Enfield Safeguarding Adults Board

Annual Report 2013/14

www.enfield.gov.uk/safeguardingadults

Working in partnership with local people and

NHS
Enfield
Clinical Commissioning Group

Message from the Chair

This is my second year as Independent Chair of the Enfield Safeguarding Adults Board. The Board partners have had a challenging year with austerity affecting all organisations. Despite this you will see from this report that they have been able to achieve a great deal. However there will always be more to do.

We have held a range of public events to try to raise awareness of adults safeguarding and encourage people in Enfield to report any concerns they may have. We have made sure that carers and older and disabled people can have access to services which can provide them with support and space to discuss concerns they might have. We have put in practical solutions such as community help points to keep people safe when they are out and about.

We have seen a 20% increase in the numbers of referrals for an investigation of an adult at risk. This has put significant pressure on the teams investigating these situations. We have been pleased to see that they have responded appropriately. We have arranged an independent view of the quality of safeguarding work undertaken. We have ensured that any improvements recommended are acted upon.

This year we have made great efforts to ensure the voice of people who use services is heard. People who have been part of safeguarding investigations have been asked about their experiences and the findings have been fed back to the social work teams to improve their practice. The quality checker programme has grown strongly. This involves volunteers going out to talk to the people who use care services about the quality of services they receive. Some of these volunteers have gone on to be part of the dignity panel which is looking in depth at the quality of care services and reporting back to the managers of these services to help them to improve. I am pleased to be chairing this panel and helping to develop this unique and valuable work.

In Enfield there are over 150 care homes, more than in almost any other London Borough. This means that the safeguarding team must ensure that they are aware of any issues about the care provided in these homes and act to ensure any shortcomings are put right. A safeguarding information panel has been set up where partner agencies make sure information is shared across the partnership so that concerns are picked up early. This ensures support can be provided to the home or the necessary enforcement action taken if the concerns are serious.

The partnerships represented by the Board have become stronger over the year. All agencies have reported back to the Board on practical ways in which they have been able to make vulnerable adults safer and have been able to learn from and encourage each other. The Clinical Commissioning Group has been hugely valuable in helping to ensure standards are improved in nursing and medical care. The police in Enfield have shown strong commitment to keeping vulnerable people safe.

I would like to thank all partner agencies for their support in this work. I particularly thank the Chairs of our sub groups for their huge contribution to the Board. I would like to thank Ray James, Director of Health Housing and Adult Social Care at Enfield Council for his constant support and commitment, to the councillors in Enfield for their interest and encouragement and to the people of Enfield for their vigilance.

Marian Harrington
Independent Chair of the Enfield Safeguarding Adults Board

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.

The Co-Chairs are pleased the group has grown with members of Enfield Deaf Image Group and the LGBT Network joining the group.

Members noted that:

"Being engaged in the group helps us become more aware of issues for vulnerable people and how we can help others become aware of safeguarding issues".

"It is important to the group to know they can do something about abuse and can challenge and flag issues in their networks and communities".

"This group is passionate about people being able to live their lives with dignity, respect and care".

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.

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
RP	Registered Providers
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

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Section 1

Introduction and Strategy

This report sets out how the Enfield Safeguarding Adults Board partners have worked to safeguard adults from abuse in 2013-2014 and how we intend to continue and expand upon this work in the coming year.

The Enfield Safeguarding Adults Board is committed and passionate about keeping adults at risk safe from abuse. The Board is a partnership of statutory and non-statutory organisations, including local people and those who use services and their carers, who have a strategic lead in how we work to prevent abuse from happening in the first place and how we respond when abuse does occur.

The aim of all partners in Enfield are 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.

These aims are set out in our Safeguarding Adults Strategy 2012-2015. This strategy was developed through consultation with local people and partners to ensure we have a clear vision and action plan for the future which will help to safeguard individuals from abuse.

The Board is well aware that despite the success of recent years and the delivery of a number of initiatives and positive outcomes for service users, we need to be smarter and more creative in order to eradicate abuse. Many of the tasks we have been working towards in 2013-2014 are a continuation and strengthening of what we have done so far – especially in raising awareness and training staff and volunteers. However there are particular areas where we have been concentrating our efforts, such as improving quality of care in services and ensuring those who use services and their carers are fully informed and participate in development of service delivery and how the safeguarding adults process is run.

The ten priorities of the strategy are set out below and progress we have made can be found in Appendix 1:

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.

Section 2

Key Developments, Objective and Progress

The Safeguarding Adult's Board believes that safeguarding is everyone's business – which has the ability to affect any one of us. By working together we can both prevent and support those who may be at risk. We have achieved a number of the objectives we have set ourselves and which were identified by local people, service users and carers during our strategy consultation as important to them.

The number of reports of abuse received by adult social care continues to increase, and this is a trend seen nationally. During 2013-2014 we saw 957 alerts, which is a 20% increase from the previous year. The Safeguarding Adults Board believes that despite the number of reports, abuse is often under reported and hidden, particularly in some of the communities. We have continued to raise awareness so that service users, carers and professionals can identify abuse and know how to report this in. Our dedicated **Enfield Adult Abuse Line** which is staffed 24 hours a day, 365 days per year received 952 this is on top of the many ways in which we try to make reporting abuse accessible.

Some of the ways we worked to raise awareness include having information available at the Enfield Town Show in September 2013 and doing bespoke presentations to community groups, such as a deaf group in Enfield. Our aim is to ensure that these events or presentations bring as much information together on how to keep yourself safe and prevent abuse. Partners on the Board also do bespoke events, such as Enfield Council's Trading Standards focus on 'Not Sure? Don't Open the Door', which was presented at the Ruth Winston Open Day in October 2013 and to Sainsbury's Veterans.

In March 2013 we saw the re-launch of the Community Help Point Scheme, which was originally set up in 2007 to provide places of support to enable young people to safely navigate the borough. This scheme was extended to cover adults at risk, so if people are lost, frightened or afraid they can access businesses and organisations which have nominated themselves as help points. Businesses and organisations nominate themselves to act as help points for people who are lost, frightened or afraid and in need of assistance. We sent out posters about this scheme throughout Enfield and information into partner publications.

The location of your nearest Community Help Point can also now also be found through a mobile application called **Tap-it**. This free app lets you keep in touch with family and friends to know you're okay and get help from someone you trust if you need assistance. Part of this app includes a safe site locator, so if you are away from home and feeling vulnerable and need to find a place of safety, the 'safe site' locator will present you with the nearest police station and community help point scheme location.

Tap-it provides a quick way for people to create and access their own network of trusted friends and family members and is available to download free from Google Play or iTunes Store.

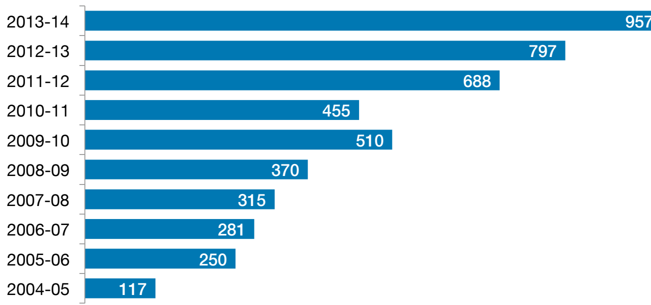
The Tap-it app helps everyone, young or old to feel connected wherever they are, whatever the situation and by creating and coordinating personal networks of family and friends, tap-it helps everyone feel a little more connected.

Tap-it has been developed in collaboration with community safety teams from Enfield Council, Southwark Council and a number of voluntary sector organisations. This initiative has been funded by The Mayor's Office for Policing and Crime (MOPAC).

Awareness of what abuse is and how to report is essential, so that adults at risk can get the support and protection they require. The Board has raised awareness through many different ways, such as articles in partner publications, the Keep Safe Week and the Essential Guide for 2012-2014. Information on fire safety and how to request a home fire safety assessment from the London Fire Brigade was put into the Enfield Talking Newspaper via one of the members of the Service User, Carer and Patient sub-group of the Board.

Safeguarding adults data indicates that the result of heightened awareness following community events and other actions having been undertaken by Board partners has been effective.

Number of safeguarding adults alerts/referrals



Key themes from the safeguarding adults referrals include (for further information, please see Appendix 2):

- April 2013 to March 2014 there were 957 referrals (alerts) received. This is an increase of 20% from the previous year.
- There has been a 16% increase in alerts related to people over 65 years of age.
- Most alerts relate to multiple abuse (35%) or neglect (24%).
- 38% of the referrals are in relation to alleged abuse in the Adult at Risk's own home and 29% are in a residential/nursing home.
- Hospital staff made the most referrals, at 22%.
- 38% of alerts relate to adults aged 18-64 while 62% 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, 282 (29%) are family/friends/neighbours of the adult at risk and 261 (27%) are formal social carers.
- Of the 957 safeguarding adults referrals (alerts) received, 733 proceeded to the safeguarding adults process.
- 45% of cases had a nominated advocate involved, which may be both paid or a family member or friend.
- 87% of the strategies agreed were within the required timeline of five working days from the alert.
- In 83% 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 226 cases that have an outcome following investigation, 48% of them were substantiated or partially substantiated (35% in 2012/13).
- 25% of outcomes for the Adult at Risk resulted in increased monitoring, 10% (23 cases) moved to different or greater care and 4% (10 cases) were removed from the Property or Service.
- In 35% of closed cases, the outcome for the person alleged to have caused harm was 'continued monitoring', whilst in 15 cases there was disciplinary action recorded.

