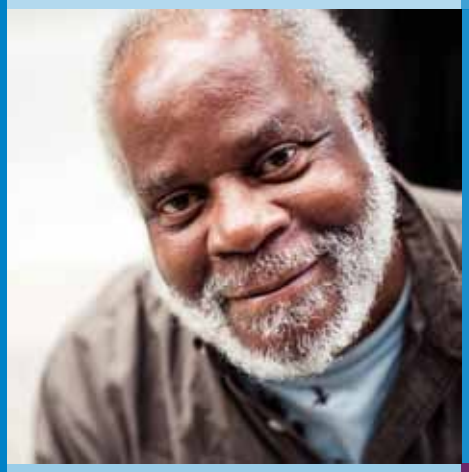
ENFIELD SAFEGUARDING ADULTS BOARD
ANNUAL REPORT 2014/15



www.enfield.gov.uk/safeguardingadults

ENFIELD Council

ENFIELD Council

WORKING IN PARTNERSHIP WITH LOCAL PEOPLE AND

NHS
Enfield
Clinical Commissioning Group

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Royal Free London NHS
NHS Foundation Trust

North Middlesex University Hospital NHS
NHS Trust

London Ambulance Service NHS
NHS Trust

METROPOLITAN POLICE
TOTAL POLICING

LFB
LONDON FIRE BRIGADE

CareQuality Commission

ageUK

over 50s forum

People with Learning Difficulties
One to One
Making Life Better

STATEMENT FROM CHAIR

Thank you for your interest in safeguarding adults in Enfield. As independent chair of the Adult Safeguarding Board I am pleased to be introducing this Annual Report. This has again been a challenging year for the partnership with all partner organisations experiencing significant challenges in this period of austerity. Nonetheless we have done everything we can to ensure we keep adults at risk as safe as possible.

One of our main areas of focus this year has been to make sure that we hear the voice of people who have been identified as "at risk". We wanted to make sure that they were included in the investigation and their views were listened to. Most importantly we wanted to make sure felt safer at the end of the safeguarding investigation. We have heard positive messages from the great majority of people we surveyed. Nationally Enfield has been identified as an area where we have made significant progress in involving victims in the safeguarding process but we recognise there is more that we can do and will continue to develop this area in the next year.

The Council Quality Checker programme has ensured that the quality of care services is checked by independent people, many of whom are users of social care services or their carers. From this programme we have developed a Dignity in Care Panel which has looked in depth at the quality of service provide by the Council. One of our panel members reminded us all "it is the small changes that can really make a difference" and we have ensured this prompts continuous improvement in the services visited.

We have continued to raise public awareness about what adult safeguarding is and how people can report concerns they may have about an adult at risk. All partners have contributed to this work and ensured that information about adult safeguarding is included in their public events.

The number of referrals for investigation as adult safeguarding enquiries continues to increase year on year. Financial abuse is a significant issue in Enfield and we will work with financial institutions and the police to minimise this. We have heard nationally in recent years of cases where adults have suffered harm in care homes and hospitals. Enfield is in a unique position with a large number of both residential and nursing care homes and because of this we are working closely with Healthwatch and our safeguarding information panel to identify places where poor care may be happening.

The partnership has continued to strengthen this year and the Clinical Commissioning Group has increased their efforts to ensure good quality services are available in Enfield, particularly by providing advice on good medical and nursing practice. I am very grateful for the support of all partner organisations for our work. I would particularly like to thank Ray James Director of Health, Housing and Adult Social Care at Enfield Council for his huge support and enthusiasm and the Councillors in Enfield, particularly Councillor McGowan for their interest and encouragement. Lastly I would like to thank the people of Enfield for their vigilance.

EXECUTIVE SUMMARY

The Safeguarding Adults Board are presenting their Annual Report for 2014-2015, which highlights the accomplishments of a partnership working in co-production with local people, service users and carers to prevent and respond robustly to the abuse of adults at risk.

The Care Act 2014 has placed Safeguarding Adults Boards on a statutory footing. This will present an opportunity to work in a strengthened partnership and a starting point with clear aims and priorities. The Safeguarding Adults Board have consulted on the next three year strategy and through feedback from service users, carers and local people, the Safeguarding Adults Strategy 2015-2018 is now complete.

Over 2014-2015 there have been a number of significant accomplishments. Enfield achieved Gold Standard in **Making Safeguarding Personal**, which means we have worked hard to ensure adults who have experienced abuse are in control of decisions and services which affect them. Further, we are one of the first London Boroughs to have set up an adult **Multi Agency Safeguarding Hub** (MASH). The MASH is a range of professionals who receive alerts or concerns and through sharing information appropriately and including this wishes of the person being harmed, can make judgements on the most appropriate route to process the referral.

Over the last year we saw **996 reports of abuse** made to the Local Authority. Of these 34% related to multiple abuse and 28% related to neglect. Further the majority occurred in people's own homes followed by being alleged to have occurred in residential or nursing homes. At the time of this report 73% of these progressed to an enquiry, while 5% required further information gathering. Our full data can be found in Appendix B of this report.

The Safeguarding Adults Board has a strong assurance role and in holding partners to account. Over the last year this has been achieved through actions including ensuring leadership in safeguarding adults; providing partnership oversight and scrutiny of data; receiving assurances that adults at risk and carers are partners in the development of partnership services; and through external audits of practice presented to the Board.

A key part of our quality assurance is through hearing from those who have been harmed and whether their outcomes were achieved. We found overall positive feedback, particularly around ensuring people felt listened to and being invited to meetings about them. There is always more that we can do, and we have set out recommendations and actions from this learning and other external audits which hold us to account.

The work of our **Quality Checkers** continues to grow and was acknowledge through an LGC Award joint with Children's for excellence in engagement in March 2015. Quality Checkers also contribute to the Dignity in Care Panel, which checks that adult social care are meeting the key Dignity in Care Standards.

Looking forward we have set ourselves some clear tasks to accomplish, which have been set out by requirements in the Care Act 2014, identified via themes and trends in our data, and through consultation feedback from service users, carers and local people:

- Develop strategies for management of self neglect, hoarding and honour based violence and domestic abuse which enables adults to have choice and control
- Continue to have receive assurances from all partners that co-production and participation with those who use services and their carers informs the development and delivery of safeguarding activity
- We will look at partnership data as a means to identify themes and trends and direct our activities to prevent abuse or address issues of significance
- Strengthen the partnership between Board and Voluntary Sector

Every partner on the Board has a strong commitment to safeguarding adults and activities take place within each organisation to contribute towards enabling people to keep themselves safe and respond when harm does occur. Our statement from partners, which includes their planned actions over the coming year, can be found in Section 8 of this report.

TABLE OF CONTENTS

SECTIONS

APPENDICES

SECTION 1
INTRODUCTION AND AIMS

This is the annual report for the Enfield Safeguarding Adults Board, setting out how we work together to prevent and respond to the abuse of adults at risk. The Board is a multi-agency partnership which includes input from those who use services and local residents. The role of the Board is to assure themselves the way which local arrangements and partners act to help and protect adults from abuse is robust.

This annual report reflects the final year of implementing the Safeguarding Adults Strategy 2012-2015. Our aim has been to work with local people and our 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.

