate the most complex adult abuse cases and provide guidance to other officers dealing with safeguarding adult investigations.
- Further analysis to be completed of Adult at Risk crimes to ensure that these more complex investigations are being appropriately dealt with and judicial outcomes being obtained where possible.

Proposed activity relating to Quality Assurance:

- Detective Inspector for Community Safety Unit to randomly dip-sample ‘Alert’ referrals where no crime created each month, to ensure crimes are being recorded where necessary.
- Comparative review to be completed to ensure that safeguarding adults investigations are achieving a similar sanctioned detection rate to non-safeguarding adults investigations. An initial analysis of performance suggests that whilst SD rates are not high, they are comparable with the SD rates for non-safeguarding adults investigations.
- Dip-sample to be completed of cases where Suspect identified but not arrested. The Domestic Violence Arrest for Named Suspects is currently 82% for Enfield Borough. There is a concern that suspects for safeguarding adults cases may be inappropriately discontinued, particularly given the positive action policy that exists around safeguarding adults cases.
- All safeguarding adults and adult abuse crimes to be brought to the daily 1,000 Pacesetter meeting in order to review the risk management measures put in place and the investigation plan set.

Statement written by:

DCI Mark Rochester
Enfield Police, Public Protection
Enfield Safeguarding Adults Board representative

North Middlesex Hospital NHS Trust

The North Middlesex University Hospital NHS Trust has a strong commitment to safeguarding adults at risk and continues to work enthusiastically to enhance this focus through stronger links with inter professional groups, community patient groups and the voluntary sector. We recognise that robust safeguarding arrangements are vital to managing risk. We believe that all patients have the right to be treated with dignity and respect.

The Trust has a good reputation for working closely with all teams to ensure that all patient care and safety is patient centred and work with our inter professional agencies within the pan London 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse' framework.

Current position

As part of the Trust's adult safeguarding responsibilities, it is required to provide trust representatives as board members on the local multi-agency safeguarding adult boards. The Trust is currently represented on both the Enfield and Haringey Safeguarding Adults Boards and is an integral decision maker in the development and progression of the local safeguarding agendas. The Trust has maintained an active participation in the Safeguarding Adults Boards undertaking work streams as required throughout the year.

The Deputy Director of Nursing has also been nominated as Chair of the Enfield Safeguarding Adults Board subgroup for the multi-agency Safeguarding Adults Policies, Procedures and Practice Group.

Key Achievements 2012/13

Each year the Trust is reviewed against the Department of Health SAAF (Safeguarding Adults Self Assessment and Assurance Framework For Health Care Services). The Trust was assessed on Friday 16th November 2012 and was found to be compliant with all areas assessed, including those relating to services for those with learning disabilities.

Areas of best practice highlighted included:

- Positive discrimination to place learning disability patients on specific wards where learning disability champions are based.
- Side room allocation to allow open visiting to family and carers where possible and in consultation with wishes of patients to stay with no restriction of visiting hours.
- Pre-surgical assessment referral to Learning Disability Acute Liaison Nurse who works between community and the acute hospital.
- Learning disability acute liaison nurse available to support patients and ward staff.
- Carers policy to support and improve the patient experience.
- Carer's passport to allow a parking badge and access to extended visiting.

Our dedicated Safeguarding Adult intranet pages have been updated to reflect latest legislation and to support staff with adult safeguarding and the use of the Mental Capacity Act.

We continue to have an Acute Liaison Nurse Specialist who works with patients from the community and into the hospital. This involves patient and carer visits to the hospital and departments, and also local teaching in the clinical areas. This overarching link between the community and hospital has proved to be very informative for both patients and hospital staff. This has resulted in easier hospital admission for patients. Pathways have also been agreed to alert staff when patients are admitted and to ensure that their needs are taken into account.

The Trust has a forum for 'Embracing Carers' to discuss and identify areas where improvements can be made. Carers have also been invited to the Trust Patient Story sessions and to the Patient Safety and Quality Committee to provide with feedback from their experiences in hospital. Following a carers story in October 2012, we continue to investigate the possibility of building a specific toilet (Changing Places[1]) and changing area for adults with learning disabilities who are also physically disabled. A proposal has been submitted to the Trust Executive team for approval to progress installation of a Changes Places Toilet facility in our outpatient department.

The Trust is also currently participating in a two way peer review of Trust policies, procedures and resources available to support those with Autism and Learning Disabilities with Moorfields Eye Hospital. This will enable us to identify gaps and best practice and to provide evidence to support compliance with CQUIN Indicator 1C.

[1] Changing Places. www.changing-places.org

Staff Training in Safeguarding Adults

Safeguarding training for adults is mandatory in the Trust for all staff. The training is provided internally by the Learning, Education and Development Team. There are 3 levels of training provided currently:

- Level 1: Basic awareness training for all staff at induction
- Level 2: Intermediate training for staff with regular contact with patients
- Level 3: Advanced training for senior clinicians and on-call managers.

As Safeguarding encompasses a wide range of legal responsibilities and types of patient the training sessions include coverage of:

- Mental Capacity Act
- Deprivation of Liberty
- Caring for patients with a Learning disability
- Caring for patients with Dementia
- Addressing issues around dignity.

The Trust has continued to develop training for all staff in conjunction with our partner Enfield Social Services who provide our level 3 training. This training will continue to be delivered by the Trust and also by our host The London Borough of Enfield.

We have identified that there is further development work in relation to a training plan for safeguarding adults, and areas will be targeted to have updates in safeguarding adults at all levels. We continue to train staff through face-to-face and e-learning packages. The level 2 training includes Deprivation of Liberty and the Mental Capacity Act. The training figures are presented to the Patient Safety and Quality Board on a quarterly basis.

Priorities for 2013/14

The Trust has a Safeguarding Adults at Risk Strategy with an associated action plan which is updated annually with a progress update and new priorities added when necessary. This years priorities have been updated accordingly to reflect the priorities outlined below:

- To ensure that the Trust Safeguarding Adults at Risk Strategy continues to remain within the current and future pan London procedures and that all subsequent and inter related Trust policies embrace this format.
- To maintain and develop training for all staff across the Trust covering all required areas to ensure compliance with our targets, and to ensure that our services are fit for purpose, whilst ensuring that retraining occurs in a purposeful cycle.
- To ensure that Prevent training is provided as part of the Trust mainstream training programme.
- To continue to work collaboratively with our multi-agency and inter professional groups to ensure that our patients are protected and that alerts are raised as necessary.
- To continue to improve our responses to reports of abuse, in order that investigations can be clearly undertaken timely with our partners.
- To make it easier for people to report abuse and make sure they receive a good-quality service when they do. To assist adults at risk to recognise and prevent abuse and to put them in touch with a range of support services, including places where they can be safe from harm.
- To clarify Domestic Abuse referral pathways and to ensure that all staff are aware of how to escalate concerns internally and to relevant authorities.