We know from our data that reports of abuse involving older adults continues to increase in Enfield. 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 (CCG). We will also continue to work with Trading Standards to raise awareness of rogue traders and scams, particularly against older people.

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 45% 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.

In addition to raising awareness, a range of actions took place across the partnership to prevent abuse and keep people safe.

Working with adults at risk of abuse and their carers is central to how together we can help to keep people safe. Partners such as Age UK work with carers of older people with dementia on safeguarding issues and support them with safeguarding alerts and the investigation process. They will also advocate on behalf of clients with dementia and where they consider poor practice has occurred, and will support an alert being raised.

The Carers Centre is also a helpful point of call for carers to obtain support and seek guidance if they have concerns that they or the person they care for are at risk of abuse. A booklet was developed and is available on how carers can keep themselves, and the person they care for, safe and well. It is important that carers who are under stress are supported in order to help prevent the risk of harm occurring; Age UK have two regular carer support groups where safeguarding issues are discussed, with an offer of peer support sessions and one to one sessions with Carers.

Domestic and familial violence and abuse is an issue that can affect anyone, and some adults at risk may find it difficult to seek help when experiencing harm from a partner or family member. Partners on the Board are expected to ensure staff have training on responding to domestic violence, and practitioners in adult social care were offered training in how to respond to cases of domestic violence. Other partners, such as Age UK, have relevant staff on domestic violence training and alerts have been raised when carers have expressed they have felt like hitting the person they are caring for. Emergency respite has often been provided in these cases.

Service User Feedback

Ascertaining service user views and experiences of the Safeguarding process can be challenging. It is vital that we capture this feedback so that we can improve but, in the past, service users have been reluctant to fill in questionnaires once the Safeguarding process has been completed.

This year, we decided to contact 20 service users and carers who had recently been through the Safeguarding Adults process (from referral to Case Conference) in order to find out what the outcomes for them were and where we could make improvements. We did this through face-to-face interviews and using the key outcomes identified in 'Effective Outcomes within Adult Safeguarding: A Toolkit' by Improving Social Care in Wales.

These focus on three main areas:

- Awareness of Safeguarding, what is an abuse and how to raise a concern.
- Were the concerns properly responded to, did the service user/carer feel listened to?
- Does the service user feel safer as a result of the Safeguarding action?

This information is still being collated but initial feedback is that the majority of service users (or their carers) do feel safer after the Safeguarding process and feel that they can raise a concern if problems occur.

Most fed back that the workers from the London Borough of Enfield that they spoke to were respectful and polite. Some service users/carers still did not have an understanding of the Safeguarding process in terms of which meetings were happening or what documents were filled in. Although they felt listened to they were not always aware of the formal Protection Plan (although they may know some of what was in it). This is clearly an area for improvement for the service and will be taken into account for future planning.

This report will inform future practice and help to shape process and professional responses for adults at risk.

Section 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:

- Held meetings between the Police Community Safety Unit and the Council's Safeguarding Adults Service to review whether referrals are being progressed appropriately. Adults at risk should have access to the justice system.
- Continued to work with the Council's Drug and Alcohol Action Team (DAAT) so those with substance misuse have the same support and protection under safeguarding adults as other adults at risk.
- Ensured all partners have in place safer recruitment, which applies to both staff and volunteers.
- Partners have reviewed their websites and the North Middlesex University Hospital has include sections on how to report abuse and has a translation facility installed to enable people with Learning Disabilities and individuals with poor literacy skills to access website information.

Barnet and Chase Farm Hospital have a number of ways that they seek the experience of patients, such as the customer response tracker from the national patient survey, asking family and friends, with a new texting service, survey on website and cards. This is reported via the quality and safety committee. The Barnet Enfield and Haringey Mental Health Trust hold peer reviews. These include interviews with service users. In addition, they have a privacy and dignity audit where a service user goes into the ward and both interviews and observes quality of care.

The London Fire Brigade (LFB) at present are focusing on those individuals who may be at increased risk of fire. This was done through the work with London Borough of Enfield in writing to 1,800 adult social care users, targeted sessions with the Over 50s Forum and mental health service users, and attendance at the Boards Service User, Carer and Patient sub-group. The LFB are now looking at how they target fire safety information at support accommodation providers in Enfield.

Personalisation is about ensuring that everyone who receives social care support has more choice and control over how services are delivered. We believe clear and transparent information about the types of services and support available will enable safer and more informed choices. Safeguarding has always been an integral part of how personalisation is developed in Enfield; the Council's Safeguarding Adults Service is currently developing a framework for those who are purchasing their own care through a direct payment.

The Safeguarding Adults Board continues to promote the Dignity Standards, believing firmly that **dignity and respect** cannot be separated from safeguarding. The standards were developed as part of the national Dignity in Care campaign in 2006 and remain the most effective set of standards for ensuring that Dignity is at the heart of health and social care services for patients, users and carers.

Winterbourne View

Further to Panorama uncovering the appalling abuse of residents in Winterbourne View work in Enfield has continued to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging.

We already had very low numbers of people in assessment and treatment settings and have reduced the numbers of admissions to our in-borough assessment and treatment service. Lengths of stays have also been shortened as people have been given intensive support after they are discharged. Personalised care programmes and support plans are produced for each individual.

Enfield is one of the top performing boroughs in terms of the number of people with learning disabilities living in the community.

Dignity Standards

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

There is underreporting of **hate crime** in Enfield generally and in particular where it is committed against an adult at risk. The Councils Community Safety Unit (CSU) has worked to tackle this area through actions such as:

- Representation by Council's CSU at Safeguarding Practice forum to educate professionals on how to identify incidents of hate crime and if necessary to alert appropriate agencies.
- Presentations/training to Learning Disabilities Partnership Board as well as training relating to additional identification of hate motivation in safeguarding situations to workers from Mencap, One to One Enfield and Enfield Disability Action.
- A permanent representative from the learning disabilities team has been nominated to attend the monthly hate crime casework management panel. This has led to improved communication and co-ordination between the two services.
- The latest version of the safeguarding alert form asks if the report relates to an incident of Hate Crime. This should lead to a higher number of accurate classification of incidents involving hate crime.

The Care Act 2014

The Care Act, which has recently attained royal assent, will bring far-reaching and welcome changes to social care provision. The Act puts principles into statute that have long been in the domain of social work, and provides a script for modern social work with adults.

The act introduces a new duty for authorities to promote wellbeing in all decisions regarding an individual's care needs, and assessments must consider the whole family. Local authorities will also have to guarantee preventative services which could help reduce or delay the development of care and support needs. The act directs public services to provide advice and information, continuity of care and inter-professional working. It puts safeguarding on a statutory footing for the first time, and extends the role of advocacy.

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.

The Health service has evolved dramatically over the last few years, with Clinical Commissioning Groups (CCG's) in each area taking on new responsibilities and challenges in how services are commissioned and delivered. Health services need to be clinically led, **patient centred** and focused on improving the health of the population. All health services have a responsibility towards safeguarding adults. Safeguarding of adults at risk and children is recognised as a significant public health issue; preventing abuse and promoting of choice will increase wellbeing within these populations.

Our work with the **Safeguarding Children's Board** is an important part of how we keep everyone safe. A number of initiatives are planned for 2014-2015, including Keep Safe Week, joint training and how we can work more effectively across both Boards. The Enfield Safeguarding Adults Board and Enfield Safeguarding Children's Board will form a joint Safeguarding Adults and Children's Group.

The Safeguarding Adults Board has continued to see the number of safeguarding adults referrals increase. Many of the initiatives we undertake aim to ensure everyone who may be at risk of abuse knows how to report it, and that carers are equally able to access support. While ensuring we prevent and respond to all reported cases of abuse, the department will continue to ensure that all reported cases of abuse are investigated appropriately.

We know from our data that 29% of alerts relate to care in nursing and residential homes. Increasingly we have seen highlighted in the media cases of abuse and neglect and in Enfield we have a Provider Concerns Process which aims to:

- Ensure the safety, dignity and care to those who use the service of the provider;
- Ensure that the customer is at the heart of the process;
- Share information appropriately in order to enable effective partnership working;
- Work together with providers to improve the quality of care;
- Take robust action in instances where a crime has been committed or to protect the wellbeing of those who use services.

Working together means recognising that no single agency can alone respond or improve the quality of care within providers. Each organisation has its own remit, focus and skills, which together, has the potential to contribute to creating the best possible outcomes. The Council and its partners will continue to intervene in cases where providers are failing to deliver the quality of services required for people using services.

It has been positive to see the number of requests for Deprivation of Liberty Safeguards (DoLS) authorisations in 2013-2014 increase. During that period 66 DoLS applications were made, compared to 36 the year before. 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. During the last year 38 applications related to people in residential or nursing homes and 28 related to people in hospital, including two in a hospice setting. Of the total applications, 42 were authorised and 24 were declined.

Whilst many more Enfield residents benefited from a Deprivation of Liberty Safeguard as applications almost doubled, the overall number of DoLS (Deprivation of Liberty Safeguards) requests from local hospitals remained low. This means that people may be subject to unauthorised deprivation of liberty, without the appropriate safeguards in place. New case law was laid down by a judgement by the Supreme Court on 19 March 2014, which has since resulted in hundreds of applications being made all across the country, which puts health and care providers under pressure to comply with the law. This was in the case of “P v Cheshire West and Chester Council and another” and “P and Q v Surrey County Council”.