We have worked hard to make safeguarding adults everybody's business, which means all of the communities which make up the borough of Enfield. We aimed to ensure that people could understand and recognise abuse when it happens, knowing how to stop it and prevent it happening in the first place. We wanted people to know how to report abuse and receive a quality service when they seek support where they are listened to, taken seriously and believed. In addition, we wanted people to receive services that are safe and do not cause harm.

We wanted people to know how to report abuse and receive a quality service

The Board will set out in this report how it has met these aims over the last year and most importantly how it will work going forward. The **Care Act 2014** and Care and Support Statutory Guidance has had a tremendous impact on safeguarding adults and preparation for when it comes into effect on April 1, 2015.

The Act is placing Safeguarding Adults Boards on a **statutory footing**, with the three core duties of publishing a strategic plan, producing an annual report and conducting Safeguarding Adults Reviews.

Our strategic plan for 2015-2018, built through consultation with a range of stakeholders, those who use services and with Healthwatch, sets out our ambitions for the coming years to make Enfield a safe place to live and work. Safeguarding services are aimed at supporting people as human beings to lead whole lives; being safe may be only a part of this.

SECTION 2
KEY DEVELOPMENTS, OBJECTIVES AND PROGRESS

The Safeguarding Adults Board has a strong role in assuring and holding to account across the partnership how we work together to provide a safe and quality service around safeguarding adults. As a Board we have done this by:

- Ensuring leaders and senior officers show a commitment to safeguarding adults
- Provide a partnership oversight and scrutiny of data which directs focus on areas of risk
- Regularly review and work to progress the sub-groups of the Board which deliver and facilitate interventions
- Receive assurances that adults at risk, carers and local people are integral partners in the development of partnership services
- Been assured by external audits of practice which are delivered to the Board
- Have worked to widen the scope of safeguarding and our strategic view, which for example included presentation and discussion around safeguarding adults

The work of the Safeguarding Adults Board is shaped by our strategy and its action plan, which is developed through our conversations with service users, local people and many partners. Our action plan required us to ensure a range of information, advice and guidance on keeping safe is promoted by partners and easy to use. The Board believes strongly in raising awareness of abuse, so that not only adults at risk can report concerns about their safety, but their families, carers, those who work with them and the wider public. Across our partnership a range of awareness raising activities were undertaken, including the Enfield Town Show, presentations with the Fire Brigade and information to Probation Services. Awareness raising is also important within partner organisations for staff and Barnet Enfield and Haringey Mental Health Trust have been delivering training in issues around domestic violence, adult and children's safeguarding and the Mental Capacity Act and Care Act 2014. Council Housing partners have run articles in our tenant and leaseholder magazine promoting safeguarding issues. We believe we can do more around this area so have set ourselves plans for the coming year to target community awareness campaigns, including links with children's services around Female Genital Mutilation, a joint Keep Safe Week in September 2015 and looking at the use of radio to target specific communities.

Safeguarding is about the person rather than the process; enquiries should seek to enable people to resolve their circumstances, recover from abuse or neglect and realise the outcomes they want. One of the biggest shifts during the year was in embedding Making Safeguarding Personal, which seeks to transform how adults who have experienced abuse are in control of decisions and services which affect them. Safeguarding adults is not linear but steps, considerations and decisions which are led by individuals and/or their representatives. The overarching intention of MSP is to facilitate person-centred, outcome-focused responses to adult safeguarding situations. MSP records 3 levels of engagement from Bronze, Silver and Gold. Enfield aimed for Gold which required an independent evaluation of work by a university.

In January 2015 we had Bournemouth University complete an independent evaluation of Making Safeguarding Personal and they found that:

- London Borough of Enfield clearly demonstrated six principles of safeguarding set out by the Department of Health are being met through MSP practice
- London Borough of Enfield demonstrated a clear commitment to empowering service users through personalised information and advice, with service users involved in the safeguarding process
- Creative methods used to engage and support service user voice

The work of the Safeguarding Adults Board is shaped by our strategy and its action plan

- Key strength is the commitment to work collaboratively with external agencies
- Evidence of learning culture
- Development of Information Technology systems and to capture outcomes

Areas for future consideration and development include:

- Exploring how information is presented to make the best impact
- Building on successful projects such as the Quality Checkers and committing to on-going recruitment and training of this resource
- Delivering an on-going commitment to share good practice within a learning culture promoted throughout the organisation and with partners
- Exploring new resources such as apps which can be used by practitioners to support their professional decision making and judgement in relation to risk and choice for service users

Enfield is operating at the Gold for Making Safeguarding Personal in March 2015. All partners on the Board are expected for the coming year to have an action plan around how Making Safeguarding Personal will be implemented. Many organisations already do, such as the Barnet Enfield Haringey Mental Health Trust, with monthly surgeries within the Trust attended by Clinicians.

A culture change in practice around how we involve adults who are harmed is challenging but not impossible. Enfield has created a shift to more personalised safeguarding which has been evidenced through face to face interviews with people who have been harmed or their advocates. These interviews identified that being part of these partnership meetings and feeling informed helps to make adults central to the safeguarding enquiry.

Building blocks of successful safeguarding include advocacy, personalised supporting, decision making by the adult at risk and access to services which prevent isolation and meet individual needs. Enfield Adult Social Care Commissioners completed a marketplace review of advocacy services, which means that we are clear which individual and organisations can provide advocacy and where their skills are. The Care Act 2014 has set very clear requirements for advocacy going forward and this will form part of our action plan for the coming year. We found from our adult social care that data that 567 out of 731 adults at risk had a nominated advocate in place to support them through the safeguarding process.

Enfield is working hard to set up a Multi-Agency Safeguarding Hub (MASH) from April 2015. A MASH has a range of professionals who receive concerns and alerts related to adults at risk and seek a range of information to understand the circumstances surrounding this alert, including the wishes of the person being harmed. The information gathered will be used by MASH staff to make judgements about the most appropriate route to process the referral; this may include passing to social work team to meet with the adult at risk, redirected to another agency or to the Police if a crime has been committed. MASH will comprise of partners from a number of agencies, some are co-located and full time and others will attend on a part time or virtual basis. The three key agencies are Police, Health and Adult Social Care.

SECTION 3
OTHER ACHIEVEMENTS, CHALLENGES AND OPPORTUNITIES

As we come to the close of the our three year strategy we have time to reflect on a number of achievements across the partnership that has improved the safeguarding care and support to adults at risk. We have an action plan which we review regularly and help us to monitor progress.

The partnership has helped to prevent and respond to abuse by also:

- Holding a Pressure Ulcer Forum at BEH MHT
- Developed tools to help ensure family and friend engagement when concerns occur within provider services. We use feedback to quality assure if the provider is indeed improving.
- Looking for trends or patterns emerging of safeguarding and quality care issues through our Safeguarding Information Panel – we want to support providers from failing by preventing poor quality care escalating
- Continuing to support the Enfield Adult Abuse Line, so that there is a single point of contact for any person to use to report concerns, which is open 24 hours a day, 7 days per week.
- A seminar by the London Fire Brigade which focused on vulnerable adults and was open to a range of partners, including housing officers.
- Council Housing partner having refreshed safeguarding adults policy and appointing four safeguarding champions to support staff

Carers are people who provide unpaid care to family or friends due to a range of issues, for example such as a learning disability or mental health. The Board recognises the contribution that carers make to supporting others in what can often be a challenging role. Carers may be at risk of harm from the person they care for or they may be at risk of harming.