Statement written by:

Eve McGrath
Senior Project Manager for Corporate Nursing and Interim Safeguarding Adults Lead
Enfield Safeguarding Adults Board representative

Appendix 1
Safeguarding Adults Strategy: Action Plan 2012-2015

Introduction

This is the Safeguarding Adults Strategy action plan, incorporating actions for year one (2012-2013) only. The plan is based on the 10 key priorities agreed by the Safeguarding Adults Board and is informed by partners own action plans and by the results of the public consultation that took place between April – June 2012. The Safeguarding Adults Board (SAB) will monitor the delivery of these actions. Partners will report on progress to the SAB at the quarterly meetings.

The other key work areas for the Safeguarding Adults Board are concerned with its leadership and partnership role and with ensuring that safeguarding is embedded with all commissioning activities across health and adult social care. These actions are described below.

Leadership, Partnership and Commissioning

The Safeguarding Adults Board will:

- review the Safeguarding Adults Board structure and Terms of Reference including membership
- ensure the Safeguarding Adults Strategy is regularly reviewed and updated to reflect changes in national and local position
- continue to support the development of the Reference Group and ensure there is effective feedback from all Sub Groups
- ensure that leaders across partnership demonstrate a personal commitment to Safeguarding Adults
- undertake a review of the training and development strategy
- ensure adults at risk are supported to attend meetings and events, both individually and as representative/s
- produce a new information sharing protocol for the safeguarding partner agencies
- ensure the Safeguarding Adults Board has effective governance and work programme
- ensure Safeguarding is embedded within all new services specifications
- develop a Commissioning Strategy for Safeguarding Adults with London Borough of Enfield (LBE) Safeguarding Adults and Commissioning Service and the Clinical Commissioning Group (CCG)
- ensure sufficient resources are available to deliver the safeguarding adults work programme
- audit the performance of the SAB against good practice guidance and relevant legislation
- work closely with commissioners to make sure that the requirement to demonstrate a commitment to safeguarding adults and to delivering against safeguarding standards is clearly laid out within contract specification, tender appraisals and contract monitoring
- work closely with the Clinical Commissioning Group to ensure compliance with safeguarding requirements
- work closely with the Safeguarding Children's Board to ensure systems are in place to ensure safe transition to adult services (minimising risk to them and from them to others) including the transition to adult mental health services and to the adult welfare criminal justice system
- develop and sustain effective professional relationships across Children's and Adults' Services in order to ensure assessment and services which minimises risk to both children and adults at risk in households with need.

"What difference did we make?"
"Is anyone better off?"

No.	Work Area/Project Outcome	Lead	Progress	Status
1.	**Community awareness**			
1.1	Information and advice: • Continue to provide an up to date portfolio of leaflets, bulletins, web- based advice/ information for use across the partnership and the Council, suitable for diverse audiences. • Provide suitable articles about preventing and tackling abuse and keeping safe. • Ensure information about how to report abuse is easily accessible and is in suitable formats including British Sign Language and easy read format. BSL changes targeted 2013/14.	All Board Partners	• Website updated and information on partner websites. Articles included in partner publications, such as Enfield Homes, Our Enfield and the Enfield Talking Newspaper. • British Sign Language changes targeted 2013/ 2014	🟢
1.2	Learning and development: • Continue to provide a range of learning and development opportunities including e-learning and workshop events that are available for staff across the partnership, including joint training where feasible • All partner agencies to publish data showing which staff are required to receive safeguarding adults training and evidence this is happening	SAB – Learning Strategy sub-group	Learning and Development Group has been restructured and a range of multi-agency training has been provided. Partners show data of the training undertaken in each of their organisations.	🟢
1.3	Learning and development: • Offer training to all Council Members and Non-Executive Directors of NHS Trusts • Offer training to Older People and Vulnerable Adults Scrutiny Panel	Safeguarding Service Head LBE	Complete.	🟢
1.4	All partners have in place organisational learning arrangements.	SAB – all Board Partners	This is in place and learning is shared at the Board.	🟢
1.5	All partners ensure that domestic violence training is available and quality assured.	SAB – all Board Partners	Not all partners have domestic violence training and this will be monitored over 2013/14.	🟠
1.6	To arrange regular public awareness raising events, including annual safeguarding awareness week • To ensure all community events feature safeguarding adults – crime prevention, preventing neglect and abuse.	SAB – all Board Partners	Two 'Keep Safe Weeks' where held with many partners in attendance.	🟢
1.7	To raise awareness of the interface between Hate Crime and Safeguarding Adults.	LBE Community Safety Unit & SAB partners	LBE Community Safety Unit has done a range of actions to promote hate crime against adults at risk. We now need to evidence that all partners are raising awareness.	🟠
1.8	To use all existing staff, engagement and partnership events – Boards, team meetings, away days etc to raise the profile of safeguarding adults.	SAB – all Board Partners	Evidence of safeguarding adults strategic outcomes in partner plans.	🟢
1.9	To use different ways to raise awareness – e.g. through opticians, dentists, pharmacists, banks, radio advertising, sandwich boards and enabling senior management to speak to local people around Enfield.	SAB – all Board Partners	We use many ways to raise awareness, but will try different methods over the coming year.	🟠

Key: 🟢 Achieved/on track 🟠 Monitor closely/behind schedule 🔴 Not achievable or no satisfactory update received