The Supreme Court has now confirmed that to determine whether a person is objectively deprived of their liberty there are two key questions to ask, which they describe as the ‘acid test’:

1. Is the person subject to continuous supervision and control?
2. Is the person free to leave? (The person may not be saying this or acting on it but the issue is about how staff would react if the person did try to leave).

This now means that if a person is subject to all three conditions, continuous supervision and control and not free to leave they are deprived of their liberty.

The judgment is significant in the determination of whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty.

Enfield, in response to this judgement, has created a steering group and plan of action. The Deprivation of Liberty Safeguards lead is the Chair of the Pan London DoLS group and involved in the national DoLS group to ensure local authorities share best practice in meeting this challenge.

Advocacy continues to be an area that the Board and those who use services and their carers are passionate about. Advocacy for safeguarding is being included in part of the HHASC Commissioning team’s Voluntary Community Sector Strategic Commissioning Framework 2013-16. It is recognised that the organisation(s) providing the advocacy service must have or develop specialist advocacy to support victims of abuse (including domestic violence) and subject to a safeguarding investigation.

Section 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.

Every year the Council's Health, Housing and Adult Social Care department commission an external safeguarding adults case audit, where an independent consultant reviews 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 and where further work needs to be done.

The audit found some areas of good practice, which included:

- A person-centred approach to adults at risk.
- The clarity, relevance and timeliness of recording.
- The quality of the investigations that were held.
- The quality and wide use of protection planning.
- Working to ensure that service users always have access to advocates (either formal or informal).
- Putting together robust protection plans.

Areas identified as needing focus, in the coming year, include:

- Ensuring that cases are reviewed appropriately so that preventative recommendations are being carried forward.
- Making sure that investigations are carried out promptly and independently where necessary.
- Ensuring that social workers always have the right support from across the multi-disciplinary team in order to complete investigations.

It is important that learning is done directly through case practice with those involved in safeguarding adults. To achieve this, the Central Safeguarding Adults Service complete quarterly case file audits with managers or staff who worked on a case. Some of the improvements that have arisen from these audits include:

- A new Review template to assist practitioners in terms of following up actions and protection plans arising from Safeguarding Adults.
- A marked improvement for some teams in terms of the quality of their recording.
- A greater uptake in Safeguarding Pan London Policies and Procedures training across the services.

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 with mental health needs, at risk. This is done on a monthly basis and promotes best practice.

Quality Checker Programme

Our Quality Checker volunteer programme puts our service users and carers at the heart of our quality improvement work. All of our Quality checker volunteers are current or former Enfield Adult Social care service users or carers. This work programme is helping us ensure that our service users' and carers' views are central in identifying and implementing improvements to service provision.

The Quality Checkers are visiting a range of adult social care services: these include all of our In-house provider services, private residential and nursing care homes, our accredited equipment retailers, and home care services. The information from the Quality Checker visits is fed back to providers to enable them to put in place improvements or to confirm good practice. Any themes identified are taken to our Quality Improvement Board where projects are agreed and governance provided for their delivery.

Achievements of the programme so far:

- 50 Quality Checker volunteers have been recruited and trained
- 150 visits to a variety of services (including 70 visits to service users in their homes)
- Successful operation of the Quality Improvement Board
- Establishment of the Dignity in Care panel (Quality Checkers and independent chair) have started the pilot to review Enfield Provider services from the Service user/carer perspective using the Dignity in care standards.

Outcomes from our visits to people who receive services in their home:

- Home Care Provider informed of poor quality care from delivered by one of their workers – faeces not cleaned up properly. This was addressed by the Provider.
- Home library service organised for service user.
- Based on feedback from clients, our Quality Checkers provide service users with a Complaints leaflet, Adult Abuse line number, and social care information booklet on every visit.

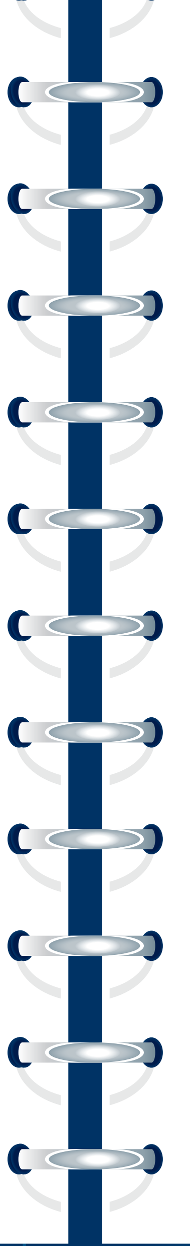
Care home Carers' Network launched on 18th February. This is a support group bringing together carers of residents of Enfield's Care homes to: share experiences; learn from each other; advise us of best practice examples and areas of improvement; and to help promote the establishment of relative and residents groups in each care home.

Section 5

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

Mr. A, an older man suffering from dementia, lives in a residential care home where the Safeguarding Adults Service were working under the Provider Concerns process. At a Residents and Relatives meeting, his sister raised that he had been found wandering in the street in a confused state – clearly putting himself at risk and showing that the home didn't have appropriate arrangements in place to keep him safe. A Deprivation of Liberty assessment was quickly arranged and Mr. A was spoken to by a Best Interests Assessor and a Psychiatrist. A more secure door was identified for the home and training done for staff. The most successful measure taken was identifying that Mr. A left the home because he wanted to go for a walk. Arrangements were made for carers to help him to walk round the garden a couple of times a day. Now, not only is the property more secure thus safeguarding Mr. A but he is also happy to be going for regular walks and therefore doesn't try to leave as regularly.

Miss. B, a young physically disabled woman in the community, has three calls a day from a domiciliary care agency. In October of last year, she found that one of her carers was frequently late and being rude to her. At first, she was not sure what to do but, during her Annual Review, an Officer helped her to raise a Safeguarding Alert showing emotional abuse. The case was investigated and the allegation found to be substantiated. Miss B is now working with another agency and very happy with her care. The carer involved is no longer with her agency.



Mr. C lives in a supported tenancy for men with mental health problems and has a history of alcohol abuse. A Safeguarding Adults alert was raised in relation to his behaviour to another resident (Mr. D) when he was drunk. Through the investigation and discussion, it was identified that Mr. C was struggling with his addiction and needed a lot more support to live his life. It was decided that he would be supported to move to another residential provision where the other residents did not have similar issues and there was intensive key worker support for when he was worried. Staff report that he has not had a drink of alcohol in three months and he seems to be a lot happier in his new home. Mr. D is also happy and feels more secure.

Mr. E, a younger man with severe learning disabilities and very limited communication, was the victim of an alleged assault by a professional. Initially it was believed that the Police would have great difficulty proving the issue given that Mr. E could not make a verbal or written statement. However, the Police worked with their own Intermediary service and the London Borough of Enfield Speech and Language team in order to get a good understanding of his communication. They also worked with the Integrated Learning Disabilities team to identify other potential witnesses and gather more evidence. The alleged perpetrator was charged and Mr. E will not have to testify. Mr. E has been protected as have other vulnerable adults within the borough.

Section 6

Quality of Care in Provider Services

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. Many partners on the Board are involved in sharing information and working together to respond to concerns about quality of services.

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 and contract monitoring staff, with that of partner organisations, such as the Clinical Commissioning Group and the London Ambulance Service. The panel is instrumental in helping partners share information and in identifying common areas of concern. Some of the outcomes from these meetings include:

- The identification of care providers, including Hospitals, where the provider concerns processes or other interventions (for example, contract monitoring visits, pharmacy audit) is necessary;
- Assurances from partners about quality of care within a particular provider;
- Joined-up interventions, such as work by the Local Authority and the Clinical Commissioning Group (visits by the shared Nurse Assessor).

The Safeguarding Information Panel has continued over the last year to meet every six weeks and has taken the lead in highlighting providers which may need support to improve the quality of their care to residents. In order to help support providers to do this, the Central Safeguarding Adults Service in Enfield Council manages the provider concerns process.

The provider concerns 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 external partners, who include the Care Quality Commission, Enfield Clinical Commissioning Group, the Police and other placing authorities and our internal partners such as the Care Teams, Health and Safety, Internal Fraud and finance.

During the course of this progress residents and friends and family are regularly engaged through professional visits and friends and family meetings. This feedback is critical in ensuring that we know what needs to improve and when we have achieved this.

A theme from friends relatives and friends meetings is that residents feel listened to. When asked if there had been any changes one family member commented "Good to see staff spending time with residents on a human level, one to one, showing caring aspect".

In 2013-2014 the Central Safeguarding Team worked with 19 providers, including nursing homes, residential care homes, hospital wards and domiciliary care agencies. This is a decrease in number from last year of 4.

Nursing Home Q was found to have issues with the dignity in care that was provided to residents, an over reliance on agency staff, concerns with medication management and poor engagement with residents and the family members over complaints. Often being under scrutiny can be challenging for any care provider, but working together to support improvements with partners such as Clinical Commissioning Groups and the Care Quality Commission, meant the home became more open to putting in place the required changes.

The home were able to put in place improvements such as a recruitment drive which meant permanent staff in place, regular meetings of residents and families, and working with a pharmacist to improve how they store and administer medication.