Actions which took place to support carers include:

- Ensured carers had information on how to keep themselves safe from abuse and who to contact if they were at risk of harming the person they cared for. This was done through our Carers Leaflet on safeguarding which was designed with service users, carers and local people.
- Our Carers Centre has posters on the Adult Abuse Line (tel: 020 8379 4432).

In spite of all the work undertaken by partners of the Board and many others, safeguarding those most vulnerable to abuse continues to be a challenge. We know from data that the number of alerts made continues to rise; there were 996 alerts in 2014-2015 compared with 957 in 2013-2014. While this is positive in that more adults at risk are getting access to support and care to help stop the abuse from happening, it also highlights the prevalence of abuse and that many more people need support.

We found from our data that the most prevalent type of abuse reported was multiple abuse in 34% of cases (this is where there are two types of abuse being experienced by the adult, such as verbal and physical). This was followed by neglect in 28% of cases. When we look at national data from the last financial year we found this is similar in neglect being reported the most. Neglect can occur anywhere, but many in the home or within care homes. Isolation can contribute towards neglect going unnoticed and for this reason the Board is looking at how we can gain assurance from partnership that there is support for people living in isolation.

In the news we often hear nationally of cases where adults have been harmed in care homes. Enfield is in a unique position with the large number of both residential and nursing care homes and because of this we remain vigilant. Our data showed that 26% of cases were of abuse that was alleged to have happened in residential or nursing homes. In light of this we will review how we manage concerns relating to safeguarding and provider failure within those organisations which provide care. Through organisational learning over the last year we discovered that how we respond to concerns without our Hospital Trusts and in partnership with Clinical Commissioning Groups has to be clarified and partnership work strengthened. We also need to work at preventing care homes from coming repeatedly under our provider concerns process.

We also found that most abuse happens in people's own homes, which can often makes it hidden. For this reason it is important that we continue to raise awareness across all people who live and work in Enfield to identify and recognise what abuse is and how to report. Our data also showed that a family member was the person alleged to have caused harm in 136 cases. We will for this reason look at how we can work with those who are at risk of harming to understand the cause and whether we can prevent repeat incidences of abuse.

Our data also showed that:

- There were 996 reports of abuse this year compared to 957 the previous year
- 40% were alleged to have occurred in the persons own home
- Multiple abuse and neglect were the most reported, but there were also high number of financial abuse (118 cases) and physical abuse (134 cases)
- We did not have any reports of discriminatory abuse, so know we need to work on raising awareness of hate crime against vulnerable groups and ensuring these are reported
- Hospital staff raised the most alerts (23%) followed by independent and private providers (in 19% cases). This was similar to previous years.

We found that 73% of alerts raised proceeded under safeguarding adults, while 5% 'requires further information gathering' at the time of this report. Of these 731 cases which progressed, 567 had a nominated advocate involved (77.5% of cases).

We can report further on those cases which have come to a conclusion. We have a conclusion on 226 cases:

- 45% of these were substantiated or partially substantiated, 19.5% were inconclusive and 29% were not substantiated. In the remaining cases no further action was taken.
- Less than half the cases were closed within 7 weeks, so we have identified timeliness as an area that we have to focus attention upon.
- Outcomes for adult at risk was no further action in 33% of cases, followed by increased monitoring in 16% of cases and move to increase or different care in 10% of cases.
- For the person alleged to have caused harm there was 24% cases of increased monitoring and 26% cases of no further action recorded.

We are changing how we report data in future so that when we speak about 'outcomes' this represents what adults at risk have identified they would like to happen. When we talk about whether we were able to substantiate or not if abuse occurs, this will relate to judgements in the future. We believe it is important that we are more accurately identifying the outcomes for people so will be looking more closely at how we record our data.

The Safeguarding Adults Board also looks at the Deprivation of Liberty Safeguards (DoLS). The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. Where someone needs to be detained in a care home or hospital to keep them safe a DoLS can be authorised which outlines the safeguards for that particular individual. There are six assessments which have to take place before a standard authorisation can be given. The Association of Directors of Adult Services (ADASS) and the Department of Health have now created new application forms to simplify the application process to Local Authorities. If a standard authorisation is granted, one of the most important safeguards is that the person has someone appointed with legal powers to represent them, to ensure that their placement or treatment stay remains in their best interests. This is called the relevant person's representative and will usually be a family member or friend. If a person is unbefriended or has no family, they will have a paid representative appointed for them and they can access the services of an Independent Mental Capacity Advocate (IMCA) if they need this level of representation. Other safeguards include rights to challenge DoLS Authorisations in the Court of Protection. There is also a streamlined process for having such safeguards put in place for people in Supported Accommodation or other settings than a care home or hospital. These judicial DoL Safeguards have to be authorised by the Court of Protection who have now streamlined the application process for these cases.

There were 996 reports of abuse this year compared to 957 the previous year

In the last year there have been 585 requests for a Deprivation of Liberty Safeguard and 66 the year prior, which is a 786% increase.

These DoLS requests can be broken down further:

- 439 were authorised
- 88 were not authorised (declined)
- 10 were found to not be appropriate to be referred for a DoLS
- 48 of the cases are still in progress

The Care Act and its implementation will be the biggest challenge over the coming year. But, with this challenge comes many opportunities. Placing Safeguarding Adults Boards on a statutory footing will help to form stronger and clearer partnerships committed to safeguarding adults; the Board already has strong links with safeguarding children, our community safety partners and working with colleagues in Trading Standards. The requirement to have Safeguarding Adults Reviews when there is a death or serious abuse occurs will aid in preventing similar occurrences where we can share learning and improve our practice.

SECTION 4 QUALITY ASSURANCE AND ORGANISATIONAL LEARNING

Ascertaining service user views and experiences of the Safeguarding process is vital so that we can hear what we do well and where we can make improvements. This year we contacted 20 service users and carers who had recently been through the Safeguarding Adults process in order to find out what the outcomes for them were and where we could make improvements to ensure their wishes are met. We did this through face-to-face interviews and found that:

- Most of those interviewed felt that they would now recognise abuse or neglect if it happened again and they would know who to contact.
- The majority of those interviewed felt listened to and able to state what outcomes they wanted.
- Service users/representatives that had the opportunity to attend the relevant meetings felt very positively about the whole Safeguarding experience and felt that their wishes were central to the process and they were listened to.
- The majority (18 out of 20) of service users/representatives were very positive in terms of their ability to direct the process and give their views. Again, involvement in meetings is a key element in terms of adults at risk feeling involved and valued.
- Those who felt that protective measures were appropriate and had been followed through also felt that they were safer following the process.

Overall, it is clear that those who felt safer and involved in the Safeguarding Adults process were those who were invited to meetings (even if they were unable to attend) and received clear and concise communication. Planned work and recommendations include:

- Increase number of adults at risk or representatives invited to meetings
- Adding prompts into templates for staff to aid communication
- More resources for adults at risk to explain the safeguarding adults process
- Ensure adults at risk or their representative can give feedback more regularly.

In Adult Social Care cases are also audited, both within teams and by the Strategic Safeguarding Adults Service. These audits have highlighted that there is an improvement in practice that keeps that adult at risk central to the process and involved in decision making. There is demonstrated improvements in areas such as partnership working, which acknowledges that combining skills and expertise to achieve outcomes for individuals is the best way forward.