No.	Work Area/Project Outcome	Lead	Progress	Status
2.	**Work with organisations and agencies – dignity and respect**			
2.1	Service users experience to be sought regularly and routinely – focus on how adults at risk are treated with dignity and respect.	SAB – All Board Partners	All Board partners fed back at the March 2013 meeting how they include service user experience. This included, for example, service user attendance at meetings and through audit process.	Green
2.2	Feedback routinely obtained after incidents of abuse and learning is captured.	SAB – All Board Partners ensure internal monitoring arrangements	There has been improvements seen through the audit process of learning but we will continue to focus on this area.	Orange
3.	**Work with organisations and agencies – dignity and respect**			
3.1	Ensure that clear standards and procedures are in place for safeguarding adults responses with achievable time targets for actions for each partner.	SAB – All Board Partners	All partners responses and involvement are in line with pan London safeguarding adults policy and procedures.	Green
3.2	50% safeguarding investigations to be completed within 7 weeks.	LBE – HHASC	Achieved.	Green
3.3	Police to conduct audit of safeguarding adult cases referred to them, focusing on decision to investigate and prosecutions.	Police	Police are reviewing their structure and policy for safeguarding adults. The audit of cases will be completed in 2013/14.	Orange
3.4	Ensure that there are well understood alert processes between partners within the initial response to an allegation of abuse and that feedback is provided to referrers.	SAB – All Board Partners	Improvement in alerts sent in timescales, meaning adults get immediate protection plan and are safe. Providing feedback to referrers is important we will continue to monitor.	Orange
3.5	Ensure that all care assessments and reviews demonstrate that adult at risk and those who support them have up to date and accessible information about safeguarding services.	NHS and LBE	Quality assurance activities demonstrate that adults at risk and carers know how to report abuse.	Green
3.6	Agree a policy and joint whistle blowing procedure across the partnership.	SAB – Safeguarding Service Head, LBE	Achieved.	Green
4.	**Service user engagement**			
4.1	Develop a range of ways in which service users can easily make their voices heard, including people with mental health problems, learning difficulties and dementia.	SAB – All Board Partners	Service user/patients are part of service development and have mechanisms to become active partners in how safeguarding work keeps people safe-evidence submitted by partners in annual report statements.	Green
4.2	All partners ensure that adults at risk are involved in quality assuring services.	SAB – All Board Partners	As above.	Green
4.3	Ensure that the review of the Safeguarding Adults Board increases active involvement from adults at risk.	SAB	As above.	Green

Key: Green – Achieved/on track; Orange – Monitor closely/behind schedule; Red – Not achievable or no satisfactory update received

No.	Work Area/Project Outcome	Lead	Progress	Status
5.	**Self protection strategies**			
5.1	All appropriate public events hosted by partnership members to include information about and for adults at risk e.g. crime prevention, keeping safe, financial training – which directly relate to self protection.	SAB – All Board Partners	Achieved. All events promote prevention of abuse and self-protection.	Green
5.2	Provide regular action and advice on preventing abuse – e.g. self protection strategies.	SAB – All Board Partners	Risk assessments demonstrate action taken to reduce risk of abuse occurring.	Green
6.	**To support people who choose to arrange their own care to do this in a way that protects them from abuse**			
6.1	Make easily available public information about the risks of adult abuse, especially targeted at: • Adults at risk who arrange own care • Carers of self-funders • At critical times like hospital discharge, using a multi-discipline approach.	SAB – All Board Partners HHASC Carers Commissioner and NHS	All partner agencies able to evidence information is given as routine to adults at risk. Work with Carers is developing through carers network in 2013/14.	Green
6.2	Ensure all service providers are able to demonstrate how service quality is assured.	HHASC – Head of Commissioning	Providers able to demonstrate quality assurance are directed to resources which prevent providers concerns process from being initiated.	Amber
6.3	Maintain multi-disciplinary approach ensuring relevant partners are aware of adults at risk at the point of hospital discharge, incl. assessing mental capacity.	SAB – Hospital Trusts	We are working to prevent hospital discharge which may put adults at risk. This is being monitored through commissioners.	Amber
6.4	Ensure all personalisation developments including risk management and the 'market place' embed safeguarding adults.	HHASC – Commissioning Department, LBE	Market place has information on how to keep safe and a plan for how services on the marketplace will be vetted.	Green
7.	**Access to justice system**			
7.1	Conduct review of barriers to adult at risk cases being prosecuted – *see 3.3 – 'Police to conduct audit of safeguarding adult cases referred to them'*.	CPS and Police	Recommendations delivered which aim at improving processes that increase access to the justice system for adults at risk.	Green
7.2	To improve understanding of barriers to prosecutions involving adults at risk, for the Board to receive learning from cases of hate crime and domestic violence which did not result in a prosecution.	LBE Community Safety Unit	Complete for Domestic Violence cases and information relating to hate crime will be presented to the September 2013 SAB.	Green
7.3	Ensure that all partners are clear about the Crown Prosecution Service (CPS) requirements/considerations for: neglect, fraud, common assault and sexual offences.	Police		Amber
7.4	Share learning when CPS decides not to pursue – explore feasibility of action through civil action.	Police	Actions to be identified from the learning which will be added to the strategy action plan.	Amber
7.5	Agree a protocol with Coroner's Office re death in care homes and investigations.	SAB– Safeguarding Service Head		Amber

Key: Green – Achieved/on track; Amber – Monitor closely/behind schedule; Red – Not achievable or no satisfactory update received

No.	Work Area/Project Outcome	Lead	Progress	Status
8.	**Work with perpetrators**			
8.1	Ensure carers and carers organisations recognise and report abuse.	HHASC Carers Commissioner, LBE and Carer Centre	Achieved and on going.	Achieved/on track
8.2	Support the early identification of carers under stress and help them understand when they need more help and where to access the support.	SAB – All Board Partners	A leaflet for carers is being developed and will be sent out in 2013/14. We also have specific events for carers as part of Keep Safe Week.	Monitor closely/behind schedule
8.3	To implement safer recruitment principles to ensure all staff and volunteers working with adults at risk are safely recruited and appropriately supervised.	SAB – All Board Partners	Our staff and volunteers are best placed to support our client bases – prevent unsuitable people from working with adults at risk and evidence we have embedded safer recruitment principles through feedback to SAB.	Achieved/on track
8.4	Staff – each agency has processes in place to manage allegations against staff and volunteers in line with Pan London policy.	SAB – All Board Partners	Partners are asked to show evidence of their process in 2013/14.	Monitor closely/behind schedule
9.	**Data and statistics**			
9.1	Safeguarding Adults Board to receive statistical reports from partners on alerts, and actions including learning from Serious Incidents Panel and risk management arrangements.	SAB – all partners	Partners to maintain own internal reporting arrangements and share data with SAB, which will help best practice to be embedded across partnership.	Monitor closely/behind schedule
9.2	Agree revised management and performance reporting requirements to SAB focussing on in depth analysis.	HHASC Strategy & Performance, LBE	Achieved.	Achieved/on track
10.	**Information technology**			
10.1	Agree use of Regulatory Investigatory Powers Act for safeguarding adults – e.g. review options for surveillance – cameras in capturing evidence for police etc.	SAB – All partners with HHASC SA	Draft policy on surveillance which will be going to the December 2013 SAB.	Achieved/on track
10.2	Explore and use Telecare alarm options for adults who have been or are at risk of abuse.	SAB – HHASC	Adults at risk have increased protective strategies in their home.	Achieved/on track

Key: Achieved/on track Monitor closely/behind schedule Not achievable or no satisfactory update received

Appendix 2
Safeguarding Adults Referral Report 2012/13

This report is an analysis of Safeguarding Adults referrals received from 1st April 2012 to 31st March 2013. The total number of referrals (alerts) received during this period was 797 compared to 688 for 2011/12, an increase of 14%.