Meetings were held by the Strategic Safeguarding Adults Service with family and friends of residents, with their feedback give to the home and included in any improvements put in place. Over time, the family and friends became more confident that their concerns and suggestions were being addressed.

This process is not only a learning experience for the nursing home, but the Council and other organisations which support them. At the end of this process we identified some areas where improvements can be made, including:

- Setting out clearly the timescales for this provider concerns process
- Improving communication between partners and providers as the process goes on
- Ways in which single alerts which are investigated when the provider concerns process is underway is managed, so that the provider is able to understand and respond to allegations made against them.

Section 7

Safeguarding Adults Board Sub-Groups

In order to achieve its aims and to influence the Board's decision making process it has established sub groups to implement the safeguarding arrangements. Where required, these groups will have project plans and reports will be made to the Board about the process and outcomes of these groups.

The Board has four sub-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 has service users, carers and patients who are committed to contributing towards how we keep everyone in Enfield safe from abuse and harm. It is a diverse group of individuals, including those with caring responsibilities, learning disabilities, from the deaf community and from the lesbian, gay, bisexual and transgendered community. The Group is aware of the need to be inclusive and representative of the population of Enfield and is constantly seeking to address any inequalities in representation.

The Group meets monthly and has contributed to safeguarding developments, such as:

- Development of the questionnaire to be used with adults at risk whom have been harmed or abused and undergone the safeguarding adults process
- Review of hate crime literature
- Review and comments on the Surveillance Policy for safeguarding adults
- Discussion around data trends, with concern noted of the low number of adults at risk from Black and Minority Ethnic communities reporting in.

The Group would like to develop a DVD on the types of abuse, in an effort to increase understanding across 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 in the Safeguarding Adults Strategy Action Plan. The group considered other mechanisms to improve awareness-raising and are currently looking at the use of radio stations.

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.

In 2013-2014 the Group have drafted a Multi-Agency Hoarding Protocol.

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 in the coming year.

Learning and Development Group

Learning is a process, not just a product. How learning is delivered in safeguarding adults spans a range of activities which ensure that staff, volunteers and even those who use services and their carers know how to keep people safe and report abuse. Learning by Board partners is undertaken through activities such as 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.

Work has been completed on mapping the Learn to Care Capabilities throughout the council against all job roles. This will support partner organisations in mapping out the capabilities against their own organisational roles in the next financial year.

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

Course	HHASC/ LBE	BEH MHT	Police	Private & Voluntary	Totals
Alerters	50	8	0	40	**98**
Investigators	13	25	0	2	**40**
Financial Abuse: Stage 1	Courses cancelled due to low uptake				
Financial Abuse: Stage 2					
Legal Context					
Chairing Strategy Meetings					
Referral to Closure					
Total	**63**	**33**	**0**	**42**	**138**

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:

- Basic Awareness (e-learning)
- Alerters (New Starters and Refresher Courses)
- Investigators
- Financial Abuse: stage 1 and stage 2
- Managing from referral to closure

Quality, Performance and Safety Group

The Board's Quality, Performance and Safety Group has been set up to provide assurances that high quality safeguarding arrangements are in place within Enfield SAB partner organisations. Where best practices are identified these need to be shared to ensure that adults at risk in Enfield are kept as safe as possible. Where areas of improvement are identified, it is imperative that the sub-group plays a constructive and supportive role to ensure improvement plans are agreed and delivered swiftly.

The sub-group will need a variety of information from providers to effectively execute its role, including independent validation which service user, carer and patient volunteers will be able to provide through invaluable insight into how all SAB partners' arrangements are working.

The Enfield SAB implemented the NHS England SAB audit which included a partner challenge event. This information, once collated will be used to provide assurances of quality, safety and effectiveness of safeguarding arrangements and derive an action plan based on the sub-group's GAP analysis.

Section 8

Partner Statements 2013-2014

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

Barnet and Chase Farm Hospitals NHS Trust

Internal arrangements for governance regarding Safeguarding adults:

- The Director of Nursing is the director responsible for Safeguarding.
- Head of nursing acts as the corporate lead for Vulnerable Adults.
- A Medical Matron 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 and there is also an eLearning package in place.
- The Trust has e-learning packages for all statutory and mandatory training including Safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguards and Dementia.
- Training in Mental Capacity Act, Deprivation of liberty and Dementia is now mandatory.
- Training has been provided on caring for patients with dementia in an acute setting as part of the Trust's Dementia Strategy.
- The Trust has also received a visit form the CQC to undertake a thematic review for the care of patients with Dementia. The CQC found the Trust to be compliant.

Work undertaken/planned and achievements/ progress in 2014/15:

- As part of safeguarding awareness week and Nurses day the Trust had information stalls on both sites.
- The Trust is replacing the butterfly scheme for Dementia with the "Forget Me Not".
- 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 is reviewing the Policy and guideline on safeguarding, Mental Capacity Act and Deprivation of liberty.
- The Trust will also be implementing a new policy on Domestic Violence.
- 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, which includes the Patient Safety training days for nursing staff.
- 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 recognising the needs of people with a learning disability as part of the student nurse induction.
- 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 2014/15:

- As part of Nurses Day, the Trust intends to continue holding safeguarding awareness stalls.
- The Trust has implemented the Tiptree table on one of our wards and this is being rolled out to our other wards.
- There is a plan for further environmental changes, as part of its dementia strategy, and extending the use of colour and symbols to identify specific areas to help create Dementia Friendly environment for patients.
- 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 Acacia team in maternity is now up and running. They are a team of midwives who provide additional support and care for vulnerable women. This includes those who experience Domestic Violence, FGM and women 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:
Noeleen Behan
Lead Nurse for Nursing Performance & Informatics
Enfield Safeguarding Adults Board representative

Barnet, Enfield and Haringey Mental Health NHS Trust

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 Safeguarding Adults Team consisting of The Head of Safeguarding People and The Safeguarding Adults Lead who report 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 2013/14

During 2013/14, 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, 2,228 staff attended level 1 safeguarding adults training during 2013/14 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 2013.
- 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 2014/15

The Trust will incorporate the following elements into its safeguarding adults work programme for 2014/15:

- 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.
- 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.

To raise awareness of the Multi-Agency Practice Guidelines for Female Genital Mutilation and ensure that staff are trained understand the issues and the how to report concerns.

Work in partnership to develop a Borough wide strategy to enable to staff to know how to assess, manage and raise concerns if a person develops a Pressure Ulcer.

Statement written by:
Mary Sexton
Executive Director of Nursing, Quality and Governance
Enfield Safeguarding Adults Board representative

NHS Enfield Clinical Commissioning Group

Introduction

"Our Vision is to ensure that safeguarding adults at risk is everybody's business."

(NHS Enfield Clinical Commissioning Group)

NHS Enfield Clinical Commissioning Group (ECCG) priority is to ensure adults at risk remain safe whilst they are receiving health care in Enfield. This priority remains at the heart of all commissioning planning and decision–making. We have continued to work in partnership with all agencies in the health economy to achieve this and make sure that all health providers in Enfield understand their role in the health and wellbeing of vulnerable adults.

ECCG has ensured that safeguarding arrangements have been embedded in NHS provider organisations. The contractual arrangements within these providers include clear service standards and performance indicators for safeguarding which are incorporated in all commissioning arrangements. These indicators are monitored through the contract performance reports and are routinely subject to additional assurance methods. These assurance methods take the form of site visits known as "Walk the Pathway". These can be both "announced" and "unannounced" visits which are undertaken for purpose of obtaining assurances against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and social care services have a right to expect.

ECCG ensures that commissioning decisions in respect of adult care placements (e.g. in care homes & nursing homes) are based on knowledge of standards of care and safeguarding concerns. The CCG has produced several assurance papers in relation to the learning associated with Winterbourne and the actions associated with the Concordat. The CCG works collaboratively with the local authority in quality assuring the care in adult care placements including the sharing of information where there are multiple concerns that are indicative of early warning signs of possible abuse.

Key Achievements and Next Steps

- A Safeguarding Adults at Risk Strategic Committee is in place which gains assurance from senior health managers in the provider organisations. This committee is established through meetings held quarterly and it provides a health based forum which advises, implements and shares good practice in relation to safeguarding adults at risk, across the Enfield Health economy.
- The CCG has employed a nurse assessor, jointly with London Borough of Enfield who is working on a pressure sore project. A review of the available data on pressure sores was gathered on ten nursing homes in Enfield. The nurse assessor will continue to work with the nursing home care managers in establishing a safeguarding alert system for reporting pressure sores within Enfield homes. A database system will also be established and this can be accessed by both Enfield Clinical Commissioning Group and Enfield Local Authority. This project should be completed by year end.
- A safeguarding GP forum has been established on a quarterly basis. GP leads for safeguarding adults at risk are invited to this group. They are updated on issues in relation to safeguarding adults.
- Enfield CCG has been successful in securing funds for training in MCA and DoLS across Enfield Care Homes. This will be delivered in partnership with London Borough of Enfield by year end.
- The PREVENT agenda has been embedded across the health economy.
- Working with care home managers on standards of nursing care.

Statement written by:

Carole Bruce-Gordon
Head of Safeguarding
Enfield Clinical Commissioning Group (CCG)
Enfield Safeguarding Adults Board representative

Enfield Homes

Enfield Homes is responsible for delivering housing management services to approximately 16,000 tenants and leaseholders on behalf of Enfield Council.