External audits are also very important to provide challenge to our work. In April 2014 we had an external audit report of cases, which was followed up by a focused audit of mental health case in July 2014. This audit identified a number of areas for improvement, such as a lack of evidence of partnership work, need to keep adults at risk more central and more work on the prevention agenda of safeguarding. The Mental Health Trust responded swiftly to these concerns by:

- Arranging a 'safeguarding surgery' with experts from different areas. The surgery has ensured better partnership working, bringing new legislation to staff awareness, promoting quality care in terms of safeguarding people, supporting staff in their practice and promoting a patient centred approach.
- Safeguarding champions, who can also address issues with performance
- Internal audit on monthly basis by managers
- Bespoke training on mental capacity and the deprivation of liberty safeguards. Subsequently awareness on the Independent Mental Capacity Advocates and Advocacy services has improved.

Enfield have a Dignity in Care Panel which checks that adult social care are meeting the key Dignity in Care standards, share examples of good practice and identify improvement where necessary. The Dignity in Care Panel are continuing to complete their pilot to review all services provided by the Independence and Wellbeing Services Teams focusing on dignity and respect.

The findings of the reviews are shared at a management level, along with recommendations for improvement and a timely revisit measures progress and the meeting of outcomes. A successful 'Launch' event of the panel took place on the 27th of February 2015, where Cllr Don McGowan and Ray James presented at the event along with the volunteer panel members. This event celebrated the significant achievements of the panel and the work plan for the future. An application for the Dignity in Care Panel has been made to present at the National Children and Adults conference in Bournemouth this year.

WHAT ARE THE DIGNITY IN CARE STANDARDS?

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

The Quality Checker Program in Enfield won at the LGC Awards for excellence in engagement in March 2015. The Quality Checker Project has continued to visit social care providers to collect meaningful feedback from social care customers. The feedback collected is shared and heard at a strategic level to drive service improvement and highlight areas of concern for appropriate consideration and interventions if necessary. The Quality Checker Project attended and contributed at a focus group facilitated by the Bournemouth University auditing Enfield's response to the Making Safeguarding Personal agenda. The Quality Checker Project are planning a recruitment drive for more volunteers to ensure that the Quality Checkers are representative of the community that they serve.

The Quality Checker Program in Enfield won at the LGC Awards for excellence in engagement

SECTION 5
DIFFERENCE THAT SAFEGUARDING ADULTS MADE TO ADULTS WHO HAVE BEEN HARMED

We use this section to report on cases where adults at risk have identified a positive outcome by means of the safeguarding process. We can't always report details because it is important for people to retain their privacy, but the Integrated Learning Disabilities Service has demonstrated how adults at risk can and should have access to the justice system. They have:

- Supported people who have experienced sexual assault and rape through the criminal justice system and secured convictions.
- When abuse has occurred within families, supported people to maintain contact with other members of the family, when these relationships have been important to them. This has include working with the court of protection to obtain orders allowing supervised contact, and supporting people to hire staff who share a first language (when not English) to make sure the person remains safe.
- Obtained a number of 'Forced Marriage Orders', that both protect people from abuse and enable them to be fully engaged in cultural and family activities, including travel overseas.

In the Older People's Service we also have examples of practice which enables individuals experiencing harm to maintain control over decisions and services which affect them. Mrs Q was an older woman who lived in her marital home and had support from a number of adult children. She had experienced a history of psychological and emotional abuse on the part of her younger son and the previous year a non-molestation order was served on him following incidents of domestic abuse which had since lapsed thus allowing him to return to the family home. The Care Agency had to pull out of providing a service as it was deemed 'unsafe' for the care worker due to the son's behavior and alcohol intoxication. The social worker met with Mrs Q and had to ensure this was done in an environment where Mrs Q was not under undue influence and able to speak freely. Through this the Care Management Team along with support from the Community Safety Unit were able to support Mrs Q to meet her identified outcomes. Consequently her daughter agreed to cover some of her mother's care and support needs supported by care workers from the crisis intervention team. Additionally a number of measures were taken to secure the property should the son attempt to return and a community alarm installed enabling Mrs Q to alert the Community Safety Unit in the event of any concerns.

Mrs Q supported by her family was referred to an organization supporting women suffering domestic abuse in pursuit of legal advice and support. This was also important because despite the risks Mrs Q wanted to maintain some contact with her son. The care agency was able to begin providing a service to Mrs Q and she was supported to attend a local day support service enabling her to meet people in her local community.

SECTION 6
SAFEGUARDING ADULT REVIEW

A Safeguarding Adults Review (SAR) is defined in the Care Act 2014 and is what was previously known as a Serious Case Review. The Safeguarding Adults Board has to carry out a SAR when an individual in their area dies or experiences serious injury as a result of abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

SARs are agreed by the Safeguarding Adults Board and an independent person is set up in Enfield to lead the enquiry. There is a separate protocol which sets out on behalf of the Board what a SAR is, how the process runs and the outcome.

Two Safeguarding Adults Reviews were set up on behalf of the Board in 2014-2015. These reviews have not been concluded but are expected to do so in the coming year. Any learning will be shared and each SAR will have an action plan which is reported to the Safeguarding Adults Board.

SECTION 7
SAFEGUARDING ADULTS BOARD SUB-GROUPS

During 2014-2015 there were four established groups which supported the work of the Safeguarding Adults Board, with a new additional group dedicated to work between Safeguarding Adults and Safeguarding Children commencing.

LEARNING AND DEVELOPMENT GROUP

Co-chaired by the Enfield Councils Learning and Development Team and a representative from the Barnet Enfield and Haringey Mental Health Trust, this group focused on how to improve the practice, understanding and the skills of those who work with adults at risk. This included for example setting up courses on Safeguarding and the Care Act, training for front line staff and managers, and completing investigations jointly with the Police.

In 2014-2015 we held the following courses and the number of staff which attended where:

Course Name	Session Date	Places Taken
Care Act – The New Safeguarding Structure	12/01/2015	29
	22/01/2015	21
	22/01/2015	25
Chairing Strategy Meetings	02/10/2014	15
Investigators – Working with the Police	08/09/2014	15
	27/01/2015	16
Safeguarding Alerters for New Starters	23/06/2014	15
	03/09/2014	21
	11/02/2015	22
Safeguarding Alerters Refresher	01/09/2014	17
	01/09/2014	16
	14/01/2015	17
	14/01/2015	19
Safeguarding Structure to SAB	23/02/2015	11

In the coming year we are expanding upon the training we provide

An e-learning package is also provided to the partnership which saw 46 staff members access this suite of courses.

In addition to the above, the Strategic Safeguarding Adults Service in London Borough of Enfield provides some specific and focused training when requested. This included for example to partners in the London Fire Brigade, Parent Champions, supporting training with Mental Health for Barnet Enfield Haringey Mental Health Trust, Learning Disabilities Partnership Board on safeguarding.

All of the courses we run have been reviewed to ensure they are compliant with the Care Act, Making Safeguarding Personal and with relevant information on the Multi Agency Safeguarding Hub.

In the coming year we are expanding upon the training we provide by providing additional courses on:

- Safeguarding and Domestic Abuse
- Female Genital Mutilation
- Completing Section 42 enquiries
- Mediation in social care
- Safeguarding from referral to closure
- Expert to enabler
- Positive record keeping

POLICY PROCEDURE AND PRACTICE GROUP

With the imminent implementation of the Care Act 2014 from April 1, 2015, the Policy Procedure and Practice group have a remit around developing the information which supports those who safeguard adults to effectively carrying out their work. This will include, for example, making sure that staff have guidance on how to involve adults at risk to make decision about their safety and the outcomes they would like so. This will also include developing procedures around self-neglect, which is now recognised formally under safeguarding.