Referrals (Alerts)

The graph below shows the number of referrals (alerts) received by team. The Hospital Teams are now only investigating cases where the alleged abuse took place on the hospital site.

Figure 1: Number of Referrals (Alerts) by Teams

- 2012-13
- 2011-12

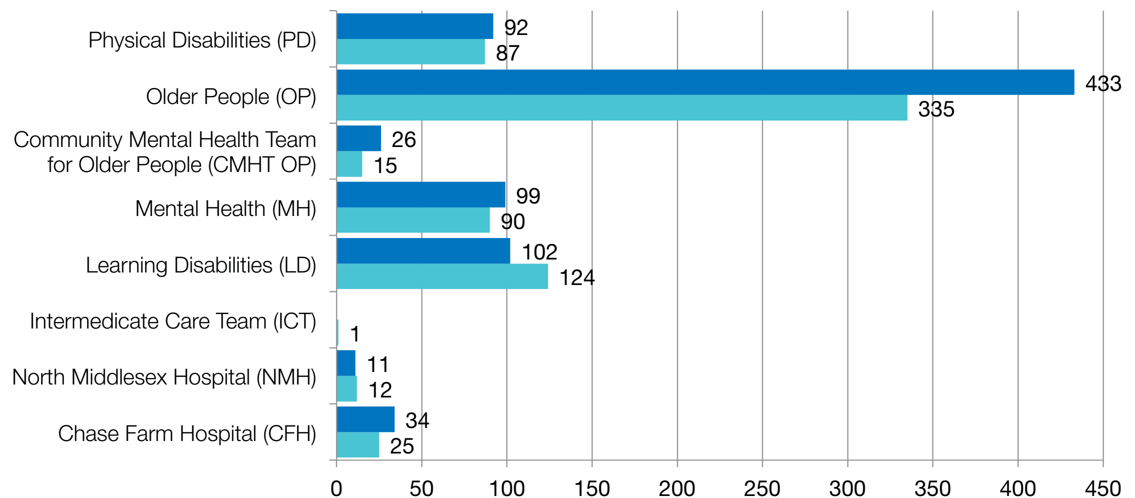


Figure 2: Type of Alleged Abuse at point of Referral (Alert)

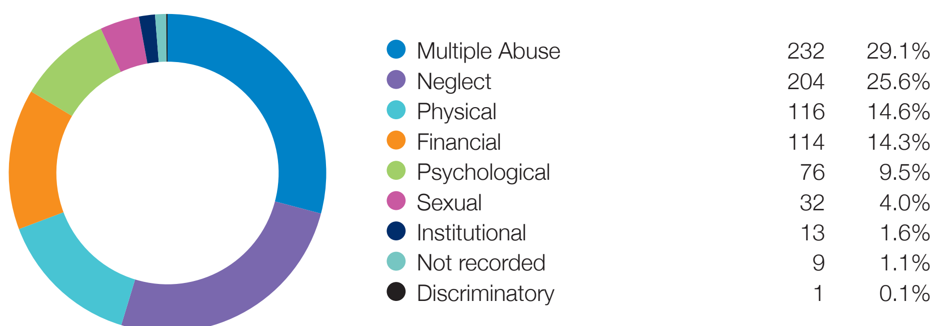
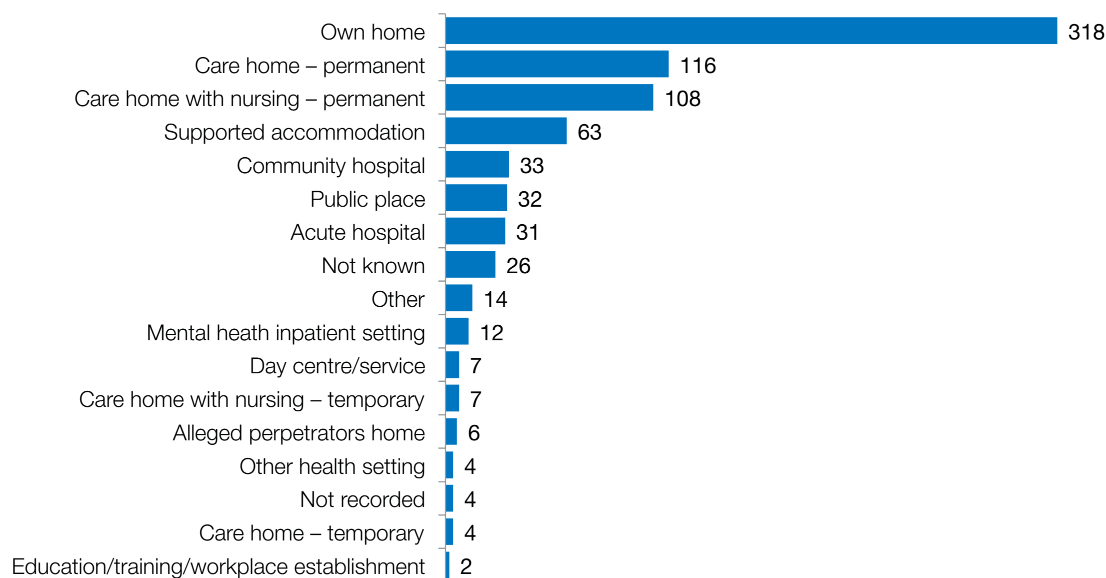


Table 1: Type of alleged abuse at point of referral (alert) by team

	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Financial	1	0	15	18	5	64	12	**115**
Institutional	0	0	0	7	0	6	0	**13**
Neglect	23	6	8	1	3	151	11	**206**
Physical	4	1	23	29	3	43	12	**115**
Sexual	0	0	12	9	2	7	1	**31**
Psychological	0	0	13	23	13	16	11	**76**
Multiple abuse	5	4	30	12	0	141	42	**234**
Not recorded	1	0	1	0	0	5	2	**9**
Total	**34**	**11**	**102**	**99**	**26**	**431**	**92**	**797**

Figure 3: Place of Alleged Abuse at point of referral (alert)



40% of the referrals are in relation to alleged abuse in the Adult at Risk's own home and 30% are in a residential/ nursing home.