Committed to creating and sustaining **successful communities** Enfield Homes believes that everyone has the right to be treated with dignity and respect and live a life free from fear or abuse. Enfield Homes also recognises that safeguarding adults is closely linked to the equality and diversity and human rights agenda. For example, the definition of a vulnerable adult used in the 'No Secrets' document and definitions of harm and abuse include protected characteristics and behaviours defined as harassment under the Equalities Act 2010.

Keeping adults safe is a priority for Enfield Homes and it will continue to work in partnership with Enfield's Safeguarding Adults Board and others to promote the safety and welfare of adults at risk.

Internal Governance

Enfield Homes' embraces safeguarding adults at the highest level and its commitment is included in its Delivery Plan[1], which feeds into relevant service plans and operational practices.

The Director of Housing Operations is the organisations Safeguarding Champion and provides leadership at strategic and operational levels, reports on progress to the executive management team and Enfield Homes Board and ensures that safeguarding issues are reflected in all relevant operational policies and procedures.

Training

Enfield Homes has access to the Enfield's Safeguarding Adults Board training programme and all staff are required to complete the Basic Awareness e-learning module.

Partnership Working

Enfield Homes continues to work with the Safer Stronger Communities Board and MARAC to report and reduce anti-social behaviour including hate crime and harassment, which can often include safeguarding issues.

The Safeguarding Champion sits on the Safeguarding Adults Board and gives a high profile to the work of the Board within Enfield Homes.

Enfield Homes works to the Pan London Safeguarding Policy and Procedures to prevent and report abuse when it is suspected.

Sheltered housing staff regularly report concerns, attend case conferences and work with other agencies to tackle abuse when it is recognised.

Raising Awareness

Enfield Homes actively promotes an understanding of adult safeguarding issues to staff and residents. Information has been published in Housing News, the residents newsletter, focussing on how to recognise adult abuse and what to do about it.

Enfield Homes' website has an adult safeguarding page with links to further advice and information about the Councils strategy for staff and residents. Information is available for residents in Sheltered Housing Blocks and at all key customer contact points within the organisation.

Continuous Improvement

Enfield Homes completed an audit of activities using the SAB assessment tool and identified a number of improvements for the coming year including:

- Reviewing policies, procedures and governance structures to meet good practice standards
- Increasing the scope of work with tenants in general needs housing to raise awareness of adult safeguarding issues and prevent abuse
- Reviewing linkages with key services, such as the anti-social behaviour team, to make sure that the needs of all tenants are considered in the safeguarding process (e.g. when allegations of anti-social behaviour are made against residents falling within the definition of an adult at risk).

Statement written by:
Ann Otesanya
Director of Housing Operations
Enfield Homes
Enfield Safeguarding Adults Board representative

1 This sets out the organisations priorities for the business for the forthcoming year

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, probation services and health agencies. Also represented are the local Youth Offending Service, other criminal justice agencies, Housing Providers, Elected Members and voluntary organisations. The Board works in partnership with community groups, neighbouring boroughs, central government and the Mayor's Office for Policing and Crime who are the Police and Crime Commissioners for London.

The partnership receives support from the Council's Regeneration and Environment Department and the manager of the Community Safety Unit is a member of the Safeguarding Adults Board.

There are considerable changes underway in the landscape of community safety, including the introduction of the Local Policing Model and the imminent introduction of Community Rehabilitation Companies who will take on around 80% of the management of offenders in the community as the key element of the Ministry of Justice reforms.

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 2013-14 include:

- Significant investment in CCTV provision
- National recognition for links with Health and Wellbeing Board agenda
- Revision of joint tasking arrangements and problem solving groups
- Further development of partnership work to tackle gangs, for which we have received international recognition
- Better oversight of ASB cases through regular case management meetings
- Continued use of powers to tackle poor behaviour, including securing over 30 ASBO's this year, including against those involved in gangs
- National award for tackling illegal money lending
- Further work around Domestic violence including supporting Project IRIS working with GPs to identify DV and intervene safely and the launch of the Tap-it mobile phone app

Priorities in this years' Partnership Plan are:

- Reducing property crimes such as burglary and car crime
- Tackling serious youth violence
- Tackling violence against women and girls
- Tackling Anti-Social Behaviour
- The management of offenders in the community

We are also aware of key cross cutting themes that impact on the above priorities such as substance misuse and hate crime. These themes will also be key areas of work for the SSCB during 2014-15.

Statement written by:

Andrea Clemons
Acting Assistant Director, Community Safety and Environment
Enfield Safeguarding Adults Board representative

London Ambulance Service

We are committed to safeguarding vulnerable members of our community and continue to work closely with partner organisations to improve this process.

Living a life that is free from harm and abuse is a fundamental right of every person andall of our staff, are committed to preventing harm or abuse occurring and taking action where concerns arise.

The London Ambulance Service NHS Trust has been working hard over the past year to ensure that we can keep our patients and their families safe.

- We held a safeguarding conference on 5th June 2013 for 100 LAS staff plus 6 national leads.
- We have undertaken a review of our referral system and processes.
- An audit of referrals was undertaken in 2013 to review quality and appropriateness.
- A further audit is being undertaken in 2014 looking at self-harm and mental health referrals.
- The Trust is fully engaged with safeguarding boards. As a Pan London provider it has identified local safeguarding leads that attend Safeguarding boards or sub groups.
- An E-learning package on the Mental Capacity Act has been developed and is available to staff via our e learning platform.
- We have undertaken Prevent training for our officers and are developing a Prevent Strategy.

Our referrals continue to rise month on month pan London for children and adults. For Enfield figure please see below.

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Adults	62	68	59	76	64	58	75	78	74	60	79	60	**813**
Children	22	19	27	16	24	17	24	25	22	15	20	35	**266**

As a Pan-London provider 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 all aspects of our safeguarding activity. Likewise we have provided a response to the Winterbourne View Report and recommendations which was given to the chairs group.

Statement written by:

John Carmichael
Community Involvement Officer (Enfield & Haringey)
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 2013 to 2014

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 the benefits of a fire suppression system in domestic and sheltered housing.
  - Outcome: Partners were encouraged to consider the benefits of fire suppression systems to reduce the damage caused by fire, reduce the number of injuries and death to vulnerable people. Work commenced on the development of a Multi-agency Hoarding Protocol through the Policy, Procedures and Practice sub group of the Adults Safeguarding Adults Board
  - All Borough fire officers were updated by the Enfield borough council safeguarding team in regards to considerations and legal requirements when carrying out their daily roles in emergency incidents at the annual information day workshops
  - Senior fire officers attending borough area forums to ensure that all communities are aware of the important fire safety work carried out by fire officers and delivering 'Home Fire Safety Visits' to the most vulnerable members of our community
  - 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 2 fatal fires, 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

Improving services for at risk groups

- Working with at risk groups such as the deaf community. This could involve 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 2014/2015

- Continue to raise awareness of the availability and provision of domestic fire suppression systems for very high risk adults.
- Continually seeking improvements to reduce the number of incidents in sheltered accommodation by working closely with service providers.
- 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 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 January 2013.

Achievements over 2012/13

The Metropolitan Police Service incorporates Safeguarding Adults as a priority within the Total Victim Care policy. This policy sets out how officers and staff should look to prioritize victim safety and satisfaction in all areas of their work. From 01/04/14 Chief Inspector Taylor Wilson has been appointed to cover Public Protection matters. This will ensure that there is increased SLT oversight of all Public Protection issues, including Adult Safeguarding.

- Recently, vulnerable adults have been incorporated into the MPS-wide Merlin system. This allows welfare concerns to be formally recorded, monitored and tasked through the Multi Agency Safeguarding Hub system
- Launch of Vulnerable Adult Toolkit, and as from 02/04/13 the use of the Merlin system to record welfare concerns relating to vulnerable adults
- Training has been provided to frontline officers outlining how the new Merlin Vulnerable Adult facility should be used. This training includes risk management measures to be put in place to protect vulnerable adults in the short-term pending multi-agency action. Training of officers is ongoing and being conducted on a weekly basis
- Co-Chairing the Quality, Performance and Safety Group of the Safeguarding Adults Board

Activities planned for 2013/14

Enfield Borough Police completed an audit of safeguarding arrangements as part of the Safeguarding Adults Board Challenge Day event. The purpose of the event was to highlight the work individual organisations undertake to ensure effective safeguarding practice and to identify areas for improvement or development.

Work to introduce the Multi Agency Safeguarding Hub (MASH). This will provide triage and multi-agency assessment of safeguarding concerns in respect of adults at risk.

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 Training:

- Training opportunities to be explored for safeguarding adults in the multi-agency arena at both DI and DCI level
- A central training team is currently delivering training to cover the Vulnerable Adult framework, including circumstances when a Merlin report should be completed and specific case law pertaining to vulnerable adult abuse
- This area of work will require refreshing as new officers join the organisation and to include changes driven by case law

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
- Dedicated Detective Constable (DC) to continue to work under the Safeguarding Adults Supervisor. Enfield is one of the few Boroughs in London to have a dedicated DC working exclusively on vulnerable adult issues. The DC will investigate the most complex adult abuse cases and provide guidance to other officers dealing with safeguarding adult investigations

Proposed activity relating to Quality Assurance:

- Analysis of the new system of vulnerable adult referrals being completed on the Merlin system
- 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:
CI Taylor Wilson
Enfield Police, Public Protection
Enfield Safeguarding Adults Board representative

North Middlesex University Hospital

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 Council 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 Trust has an established Safeguarding Adults Group which has representation from our inter professional and inter agency groups. It provides the strategic direction to safeguarding adult activities across the Trust and ensures that all safeguarding commitments and responsibilities are met. Its purpose is to promote engagement with all agencies and to gain assurance that standards set out in the Pan-London 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse' are met.