SERVICE USERS, CARERS AND PATIENTS

The Service User, Carer and Patient group represents those in the community in Enfield who are passionate and committed about keeping people safe. The group

provide a challenge and steer to actions that partners take and also take forward projects that are of interest to them.

Over the last year the group:

- Gave feedback on the Making Safeguarding Personal toolkit to the Local Government Association
- Received training on the Care Act and safeguarding, while raising questions about areas such as advocacy
- Has been discussing issues around equalities and communication, with a particular focus on health services and barriers to access
- Received presentations from Healthwatch and Local Authority on equalities
- Feedback on the Safeguarding Adults Board strategy and action plan.

The group also reviewed their terms of reference and developed an action plan for the coming year. This will include for example reviewing and developing the publicity and communication for safeguarding adults. The group also feel there was a gap in how the care industry responds and supports the Lesbian, Gay, Bisexual and Transgendered community so are looking to address this area.

QUALITY, SAFETY AND PERFORMANCE

The Quality, Performance and Safety sub group of the Safeguarding Adults Board has been set up to monitor the performance of partners in terms of how they keep adults at risk of abuse safe. In addition, this will include going forward the quality of services which both prevent and respond to abuse within their organisations.

The Group will agree the ToR yearly in order to focus on areas requiring oversight or additional challenge from partnership to embed service improvements. New terms of reference and an action plan has been drafted which will include focusing on:

- Scoping audits across partnership and providing quality assessments and gap analysis
- To assure the Board that partners are appropriately flagging domestic violence where there is an adult at risk, with appropriate outcomes recorded.
- To ensure that Serious Incidents within Hospitals which are appropriate for safeguarding adults are being referred in line with current pan London Policy.
- Establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements.
- Establish ways of analysing and interrogating data on safeguarding notifications that increase the SAB's understanding of prevalence of abuse and neglect locally that builds a picture over time.

SAFEGUARDING ADULTS AND SAFEGUARDING CHILDREN

Both the Enfield Safeguarding Adults Board and Enfield Safeguarding Children's Board recognises the importance of working together. A group has been set up to help support the completion of actions which will benefit the safety of children, young people and adults at risk.

This group has agreed to focus on the following areas:

- 'What about the Children?' A report by Ofsted on joint working between adults and children's services when parents or carers have mental ill health and/or drug and alcohol problems.
- Awareness raising events across services
- Community Help Point Scheme
- Child sexual exploitation and supporting adults who have experienced sexual exploitation as a child

Both the Enfield Safeguarding Adults Board and Enfield Safeguarding Children's Board recognises the importance of working together

SECTION 8
PARTNER STATEMENTS

- Barnet Enfield and Haringey Mental Health Trust
- Enfield Borough Police
- NHS Enfield Clinical Commissioning Group
- London Community Rehabilitation Company
- London Fire Brigade – Enfield Borough
- North Middlesex Hospital NHS Trust
- One-to-One (Enfield)
- Royal Free London NHS Foundation Trust
- Safer and Stronger Communities Board

BARNET ENFIELD AND HARINGEY MENTAL HEALTH TRUST

INTERNAL ARRANGEMENTS FOR GOVERNANCE REGARDING SAFEGUARDING ADULTS

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) and Enfield Community Services (ECS) understands and acknowledges that safeguarding adults is everybody's business and that everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The safeguarding of all our patients remains a priority for the Trust as we see it as a fundamental component of all care provided. Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust is essential. Over the past year, the safeguarding arrangements across all Trust services has continued to be strengthened, with a particular focus on ensuring our staff receives an appropriate level of safeguarding training.

The Executive Director of Nursing, Quality and Governance is the Executive Lead for Safeguarding Adults in the Trust. The Trust has a Safeguarding Team consisting of the Head of Safeguarding People, the Safeguarding Adults Lead and Safeguarding Children's Lead.

The Trust's Safeguarding Annual Report and work plan continues to be developed on a yearly basis, for consideration and approval at the Governance and Risk Management Committee (GRMC) and is ratified by the Trust Board. The executive lead represents the Trust at the three Safeguarding Adults Boards. The management of safeguarding cases in Haringey is co-ordinated by Haringey Council. In Barnet, the management of safeguarding cases is co-ordinated by the Community Mental Health Team Managers and Team Managers within the integrated teams. This is similar to Enfield for the year 2014/15.

As part of our integrated governance structure, the Board receives an Annual Report and work plan on the Trust's Safeguarding Adults activities. At each public Board meeting the Trust Board receives an update on the number of alerts, investigations and related activities.

The Trust ensures the Safeguarding Adult Committee meets on a quarterly basis. The Committee 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 authorities and CCGs. This meeting affords for the discussion and follow up on actions from both internal and external issues regarding safeguarding adults. The function of the Trust Safeguarding Adults Committee is to direct and ensure an overview of the safeguarding adult work programme and practice in the Trust. The Committee ensures that national and local practices are adhered to within the organisation and the sharing of learning.

There is a bi monthly practice development group co-ordinated by the Enfield Safeguarding Adults Team of which the Trust is a member. This forum allows for sharing of best practice and learning across all agencies.

The Trust has in place a Safeguarding Surgery. The surgery was developed in 2014 and has been well received and utilised by staff. The forum promote patient-centred approach; Making Safeguarding Personnel (MSP), collaborative working with our partners and bringing new legislation to staff awareness.

The Trust has a safeguarding audit that is completed on a monthly basis by managers. Strengths, areas for improvement and actions plans are agreed and delivered. The Trust's safeguarding committee has oversight of the process and improvements.

NOTABLE ACHIEVEMENTS IN ADULT SAFEGUARDING 2014/15

- The Safeguarding team has been working closely with the local authority and the various teams in driving the MSP agenda.
- Strong multi-agency partnership working, including internal and external partners.
- Review the DoLS and MCA policies and frameworks in light of Cheshire West ruling

- There are monthly safeguarding surgeries in the trust, attended by clinicians from across the organisation. Presentation includes the Care Act- (MSP), domestic violence/abuse, Child Protection and opportunity to discuss complex issues concern to staff.
- The pressure ulcer forum now meets monthly and is attended by clinicians from across services, the protocol has been agreed and a plan for roll out is being implemented.
- Datix Incident Reporting to link with safeguarding team enabling automatically generated alerts when incidents with a safeguarding element are reported.
- A restraint in care protocol has been developed for our older adults services.
- The Trust took part in the Oaks learning event. Areas for improvement/development have been fully implemented.
- Compliance inspections against the criteria in Outcome 7 (safeguarding) of the CQC's regulatory framework on all inpatient units and Community Teams. The Trust is fully compliant
- The Safeguarding Team have been delivering bespoke training to teams which has led to an increase in awareness that safeguarding is everyone business to ensure that the Trust deliver a safe, friendly and caring environment where people are treated with respect, courtesy and dignity
- We have developed safeguarding champions in different areas to support staff. Issues where processes are not understood or where there are performance issues these are brought to the attention of the champions and staff are supported to address issues/concerns.
- MCA/DoLS lead for the Trust has led on the delivery bespoke training to teams. Subsequently awareness in IMCA and Advocacy services has improved.
- Adult Safeguarding training level 1 is part of the mandatory training programme for all staff of which compliance is monitored through the Electronic Staff Record. Attendance record achieved above 85% throughout the year.
- There has been an increase in referrals for MARAC by the Trust as compared to last year. This is due to domestic violence training through the Safeguarding surgery.
- Safeguarding training have included the following; Female Genital Mutilation, Prevent and whistleblowing. This ensures staff are trained and understand the issues and know how to report concerns.