Table 2: Referral routes

Referer	2012-13	%	2011-12
Hospital Staff	142	17.8%	*104*
LBE – HASC	112	14.1%	*93*
Residential Care Home	92	11.5%	*0*
External Provider	78	9.8%	*124*
Ambulance Service	50	6.3%	*18*
Relative	47	5.9%	*40*
Community Health Professional	43	5.4%	*53*
Housing/RSL	29	3.6%	*32*
Domiciliary staff	27	3.4%	*9*
LBE not HASC	26	3.3%	*94*
Third sector organisation	21	2.6%	*14*
Mental health staff – joint teams	15	1.9%	*22*
Police	15	1.9%	*24*
Homecare external	14	1.8%	*0*
Day care staff	10	1.3%	*8*
Self Referral	10	1.3%	*10*
Other	7	0.9%	*14*
Primary Health/ Community Health Teams	7	0.9%	*0*
CQC	5	0.6%	*1*

Referer	2012-13	%	2011-12
Ward staff	5	0.6%	*0*
General Practitioner	4	0.5%	*7*
Hospital Psychiatry	4	0.5%	*0*
Neighbour/Friend	4	0.5%	*14*
Anonymous	3	0.4%	*0*
Carer	3	0.4%	*4*
Community Mental Health Trust	3	0.4%	*0*
Other Service Users	3	0.4%	*0*
Out of Hours Team	3	0.4%	*0*
Primary/Community Mental Health Teams	3	0.4%	*0*
Financial Institution	2	0.3%	*2*
Guardian/Office of Public Guardian	2	0.3%	*0*
Member of Public	2	0.3%	*1*
Secondary Health Staff	2	0.3%	*0*
Not recorded	2	0.3%	*0*
Education/training/ workplace establishment	1	0.1%	*0*
Fire Brigade	1	0.1%	*0*
Total	**797**	**100.0%**	**688**

Those referred

Information about the Adults at Risk referred

The following information is the demographic information for each of the 797 referrals (alerts) received. The gender of 'various' is used when the alert relates to a complete residential home.

Figure 4: Gender of Adults as Risk

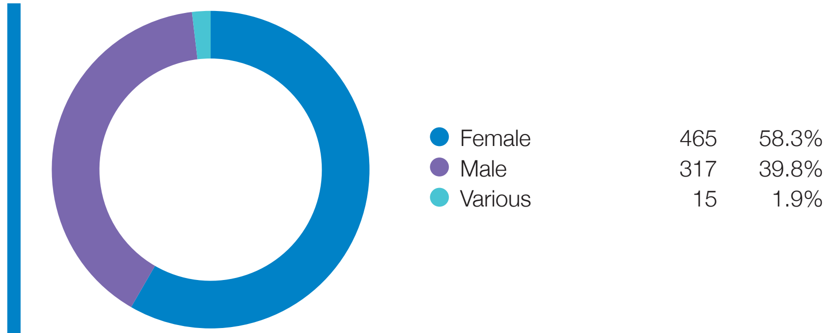


Table 3: Gender of Adults at Risk

	Female	Male	Various	Total
Multiple abuse	147	77	8	**232**
Neglect	124	77	3	**204**
Physical	72	44	0	**116**
Financial	53	61	0	**114**
Psychological	41	35	0	**76**
Sexual	22	10	0	**32**
Institutional	1	8	4	**13**
Not recorded	5	4	0	**9**
Discriminatory	0	1	0	**1**
Total	**465**	**317**	**15**	**797**

For both females and males, the highest alleged abuse types are Multiple (31% for females, 24% for males) and Neglect (27% for females, 24% for males).

Figure 5: Age Band of Adults at Risk

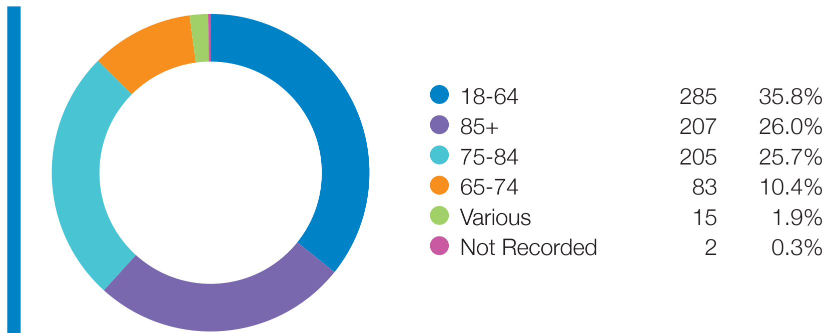
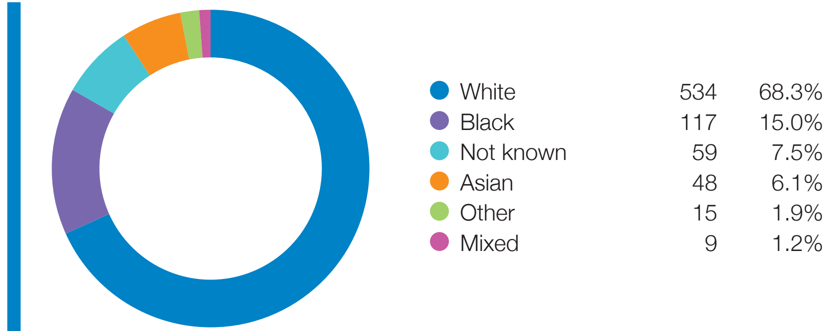


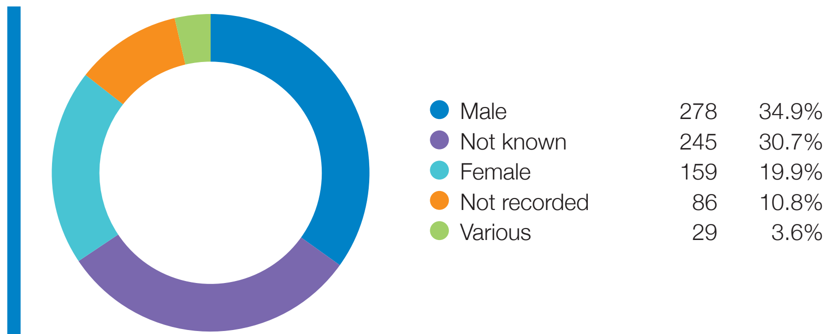
Figure 6: Ethnicity of Adults at Risk (excludes 'Whole Homes' Alerts)



67% of the referrals received are for White British, White Irish, and White Other ethnicities (71% in 2011/12).