The Safeguarding Adults Group is chaired by the Director of Nursing and Midwifery (Executive Director responsible for Safeguarding Adults at the Trust) and reports to the Trust Risk and Quality Committee. This ensures that scrutiny can be achieved at several levels which also involve Trust Non-Executive Directors.

The Safeguarding Adults Group also maintains an organisational overview of the implementation of the legal provisions in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards (DOLS). During 2013/14, there were two requests for DoLS authorisations to the Court of Protection. The Trust Board receives an Annual Report and work plan on the Trust's Safeguarding Adults arrangements.

Key Achievements 2013/14

The Trust completed the NHS London Safeguarding Adult Self-Assessment Audit and this was presented at the Enfield and Barnet Safeguarding Adult Board Challenge Event on 26th March 2014. The presentation was well received and in summary areas of good practice identified included:

- Board sign up for Safeguarding Adult Strategy 2014-2017 up to date policies and procedures
- Good Safeguarding Adult structures with links between Safeguarding Adults and Child Protection and partner organisations
- Good risk awareness reporting systems.

Other initiatives that have been taken forward include:

- introduction of a new Adult Patient Restraint Policy which shows the correct process for dealing with situations where patients are in need of close surveillance and where there is a risk that they might leave the ward unsupervised
- an updated Safeguarding Adult at Risk Policy which includes a section on the interface between Serious Untoward Incidents and Safeguarding Adult procedures
- an updated Mental Capacity Act and Deprivation of Liberty Safeguards Policy which includes additional information on how to progress mental capacity assessments, best interest decisions and applications for Deprivation of Liberty Safeguards
- introduced a new discharge form which includes a patient body map diagram to ensure staff record any marks on the body, bruises or pressure ulcers prior to discharge. This enables us to have a baseline should any discrepancies arise at a later date
- implemented a SSKIN bundle and moisture lesion training programme on all inpatient wards which has enabled the Trust to accomplish its overall ambitious stretch target of an 80% reduction in severe hospital acquired pressure ulcers over the last 3 years
- partnership working with Enfield and Haringey Local Authorities in matters relating to domestic violence and abuse
- contribution to Individual Management Reviews as required
- developed a website link to sources of advice and help for domestic violence victims and internal domestic abuse referral protocols
- a 'Patient Passport' which supports people with learning disabilities who are admitted to the Trust. This provides staff with important information about the patient and it also includes contact details for community learning disability teams

- good processes in place for identifying and anticipating patient appointments for those with Learning Disabilities. The Learning Disability Acute Liaison Nurse takes a lead role and acts as link between Trust staff and patient and community support services
- introduction of Word-Bank facility on the Trust website to enable people with Learning Disabilities and individuals with poor literacy skills to access website information. This enables them to simplify the meaning of difficult words using an automated plug-in dictionary or in animation or picture format. A button at the top of the Trust's front page of the website allows the user to switch on Word-Bank which provides preset explanations of difficult words and medical terminology
- audit of the Michael Inquiry and Six Lives: Public services for people with learning disabilities Trust action plan
- completed a Trust Self-assessment audit on PREVENT, using the tool kit outlined the Department of Health – Building Partnerships, Staying Safe document.

Staff Training in Safeguarding Adults

The Trust has approved a Safeguarding Adult Training Strategy and has undertaken a training needs analysis to identify which level of training is required for each member of staff in the Trust. Safeguarding Adult level 1 training is mandatory in the Trust for all new staff at induction. All new staff receive training in relation to Learning Disabilities at induction.

We continue to train staff through face-to-face training and e-learning packages. Safeguarding Adult Level 2 training is provided as face to face training for relevant groups of staff and covers the Mental Capacity Act and Deprivation of Liberty Safeguards. The training figures are presented to the Risk and Quality Committee on a quarterly basis.

There is also an ongoing training programme to raise staff awareness on the Government PREVENT programme which teaches them how to recognise vulnerable individuals who may be at risk of being drawn into terrorist activity.

Priorities for 2014/15

The Trust has updated its Safeguarding Adults Strategy with an associated action plan which will be updated annually with a progress update and new priorities added as necessary. This year's priorities are to:

- ensure that Trust Safeguarding Adults Policies and procedures are up to date and comply with current legislation
- ensure that the Trust Safeguarding Adults/Learning Disabilities and Domestic Violence web pages are up to date
- ensure that all staff receive appropriate training
- improve our links and cooperation with partner organisations working with adults at risk
- ensure that reasonable adjustments are made as necessary for those with Learning Disabilities
- improve Domestic Violence support available to patients
- ensure that the Prevent agenda is part of mainstream Safeguarding Adult processes
- strengthen links for Safeguarding Adults and Child Protection and implement improvements identified from lessons learned.

Statement written by:

Eve McGrath
Safeguarding Adults Lead
North Middlesex Hospital
Enfield Safeguarding Adults Board representative

Appendix 1

Safeguarding Adults Board Key Tasks 2014–2015

Introduction

This is the Safeguarding Adults Strategy action plan, incorporating all actions for 2012-2015. 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 Service User, Carer and Patient 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	Outcome	Target date	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	SAB – All Board Partners	■ All partner agencies able to evidence information is given **as routine** to adults at risk ■ The accessibility of our information means that more people are able to understand what abuse is and how to report – this is reported by board partners through their user engagement feedback processes	2012 and ongoing	BSL 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	■ All partners able to demonstrate compliance with mandatory training requirements as agreed by SAB	2012 and ongoing March 2013	On track Complete
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	Senior leaders show visible leadership, including community and political leadership, strategic planning, partnership and collaboration to promote safeguarding	March 2013	
1.4	All partners have in place organisational learning arrangements	SAB – All Board Partners	Internal audits demonstrate improved practice and/or organisational change resulting from learning opportunities	March 2013	
1.5	All partners ensure that domestic violence training is available and quality assured	SAB – All Board Partners	Partners can demonstrate improved internal reporting of domestic violence. Training available via learning pool by DV Coordinator, LBE	March 2013	
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	Events provide an opportunity to raise concerns and receive feedback-evidenced through reports of abuse, referrals and feedback forms obtained through events	2 per year	
1.7	To raise awareness of the interface between Hate Crime and Safeguarding Adults	LBE Community Safety Unit & SAB partners	Increase in hate crime cases brought to hate crime panel – improvement to be evidenced during 2013/2014	2012 and ongoing	
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	2012 and ongoing	

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

No.	Work Area/Project Outcome	Lead	Outcome	Target date	Status
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	Mechanisms for reaching residents of Enfield diversified- measuring referral routes and use of adult abuse line as indicator. Events held at Over 50's Group, Safeguarding article in Our Enfield, raised at Keep Safe Group.	2012 and ongoing	
1.10	Develop a Safeguarding Adults Competency Framework for staff and commission in line with this	HASC Learning and Development		March 2014	
1.11	To agree and implement projects targeting specific groups, including drug and alcohol users and the deaf community	SAB – All Board Partners	**Projects Agreed at Sept 2013 SAB. Targets, dates and updates from Leads required.** Deaf community supported via Service User, Carer and Patient Sub Group to coordinate awareness raising. Training provided to DAAT partners on safeguarding levels 1 & 2.		
1.12	To arrange targeted events for BME groups, carers, GP's, police, CCGS, schools and health centres staff	SAB – All Board Partners		Ongoing	
1.13	Target information about safeguarding services to vulnerable young people without on-going care needs and seek their consent to share relevant information with adult services to improve any future response required	Representative from Safeguarding Children's Board		March 2014	On track
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	Feedback from adults at risk confirms that they feel safe and have a positive experience of care and support	2012 and ongoing	
2.2	Feedback routinely obtained after incidents of abuse and learning is captured	SAB – All Board Partners ensure internal monitoring arrangements	Organisational learning is embedded and can be evidenced through service change/improvements – evidenced in audits. Also process/system available at Practice Forum	2012 and ongoing	Improve-ments noted in audits
2.3	Implement regular reviews of service provision with the involvement of adults at risk to identify specific areas for improvement in ensuring dignity and respect, set local targets and monitor progress	SAB – All Board Partners	Service User Interviews being undertaken with final report produced to inform good practice and areas for improvement	2014-2015	
2.4	Arrange Dignity Conference and specific publicity material	SA Service Head	March 5th 2014 Dignity Conference booked	February 2014	
3.	**Quality assurance and practice**				
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 must have clear standards in place to demonstrate to Board via self assessment audit during 2012/13	March 2013	
3.2	50% safeguarding investigations to be completed within 7 weeks	LBE – HHASC	Compliance with pan London Safeguarding Adults Policy, as evidenced in audits	March 2013	