WORK PLAN AND PRIORITIES FOR 2015/16 IN ADDITION TO REGULAR AND CONTINUING ADULT SAFEGUARDING WORK TO SUPPORT BEST PRACTICE AMONGST PRACTITIONERS IN BEHMHT

- Have a continued programme of level 1 Safeguarding Adults training with 85% compliance achieved.
- Review of the Trust Self-Assessment using the Safeguarding Adults Assurance Framework for Healthcare Services.
- BEHMHT recognises the importance of people's voices being heard and listened to within the safeguarding adult's procedures, staff to be compliant with the Care Act in relation to Making Safeguarding Personal (MSP) and the use of Advocacy services.
- Ensure learning from safeguarding cases is embedded into practice, via supervision and Trust training programmes.
- Remain responsive and reactive to changes as they occur in policy directives or good practice guidance.
- Continue to raise awareness of the PREVENT agenda and support staff to raise concerns
- Raise awareness and promote the system of reporting Mental Capacity Assessments (MCA) and Deprivation of Liberty (DoLS) applications amongst staff.
- As part of a quality measure, team managers to audit one case file per month on Meridian. Action plans, recommendations and lesson learnt for followed up to improve practice.
- The Trust will be strengthening the links between safeguarding and complaints and/or incident investigations.

ENFIELD BOROUGH POLICE

Enfield Borough Police is committed to making Enfield a safer place to live, work and visit. This will be achieved by working together, and safeguarding some of the people who are most at risk of abuse, harm and neglect. The Enfield Borough Police is now a statutory partner on the Safeguarding Adults Board, as set out by the Care Act 2014. This presents a real opportunity to work with partners, communities and local people to prevent abuse and ensure a robust and transparent response when abuse of a vulnerable adult occurs.

ACHIEVEMENTS OVER 2014-2015

There have been some key developments across this year, each of which have been founded upon excellent working relationships and partnerships. The innovative activity around setting up an adult Multi Agency Safeguarding Hub, to ensure greater cooperation and sharing of information, has been an exemplar of practice. The Enfield Borough Police has recruited a new Public Protection Lead, T/DCI Ben Warriss, who is committed to continue to drive forward improvements.

- Continued use of the Merlin System to properly record and identify vulnerable adults encountered by Police and share concerns with our strategic partners
- Officers have had ongoing training and the use of Vulnerable Adult Toolkit provide to officers which assured that officers are able to identify adults at risk
- Senior Police attend and actively participate in Safeguarding Adults Board and are an acting co-chair for the Quality, Safety and Performance sub-group of the Board
- Actively participated in the identificant, then implementation of actions as a consequence of the Care Act 2014
- The Police is proud to have collaborated with the Local Authority and partners to be one of the first London boroughs to set up and deliver the adults Multi Agency Safeguarding Hub (MASH)

ACTIVITIES PLANNED 2015-2016

The work of 2014-2015 has put our partnership in an excellent position to drive forward the safeguarding agenda over the next 12 months.

- We will strive to provide an outstanding service to adults at risk who have experienced abuse and come to the attention of the Police, to ensure a level of satisfaction with the support that is provided; this sits within the MPS Total Victim Care Strategy
- We will strive to engage with all the communities in the Enfield Borough with the ambition to improve confidence in the services provided
- We will continue to develop and contribute to the adults Multi Agency Safeguarding Hub, with the aim of capturing as many safeguarding adult concerns and referring to appropriate service.
- Ensure process are in place that identify Vulnerable adults victims of crime at an early stage and that these cases are appropriately resourced by specialist officers to improve victim care and case outcomes.

PROPOSED ACTIVITY RELATING TO TRAINING

- Police will participate at DI and DCI level in Local Authority commissioned training. This will include undertaking Section 42 enquiries.
- We will refresh training, particularly for new officers to the Borough on vulnerable adult crime and circumstances where a Merlin report can be completed.

PROPOSED ACTIVITIES IN RELATION TO PROCESSES

- Daily review at management level of all crimes involving vulnerable adults
- All adults who come to notice (ACN Merlin) to be reviewed daily by police officers who form part of the adult Multi Agency Safeguarding Hub. Any of which that amount to a crime are to be fed back to the unit Detective Inspector.

PROPOSED ACTIVITIES IN RELATION TO QUALITY ASSURANCE

- Detective Chief Inspector to co-chair the Quality Safety and Performance sub-group of the Safeguarding Adults Board

- Monthly oversight by unit Detective Inspector of all open and ongoing vulnerable adult crime investigations.

ORGANISATIONAL LEARNING AND ENGAGEMENT

With Safeguarding Adults Boards on a statutory footing there is now a requirement to complete Safeguarding Adult Reviews where there has been a death or serious injury and (insert wording). The Enfield Borough Police will contribute and ensure that any learning in the coming year from SARs are fully embedded in the organisation.

STATEMENT WRITTEN BY:

T/DCI Ben Warriss
Enfield Police, Public Protection
Enfield Safeguarding Adults Board representative

NHS ENFIELD CLINICAL COMMISSIONING GROUP

Enfield CCG unequivocally has clear safeguarding expectations of organisations that provide both NHS services and private health care, ensuring that safeguarding is embedded into their core business. Specific safeguarding standards are included in the NHS contracts. With the current statutory requirements set out in the Care Act (2014); Enfield CCG will ensure NHS health care delivery complies with the criteria laid down in the Clinical Quality Review Group (CQRG). This group provides the accountability for providing proactive assurance, challenge and robust governance processes, for adults at risk in the population of Enfield. The CQRG meetings ensure that health services are working together with partners to protect people from abuse. With private providers of health care they are invited to the CCG strategic safeguarding committee to discuss and give assurance of how they discharge their safeguarding responsibilities. In Enfield nursing homes the safeguarding nursing team provides quality assurance and challenge in relations to the quality of nursing care offered.

Quality is at the heart of the work with the CCG, this can be seen in the Corporate Objective agreed for 2013/14: Delivery of Quality and Safety of the services.

Commissioning for quality is everyone's business and will be delivered through integrated, collaborative working which is fundamental to the principles of the CCG and central to the CCG's Quality Strategy which underpins the work of safeguarding adults at risk.

Through a partnership approach, the CCG will:

- Continue to work with people in aiming to improve their health and well-being by focusing on preventative services, reducing health inequalities, and enabling the population to take responsibility for their own health.
- Work with people to ensure the provision of safe, high quality, efficient and effective health services within available resources.
- Facilitate integration between health and social care services.
- Ensure good quality, safe healthcare in all settings.
- Have an Enfield Quality strategy that is clinically led; draw on research evidence and uses innovative, radical solutions to deliver the best possible care to patients and their carers.
- Focus on education and development support for clinicians to improve care and ensure that high quality services are delivered.
- Take action when we are not receiving high quality, efficient and effective health services.

The Quality Strategy is delivered using a patient-centred approach and implemented through working in a collaborative manner with patients, healthcare professionals and other non-clinical staff, as well as effective working relationships with the Commissioning Support Unit, London Borough of Enfield and other appropriate organisations.