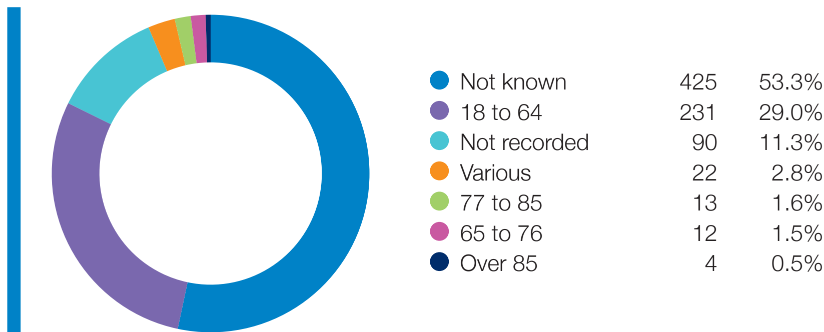
Information about the Person alleged to have caused harms

Figure 7: Gender of Person alleged to have caused harm



35% of Person alleged to have caused harm are male and 20% are female. Of all referrals (alerts) received, in 31% of the cases, the gender of the Person alleged to have caused harm is unknown.

Figure 8: Age of Person alleged to have caused harm



29% of Person alleged to have caused harm are aged 18-64. There are a high percentage of Person alleged to have caused harm with unknown age (53%). It is often difficult to obtain this information, as the Person alleged to have caused harm is not always known or they are unwilling to give personal details.

48 (21%) of the Person alleged to have caused harm aged 18-64 are care staff. 114 (49%) of Person alleged to have caused harm aged 18-64 were a family member or friend.

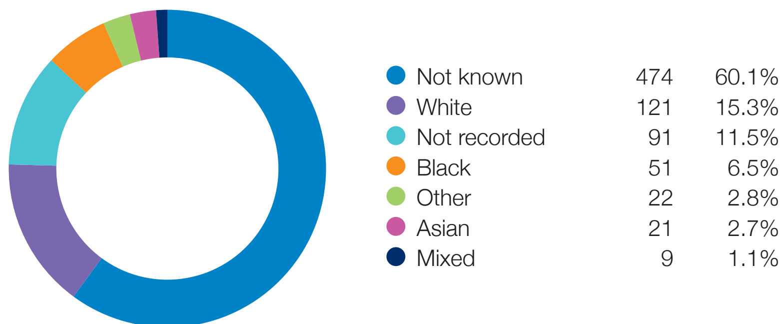


Figure 9: Ethnicity of Alleged Perpetrator

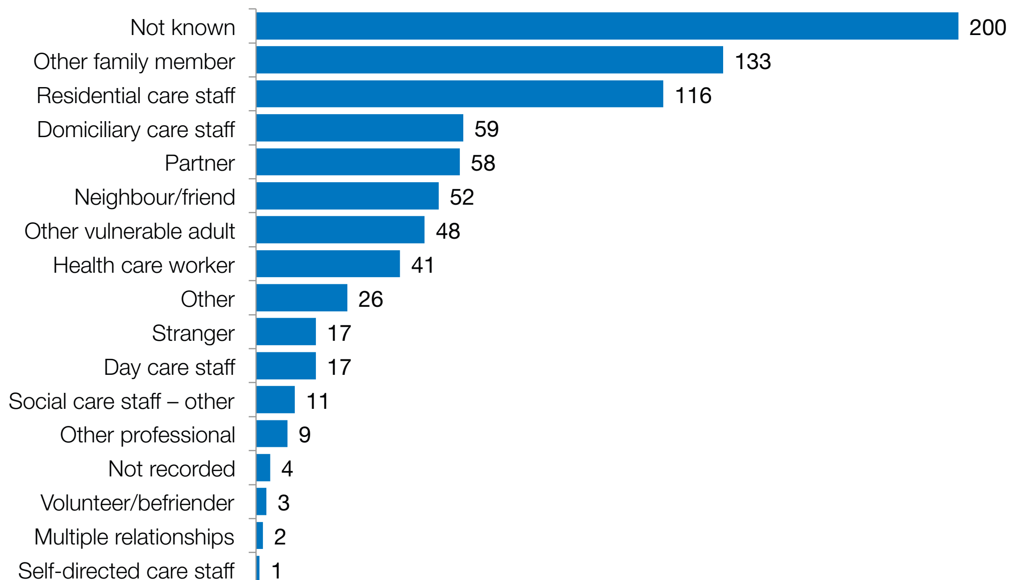


Figure 10: Person alleged to have caused harms Relationship to Adult at Risk

Figure 11: Outcome from Initial Inquiries

Of the 797 safeguarding adults referrals (alerts) received, 660 (82%) proceeded to the safeguarding adults process.

Safeguarding adults process

The following sections of this report look at the 660 referrals that have had a strategy agreed. An action plan has been developed to look at the timescales and also to consider ways to improve the performance against timescales and outcomes.

Figure 12: Police informed of Referrals

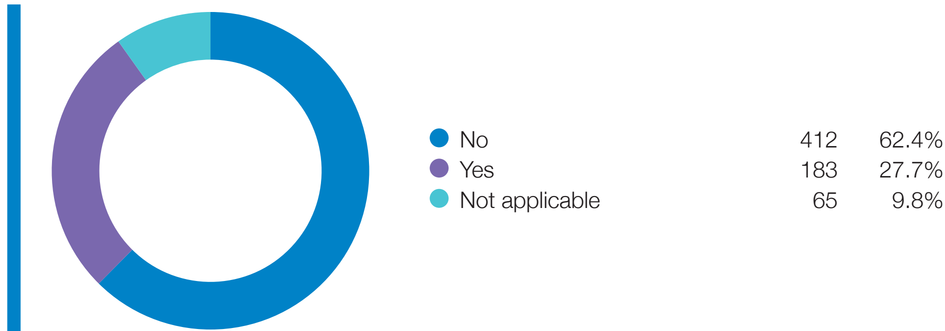


Table 4: Interim Protection Plans

Type	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Protection Plan Offered	8	4	65	36	20	333	64	**530**
Total	**10**	**9**	**89**	**54**	**22**	**398**	**78**	**660**
% age of alerts offered a protection plan	80%	44%	73%	67%	91%	84%	82%	**80%**