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

No.	Work Area/Project Outcome	Lead	Outcome	Target date	Status
3.3	Police to conduct audit of safeguarding adult cases referred to them, focusing on decision to investigate and prosecutions	Police	Recommendations delivered which aim at improving processes that increase access to the justice system for adults at risk	By March 2013	
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	Alerts are sent in timescales, meaning adults get immediate protection plan and are safe- evidence through feedback from adult social care receiving alerts. In 83% 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.	Partners 2012/13 and ongoing	Improved
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 (audits)	March 2013	
3.6	Agree a policy and joint whistle blowing procedure across the partnership	SAB – Safeguarding Service Head, LBE	Improved mechanisms for staff to raise concerns relating to their own organisation-embed policy in 2013/2014 and for the use of the policy to be audited in 2014/2015, in order to evidence increase in whistle blowers	Board partners by March 2013 Commission-ed services by March 2014	
3.7	Embed quality assurance mechanisms across partner agencies – driven by service user experience. Include case file audits and quality checks, translating into shared learning across partnership to help improve the quality of referrals and outcomes		SAB will quality assure processes across partnership, included via SAB audit during 2013/2014		
3.8	Undertake an audit of cases to quality assure service user involvement from alert through to closure	SAB – Safeguarding Service Head, LBE		Report due March 2014 Board meeting	
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	2012 and ongoing	
4.2	All partners ensure that adults at risk are involved in quality assuring services	SAB – All Board Partners		By March 2013	
4.3	Ensure that the review of the Safeguarding Adults Board increases active involvement from adults at risk	SAB		By March 2013	Via sub-group
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	Service users and carers feedback at events identifies information contributes to preventing abuse	2012 and ongoing	

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

No.	Work Area/Project Outcome	Lead	Outcome	Target date	Status
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	2012 and ongoing	
5.3	Review how we provide information to adults at risk who are experiencing domestic violence	SAB – Head of Community Safety LBE		2013/2014	
5.4	Identify isolated adults at risk and explore ways of providing advice and support to them to protect themselves, possibly using local neighbourhood schemes; accessing suitable funding as appropriate	SAB – All Board Partners	e.g. discuss with CCGs using home visits by GP's and other health professionals	2013/2014	
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	2012 and ongoing	
6.2	Ensure all service providers are able to demonstrate how service quality is assured	HHASC – Head of Commissioning and CCG commissioners	Providers able to demonstrate quality assurance are directed to resources which prevent providers concerns process from being initiated	2012 and ongoing	Via sub-group
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	Prevent unsafe hospital discharge and evidenced reduction of unsafe discharges raised to safeguarding adults service	2012 and ongoing	Being monitored
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 evidence strategically of how safeguarding is embedded (project plans)	2012 and ongoing	
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	March 2013	
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	Actions to be identified from the learning which will be added to the strategy action plan	March 2013	
7.3	Ensure that all partners are clear about the Crown Prosecution Service (CPS) requirements/considerations for: neglect, fraud, common assault and sexual offences		Improve understanding across partnership	2012 and ongoing	
7.4	Share learning when CPS decides not to pursue – explore feasibility of action through civil action		Actions to be identified from the learning which will be added to the strategy action plan	2012 and ongoing	
7.5	Agree a protocol with Coroner's Office re death in care homes and investigations	SAB– Safeguarding Service Head	As evidenced through case audits, appropriate action taken when death occurs in care homes-audits 2013/2014	March 2013	Draft complete – presently with Coroner

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

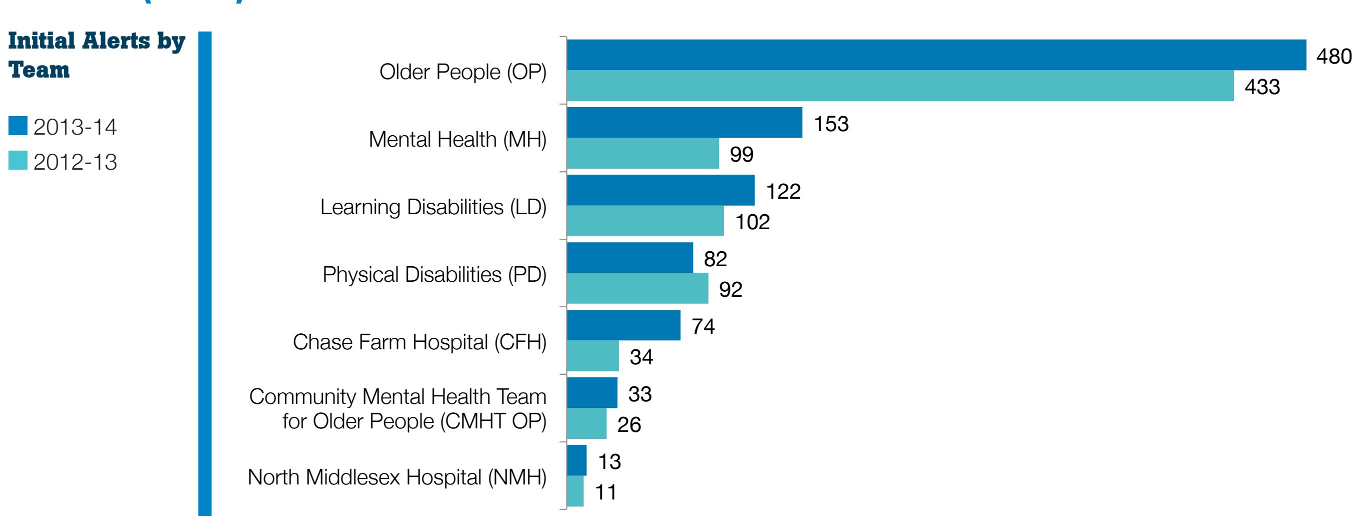
No.	Work Area/Project Outcome	Lead	Outcome	Target date	Status
8.	**Work with perpetrators**				
8.1	Ensure carers and carers organisations recognise and report abuse	HHASC Carers Commissioner, LBE and Carer Centre		2012 and ongoing	Improved via events – new leaflet
8.2	Support the early identification of carers under stress and help them understand when they need more help and where to access the support	SAB – All Board Partners		2012 and ongoing	
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	2012 and ongoing	
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	Allegations management procedures which can be evidenced to the SAB	2012 and ongoing	Awaiting evidence
8.5	Produce information and training for carers who may be abused or at risk of abusing	HHASC Carers Commissioner, LBE and Carers Centre		March 2014	Carers Centre now launched
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 – best practice embedded across partnership which helps to keep people safe and demonstrate effective responses	2012 and ongoing	Report by all partners December 2013
9.2	Agree revised management and performance reporting requirements to SAB focussing on in depth analysis	HHASC Strategy & Performance, LBE	SAB are able to identify area for organisational learning or targeted work to improve processes	December 2012	
9.3	Board to receive national and local data (using GIS to demonstrate incidence spread) and use to improve safeguarding adults arrangements	Suzanne Gumble		March 2014	
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	Evidence to improve access to justice systems and base for actions against failing providers	March 2014	
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 – feedback through quality assurance processes and adult social care	March 2013	
10.3	Use IT to ensure access to SA information to deaf community	SAB with HHASC Safeguarding Head	Partners forwarding resources including DVD's accessible online. Library resource file held in Central Safeguarding Adults Service.	March 2014	

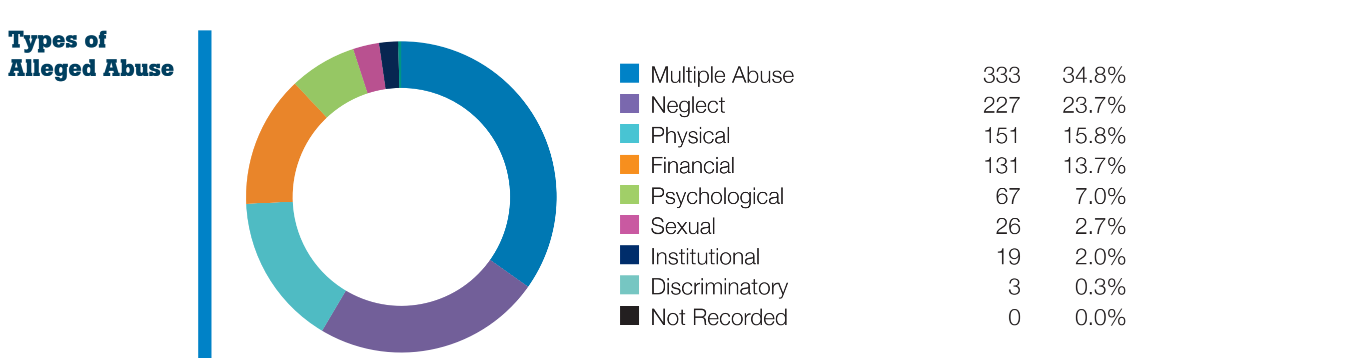
Key: Achieved/on track | Monitor closely/behind schedule | Not achievable or no satisfactory update received