A focus on the patient not only creates a positive experience of care for patients and their families but also supports clinical effectiveness and patient safety. The Quality Strategy will build upon the integrated approach to service planning and delivery already established locally.

Provider organisations and clinical staff will therefore be encouraged to focus on the needs of patients, as well as satisfying the requirements of regulators or other external bodies. This has shown to be a recurring theme in documents on quality in the NHS: 'Effective involvement of patients and carers is essential to ensuring that everyone is fully engaged in the drive for quality, and that this focuses on what really matters' (Department of Health 1998, para 3.10). Enfield CCG has devised and piloted a Patient Engagement Questionnaire in Enfield Nursing homes. This is to assist in gaining a holistic view of what the quality of life is for clients who live in Enfield nursing homes. The results are currently being populated.

STAFF TRAINING

- The Safeguarding team has provided Safeguarding Adult Training to all the CCG staff to help them identify how they might recognise abuse
- All staff with Enfield CCG has had PREVENT training.

KEY ACHIEVEMENT 2014-2015

- In September 2014, NHS England circulated a guide to all Clinical Commissioning Groups and gave advice on what assurances the CCG should be looking for from their providers regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLs). Based on the guidance, an audit and information collection tool was developed by Enfield CCG. The audit has been project managed as part of the MCA programme work being undertaken by Enfield and funded by NHS England.
- A number of nurse practitioners have been identified as requiring the Best Interest Assessors training (MCA and DoLS). Enfield CCG has ring-fenced funding for 6 practitioners.
- The Assistant Director for Safeguarding has undertaken and passed the Best Interest Assessors Course and is now assessing the Mental Capacity of patients in Enfield.
- Enfield CCG hosted a MCA and DoLS Conference in October 2014. The conference aimed to deliver a learning and awareness opportunity to providers across the borough of Enfield. Initially targeted at nursing homes and domiciliary care providers, the event was broadened to include health professionals from Primary Care mental health and the acute sector providing an opportunity for networking across the care pathway.
- Following the conference, workshops were developed by the CCG and the MCA and DoLS lead for the local authority to facilitate care home managers to attend to continue increasing awareness and training on this issue.

The CCG has secured some further funding to promote training of MCA and DoLS amongst GPs and other primary care staff. Training will take place in 2015-16.

- NHS Enfield designed and piloted a Patient Engagement Questionnaire in Enfield nursing homes. Analysis of findings will be included in the CCG Annual Report and reported at the Safeguarding Adults Board.
- The borough-wide Pressure Ulcer Protocol was facilitated and completed by Enfield CCG safeguarding staff.
- As part of the roll out programme for the Pressure Ulcer Protocol, the CCG have arranged workshops to be held locally to facilitate increased awareness and training on this issue for care homes and residential home staff. The workshops are open and available to staff at all levels in the care home. The workshops have been positively evaluated.
- Enfield CCG nursing staff has produced a number of investigator reports on nursing homes and the Coroners' office.

PRIORITIES AND WORKPLAN 2014/15

- To continue face-to-face Safeguarding and PREVENT training for the continuation of promoting Safeguarding awareness in health professionals.
- Continue to ensure that the CCG provide assurance and monitoring of provider agencies in their delivery of the safeguarding adults' agenda.
- Ensure that CCG Staff in relation to Safeguarding adult receives adequate supervision.
- The CCG will work jointly with the local authority in embedding the Making Safeguarding Personal agenda, ensuring staff are trained in this concept.
- Support all identified staff in completing the Best Interest Assessors course in their understanding of Mental Capacity and DoLS.
- To work with the local authority in monitoring and reporting of pressure ulcers using the borough-wide Pressure Ulcer Protocol.
- Roll out Safeguarding training across the nursing homes.
- To continue to focus on delivering CQRG work plan in conjunction with the providers.
- CCG will continue with quarterly GP forums in updating on Safeguarding adults at risk issues.
- To ensure that GP's are trained in PREVENT.
- Safeguarding Conference to be held in July 2015 for the health economy and partner agencies.

STATEMENT WRITTEN BY:

Carole Bruce-Gordon
Assistant Director for Safeguarding
Enfield Safeguarding Adults Board representative

LONDON COMMUNITY REHABILITATION COMPANY

COMMITMENT TO SAFEGUARDING ADULTS AT RISK

The London Community Rehabilitation Company is committed to eliminating discrimination and encouraging diversity amongst the services we provide. Our aim is that we provide equality and fairness for all and not to discriminate on the grounds of gender, marital status (including civil partnership) race, disability, sexual orientation, age, gender reassignment, pregnancy or maternity and religion or belief. We oppose all forms of unlawful and unfair discrimination.

Safeguarding adults needs to be considered alongside responsibilities for safeguarding children.

Probation staff who work directly with service users who become aware, or have concerns that a service user; a) has care or support needs, b) is experiencing, has experienced or is likely to experience abuse and c) is unable to protect themselves, have a duty to act in a timely manner. Similarly, if they become aware of a service user presenting a risk of harm to an adult 'at risk'. This applies to staff in any probation setting.

The London CRC has introduced single points of contact in each area that are required;

- To be aware of what safeguarding adults arrangements are, including to whom they apply.
- To undertake training in Safeguarding Adults – probation, local authority.
- To promote Safeguarding Adults practice within the Cluster. For example, team meetings, daily briefings, discussions with colleagues.
- To undertake Suicide Prevention Training and cascade learning to colleagues within their Cluster.
- To promote Suicide Prevention best practice within their Cluster. For example, team meetings, daily briefings, discussions with colleagues.
- To be aware of how to contact/make referrals to the local authority Adult Safeguarding team within their Cluster and to share these details with their Cluster.
- To identify and promote local services for 'adults at risk'. For example, local adult learning disability services.

The London CRC intranet lays out the commitment of the London CRC to ensuring that all vulnerable adults get the service(s) that they require. The page has links to internal and external resources with practitioners guides and links to the Care Act.

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.

Our aim to reduce the risk of harm from fire to those most vulnerable within the community.

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 2014 TO 2015

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. To increase the total amount of Home Fire Safety Visits (HFSV's), compared to previous years, where we can provide safety information and fit where necessary, smoke alarms to provide early warning of fire within the home
  - 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 Policies, Practices and Protocols 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
  - Two thousand three hundred and eighty six home fire safety visits were completed within the borough and at least 80% of these were carried out in homes that statistically, were most likely to have a fire.
  - A Housing providers Forum was held in partnership with Enfield Council, where 68 housing providers attended, where we educated/informed them of the services we provide. Most importantly we stressed the importance of the responsible person concept for care homes and housing stock. Highlighting the importance of providing adequate care and fire protection for residents.