Figure 13: Police informed of Referrals

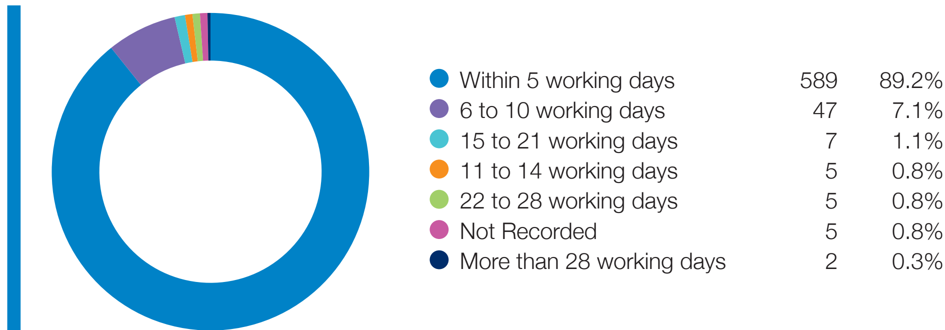
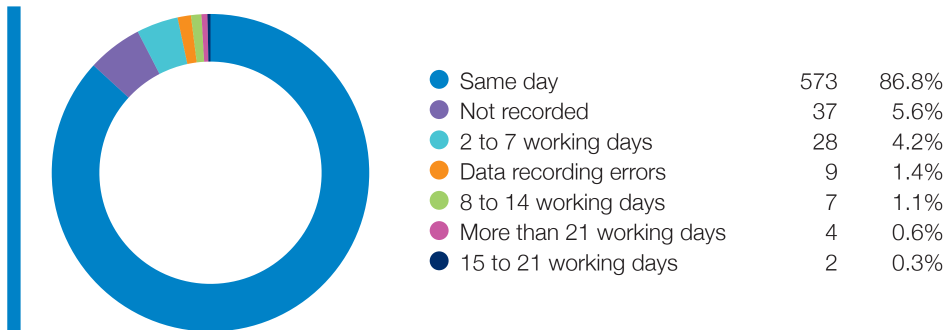
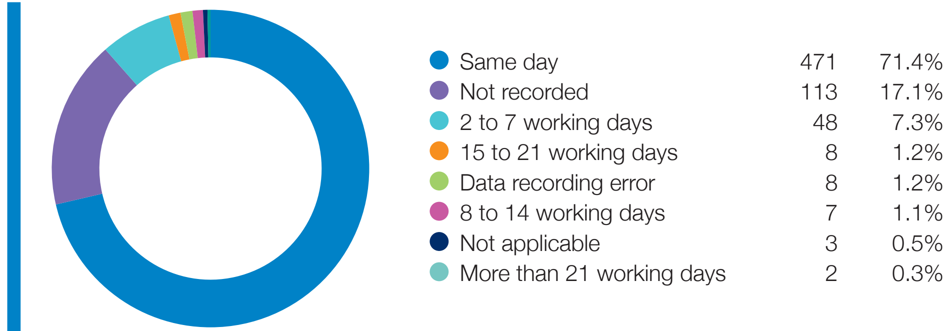


Figure 14: Days from Strategy agreed to Alerter informed



88% of the strategies agreed were within the target of five working days from the alert. This is a reduction from the full year 2011/12 position of 93%.

Figure 15: Days from Strategy agreed Adult at Risk informed

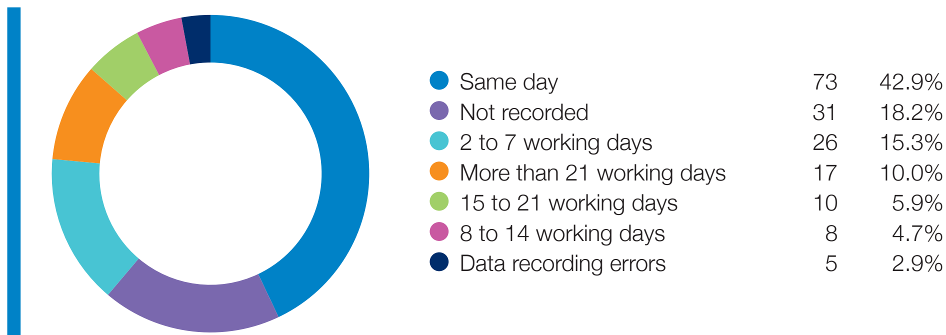


In 87% of cases, the alerter was informed of the strategy on the same day it was agreed, if considered appropriate. This is an improvement from 38% in 2011/12.

Outcome of the Safeguarding Adult Inquiry/Investigation

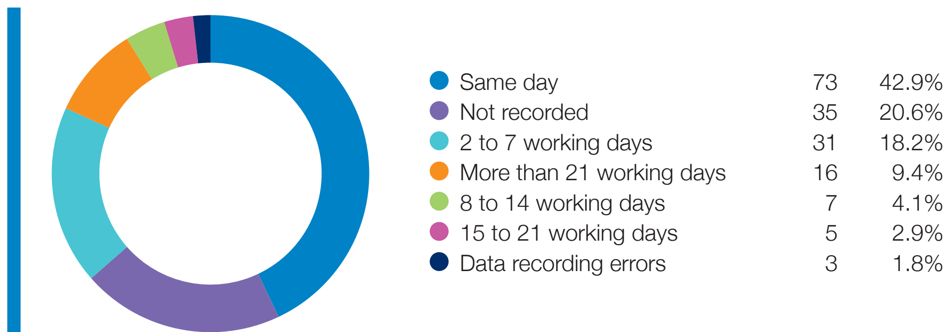
Of the 660 Alerts that have had a strategy agreed, 248 required an investigation of which 170 are now closed. The following information relates to those 170 closed cases.