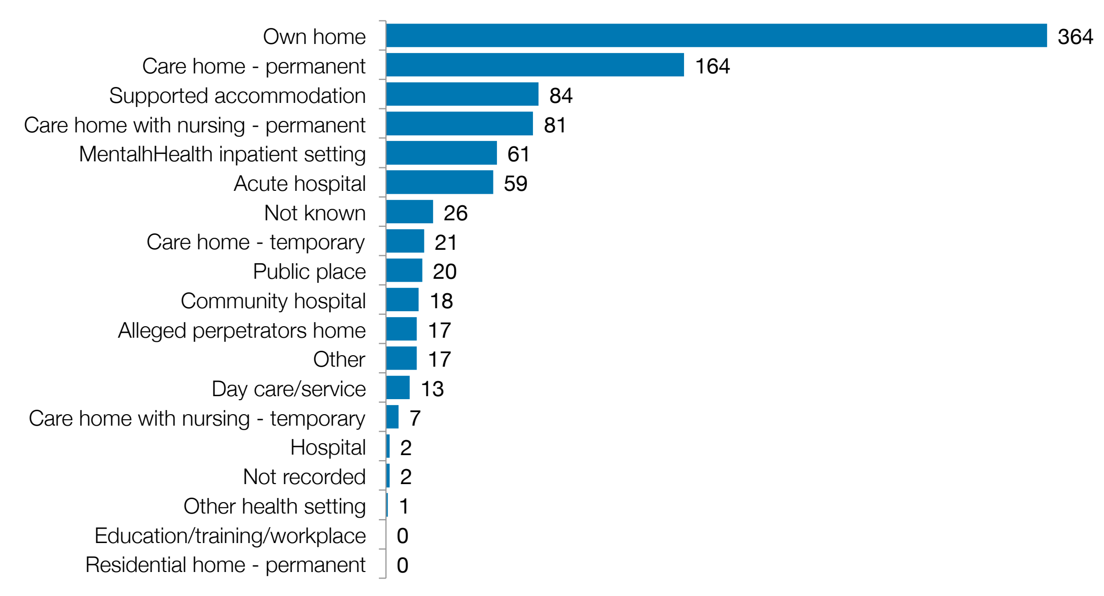
Appendix 2

Safeguarding Adults Referral Report 2013-2014

Referrals (Alerts)







Routes of Referral

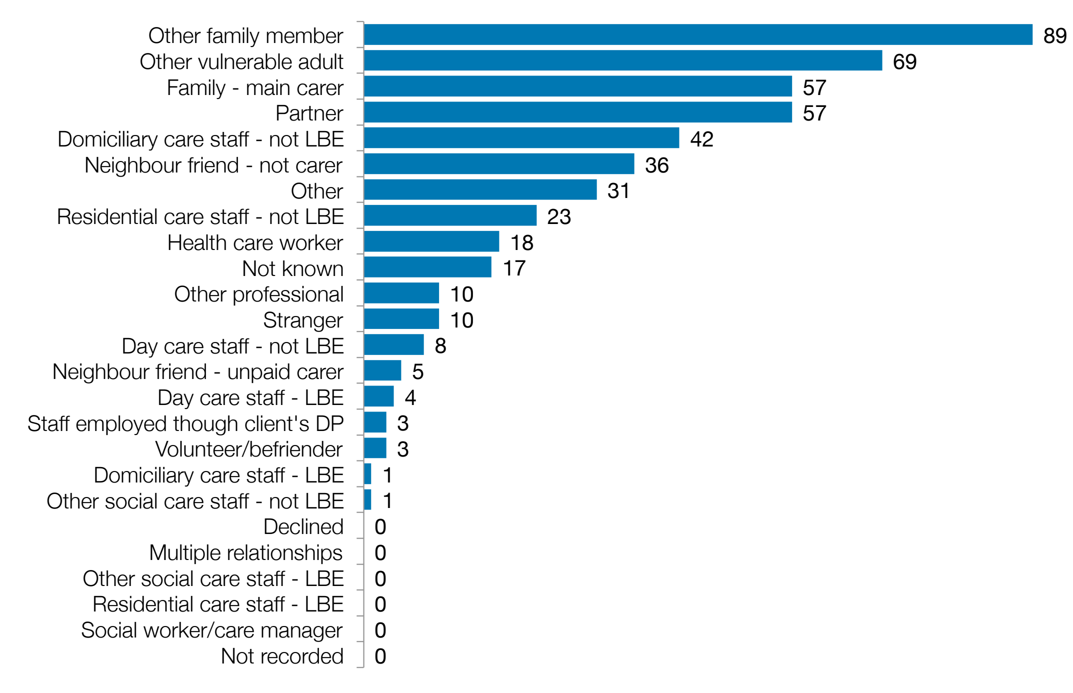
Referer	2012-13	2013-14	% change
Hospital staff	153	208	*35.9%*
Private/Independent Provider	184	151	*-17.9%*
LBE – HASC	115	139	*20.9%*
Community Health Professional	56	95	*69.6%*
Relative	47	68	*44.7%*
LBE not HASC	26	33	*26.9%*
Mental Health staff – Joint teams	15	32	*113.3%*
Ambulance Service	50	30	*-40.0%*
Domiciliary staff	27	27	*0.0%*
Other	8	27	*237.5%*
CQC	5	21	*320.0%*
Housing/RSL	29	17	*-41.4%*
Day care staff	10	16	*60.0%*
Police	15	15	*0.0%*
Anonymous	3	15	*400.0%*

Referer	2012-13	2013-14	% change
Self referral	10	13	*30.0%*
Voluntary/Religious	21	11	*-47.6%*
General Practitioner	4	11	*175.0%*
Neighbour/Friend	4	9	*125.0%*
Carer	3	7	*133.3%*
Council staff	0	7	*n/a*
Not recorded	2	5	*150.0%*
Other service users	3	0	*-100.0%*
Financial Institution – Bank	2	0	*-100.0%*
Guardian/Office of Public Guardian	2	0	*-100.0%*
Public	2	0	*-100.0%*
Education provider	1	0	*-100.0%*
Social Services staff – not LBE	0	0	*n/a*
PCT	0	0	*n/a*
Total	**797**	**957**	

Information about the person alleged to have caused harms

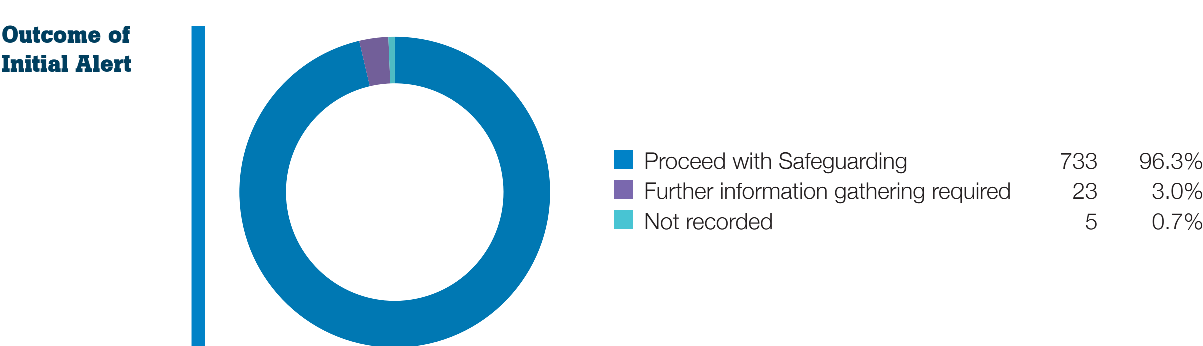
Relationship to Adult at Risk of those alleged to have caused harm. Only for those alerts where the type of alleged perpetrator is an individual.

Person alleged to have caused harms Relationship to Adult at Risk



Outcomes of alerts

Outcome of Initial Alert



Nominated Advocate Involved?

	2012-13	2013-14	% change
Yes	220	433	*96.8%*
No	372	264	*-29.0%*
Not applicable	68	31	*-54.4%*
Not recorded	0	5	*n/a*
Total	**660**	**43**	

Outcomes of closed cases

Outcome of the Safeguarding Adult Inquiry/ Investigation

Days from Alert to Inquiry Closed

Outcome proposed for Adult at Risk

	2012-13	2013-14	% change
No further action	48	63	*31.3%*
Increased monitoring	48	57	*18.8%*
Other outcome	35	25	*-28.6%*
Moved to increase/different care	7	23	*228.6%*
Not recorded	9	18	*100.0%*
Community Care Assessment and Services	10	11	*10.0%*
Removal from property or service	8	10	*25.0%*
Restriction/Management of access to AP	2	4	*100.0%*
Management of access to finances	2	4	*100.0%*
Application to Court of Protection	-	3	n/a
Application to change appointee-ship	0	2	n/a
Continuing care placement required to meet patients cultural needs	0	2	n/a
Referral to MARAC	-	2	n/a
Review of Self Directed Support	1	1	0.0%
Referral to Counselling/Training	-	1	n/a
Total	**170**	**226**	**32.9%**

Outcome proposed for persons alleged to have caused harm

	2012-13	2013-14	% change
Action by Continued Monitoring	32	78	*143.8%*
No further action	75	59	*-21.3%*
Not recorded	12	20	*66.7%*
Disciplinary Action	11	15	*36.4%*
Action by Contract Compliance	9	9	*0.0%*
Not known	5	9	*80.0%*
Management of access	3	8	*166.7%*
Removal from property or service	3	8	*166.7%*
Counselling/Training/Treatment	9	6	*-33.3%*
Exonoration	5	4	*-20.0%*
Action by CQC	1	3	*200.0%*
Criminal Prosecution/Formal Caution	-	2	*n/a*
Police action	3	2	*-33.3%*
Referral to registration body	-	2	*n/a*
Community Care Assessment	-	1	*n/a*
Other (specified)	2	0	*-100.0%*
Total	**170**	**226**	**32.9%**

HHASC442

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Safeguarding Adults
Health, Housing and Adult Social Care

August 2014