Figure 16: Days from Inquiry closed to Adult at Risk Informed



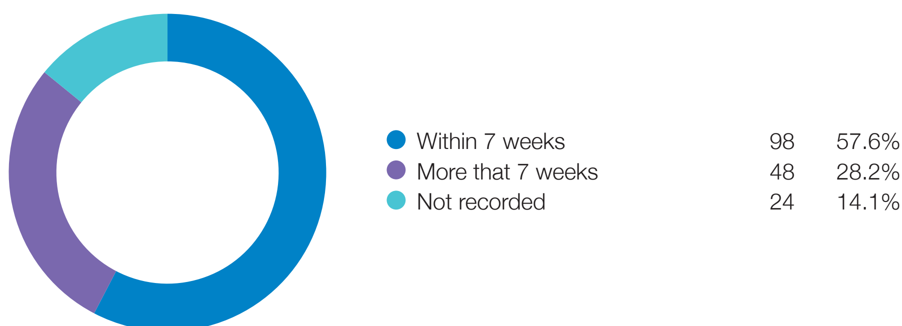
In 43% of cases, the Adult at Risk was informed of the outcome of the Inquiry on the same day it was decided, if considered appropriate.

Figure 17: Days from Inquiry closed to Alerter Informed



In 43% of cases, the Alerter was informed of the outcome of the Inquiry on the same day it was decided, if considered appropriate.

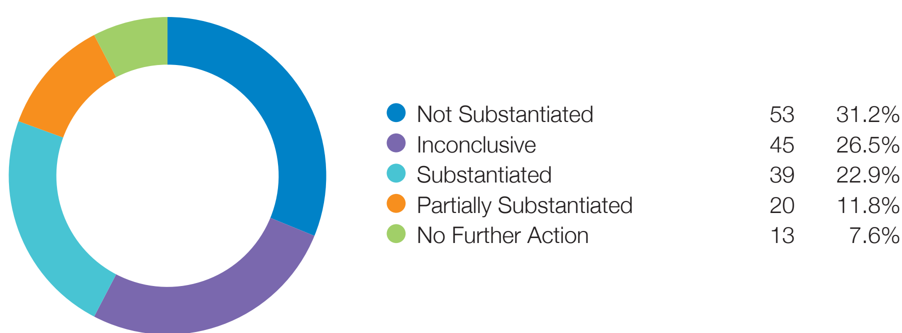
Figure 18: Time from referral received to inquiry closed



The policy requires the timescale from the receipt of referral to either a reconvened strategy or inquiry closure to be 35 working days or less. In some cases, depending on the complexities of the case, it can be longer.

Outcomes

Figure 19: Outcome of the Safeguarding Adult Inquiry/ Investigation



Of the 170 cases that have an outcome following investigation, 35% of them were substantiated or partially substantiated (34% in 2011/12).

Table 5: Breakdown of the outcomes by team

Type	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Substantiated	0	0	7	13	2	15	2	**39**
Partially Substantiated	0	0	4	9	1	6	0	**20**
Inconclusive	0	0	13	5	8	17	2	**45**
Not Substantiated	3	1	5	19	8	17	0	**53**
No Further Action	0	1	1	0	0	10	1	**13**
Total	**3**	**2**	**30**	**46**	**19**	**65**	**5**	**170**

Table 6: Outcome of the allegation and the type of abuse

Type of Abuse	Substantiated	Partially Substantiated	Not Substantiated	Inconclusive	No Further Action	Total
Multiple Abuse	7	8	10	9	6	**40**
Financial	11	2	9	6	2	**30**
Neglect	8	4	10	6	1	**29**
Emotional	6	3	7	11	2	**29**
Physical	6	2	10	8	0	**26**
Sexual	0	1	3	4	2	**10**
Institutional	1	0	3	0	0	**4**
Not recorded	0	0	1	1	0	**2**
Total	**39**	**20**	**53**	**45**	**13**	**170**

Review process

The following tables show the review type and outcomes of the completed safeguarding investigations. 63% of eligible cases had a review (this compares to 64% in 2011/12).

Table 7: Review type

	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Safeguarding Review	0	0	26	0	1	13	0	**40**
Care Plan Review	0	0	0	33	11	7	1	**52**
Not required	3	1	3	12	7	26	1	**53**
Not recorded	0	1	1	1	0	18	3	**24**
Total	**3**	**2**	**30**	**46**	**19**	**65**	**5**	**170**
% age of eligible cases with a review	0%	0%	90%	73%	63%	43%	50%	63%

Table 8: Outcome for the Adult at Risk

	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Increased monitoring	0	0	10	12	10	15	1	**48**
No further action	1	1	2	20	1	23	0	**48**
Other	1	0	13	9	0	8	0	**31**
Community care assessment and services	1	0	1	1	4	3	0	**10**
Not recorded	0	1	1	0	0	5	1	**8**
Moved to increase/different care	0	0	0	0	0	5	2	**7**
Vulnerable Adult removed from property or service	0	0	2	0	0	5	0	**7**
Management of access to finances	0	0	1	1	0	0	0	**2**
Restriction/Management of access to Person alleged to have caused harm	0	0	0	2	0	0	0	**2**
Action Under MHT Act	0	0	0	0	1	0	0	**1**
Information not available	0	0	0	0	1	0	0	**1**
Referral to complaint procedure	0	0	0	0	1	0	0	**1**
Referral to counselling/ training	0	0	0	1	0	0	0	**1**
Referral to MARAC	0	0	0	0	0	0	1	**1**
Removed from property/ service	0	0	0	0	1	0	0	**1**
Review of Self-Directed Support	0	0	0	0	0	1	0	**1**
Total	**3**	**2**	**30**	**46**	**19**	**65**	**5**	**170**

Table 9: Outcome for the Person alleged to have caused harm

	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
No further action	1	1	9	22	12	28	2	**75**
Continued monitoring	1	0	7	8	1	15	0	**32**
Not recorded	0	1	2	0	1	7	1	**12**
Disciplinary action	0	0	3	0	1	6	1	**11**
Action by Contract Compliance	0	0	0	8	0	1	0	**9**
Counselling/training/ treatment	0	0	5	3	0	1	0	**9**
Exoneration	1	0	0	0	2	2	0	**5**
Not known	0	0	3	0	0	1	1	**5**
Management of access to the Vulnerable Adult	0	0	0	3	0	0	0	**3**
Removal from property or Service	0	0	1	1	1	0	0	**3**
Police action	0	0	0	1	1	0	0	**2**
Referral to PoVA List/ISA	0	0	0	0	0	2	0	**2**
Action by Care Quality Commission	0	0	0	0	0	1	0	**1**
Criminal prosecution/formal caution	0	0	0	0	0	1	0	**1**
Total	**3**	**2**	**30**	**46**	**19**	**65**	**5**	**170**

HHASC442

This report is designed by Enfield Council Design & Print Service. Please call 020 8379 5283
for information on how they can help you with your design and print requirements.

Safeguarding Adults
Health, Housing and Adult Social Care

June 2013