- 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 1 fatal fire, an internal review recommended considerations for serious case review where appropriate and recommendations made to housing providers to risk assess residents with medical conditions in regards to fire and escape routes.
  - Through joint working with Enfield Adult Social Services and Enfield Borough Council Safeguarding Adults Service identified and offered a free home fire safety risk assessment to adults vulnerable to fire incidents in the home
- Raising awareness of fire crews as to what other services are available for adults at risk
  - A training programme is incorporated into each Fire Stations training plan in relation to Safeguarding policy and procedure for both Children and Adults
- Monitor outcome reports.
  - Standing agenda item on all Borough management meetings to monitor and evaluate/ quality assure previous 28 days safeguarding issues and referrals
- Working with at risk groups such a the deaf community to improve services, involving the provision of free smoke detectors for the deaf and provision of information about home fire safety and calling the emergency services.
  - London Fire Brigade have made excellent links with the local drop in services and received a number of referrals from the deaf community for home fire safety visits. This has been delivered by fire fighters with British Sign Language level 2 proficiency
- Officers to refer to appropriate agency through Safeguarding protocol where evidence suggest this is necessary
  - London Fire Brigade Watch officers have made a number of referrals throughout the year in accordance with Brigade Policy. Of these only a small number have been referred through the urgent referral agreement. The remainder have been referred to appropriate services and agencies.
- Work with partners to address vulnerable adults at risk from exploitation by unscrupulous land lords to receive support through implementation of statutory enforcement.
  - London Fire Brigade Regulatory Fire Safety Team have worked with Enfield Council to raise awareness of these issues and offer assistance and advise when necessary
- Officers to identify evidence of abuse, preserve scene and early passing of information to the Police as possible crime scene.
  - London Fire Brigade Officers have received awareness training and referred cases to Police where appropriate
- Support partners by providing advice in relation to fire safety in the home when requested.
  - Senior Officers attended a seminar hosted by Enfield Borough Council Safeguarding Adults Services, for Residential Social Landlords, to raise awareness of home fire safety and regulatory fire safety matters
- A centrally held safeguarding referral database to identify safeguarding adults trends pan London, by developing LFB policy and outcomes shared with partners is ongoing.

STAFF TRAINING IN SAFEGUARDING ADULTS

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

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

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

PRIORITIES FOR 2015/16

- Carry out home fire safety visits to all sheltered housing facilities within the borough
- Continually seeking improvements to reduce the number of incidents in sheltered accommodation by working closely with service providers
- Continue to raise awareness of the availability and provision of domestic fire suppression systems for very high risk adults
- 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

NORTH MIDDLESEX HOSPITAL NHS TRUST

COMMITMENT TO SAFEGUARDING ADULTS AT RISK

The Trust's Board takes the issue of safeguarding extremely seriously and receives annual reports on both safeguarding children and safeguarding adults. The Director of Nursing and Midwifery is the Trust's board lead for safeguarding adults.

This report outlines the work that has been undertaken by the Trust over the past year in respect of its commitments and responsibilities in maintaining the safety and protection of adults at risk. It contains a review of the Trust's progress against national and local commitments and identifies key objectives for further developments in Safeguarding Adults for 2015 to 2016.

KEY ACHIEVEMENT FOR 2014-2015

The Trust is committed to learning so that we can make improvements. Some examples include:

- the Mental Capacity Act and Deprivation of Liberty Safeguards Policy has been updated to reflect the guidance provided following the Cheshire West Case Law issued in April 2014
- updated the Deprivation of Liberty Safeguard application forms issued by ADASS in January 2015
- the Trust has developed a Domestic Violence Policy which is available on the hospital intranet
- on 25th June 2014, Ward Managers and Matrons were invited to attend a Mental Capacity Act and DoLS training update
- a significant amount of work has been done to ensure that staff are trained to the correct level for level 1 and level 2 Safeguarding Adult training
- a DoLS briefing sheet/flowchart has been agreed and this has been circulated to all Consultant Medical Staff, Matrons and Ward Managers

The number of DoLS applications progressed by the Trust has gradually increased over the previous year as ward staff are now more aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguard requirements.

We continue to train staff through face-to-face training and e-learning packages. Safeguarding Adult Level 1 training is mandatory in the Trust for all new staff at induction. At the end of March 2015, 80% of all staff had completed their Safeguarding Adult level 1 training.

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 Trust Risk and Quality Committee on a quarterly basis. At the end of March 2015, 66% of relevant staff had completed their level 2 Safeguarding Adult training.

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

PRIORITIES AND WORK PLANNED FOR THE COMING YEAR

The Trust needs to update its Safeguarding Adults Strategy in line with the recommendations from the Department of Health Care Act 2014 statutory guidance for implementation1 and in response to national directives arising from the Supreme Court judgement on the Cheshire West case.

Key priorities for the Trust in 2015/16 are to:

- ensure that Trust Safeguarding Adults Policies and procedures are up to date and comply with current legislation and implications of the Care Act 2014
- progress further work on the 'Making Safeguarding Personal' programme, to ensure that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices
- further work to develop a training plan for Mental Capacity, Best Interest Decisions and Deprivation of Liberty Safeguards
- ensure that reasonable adjustments are made as necessary for those with Learning Disabilities

1 https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

- improve Domestic Violence support available to patients
- further work in PreventWrap training for all staff to be progressed in 2015/16
- strengthen links for Safeguarding Adults and Child Protection work
- continue to implement recommendations from lessons learned from Safeguarding Adult investigations.
- develop our work with patients who may need to have restrictions and restraints on their behaviours in their best interests
- ensure that Deprivation of Liberty Safeguard applications are progressed as required
- ensure that Mental Capacity Assessments are audited by CBU Matrons.

ORGANISATIONAL LEARNING AND SERVICE USER PARTICIPATION

The Making Safeguarding Personal programme requires us to ensure that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices. Family or representatives are now routinely invited to Safeguarding Adult Strategy meetings and Case Conferences to ensure their early involvement in decisions made and Protection Plans. Examples of recommendations made in respect of the substantiated SOVA's have been for staff to:

- ensure adequate handover of information about the patient's condition on discharge, including a discharge letter with a body map and description of any injuries and pressure ulcer management required
- utilise discharge checklists for discharge procedures in order to ensure that patients are discharged with relevant and up to date information
- ensure that capacity assessments (Mental Capacity Act 2005) and rationale for Best Interest Decisions are fully completed and discussed with family members
- discuss medical decisions/recommendations regarding treatment and care with family i.e. withholding treatment
- ensure that a Best Interest Assessment is completed and documented on patient's medical file, in the event that treatment is withheld
- give consideration to completing an End of Life plan, in the event that treatment is withheld
- give consideration to making applications for Deprivation of Liberties Safeguard for patients who lack capacity and are provided with one to one supervision

STATEMENT WRITTEN BY:

Eve McGrath
Safeguarding Adults Lead

ONE-TO-ONE (ENFIELD)

One-to-One (Enfield) is very committed to protecting our members' physical and psychological well-being and safeguarding them from all forms of abuse. At One-to-One we recognise that safeguarding is a responsibility for everyone, and therefore seek to ensure that safeguarding is a priority throughout the organisation.

One of our key achievements for the year 2014-2015 is our work on Hate Crime. On 14th May 2015 One to One held a conference with over 100 people attending. This involved raising awareness on Hate Crime for our members, staff, volunteers, services working with people who have LD and carers. Hate crime is when someone does something bad to someone or takes advantage because the person has a learning disability. We want all safeguarding alerts to be considered as a potential Hate Crime.

To ensure our members are safeguarded against any abuse we work with the integrated learning disabilities team. At One-to-One we have a positive relationship between members, staff, volunteers and other partner organisations that encourages people to be open about concerns and helps people to learn from each other. There are continuous training and development opportunities for staff and volunteers.

We are currently working on our website to include information about One-to-One including safeguarding adults and protecting people from risks. Our website will have links to other service providers.

ROYAL FREE LONDON NHS FOUNDATION TRUST

Since the acquisition of Barnet and Chase Farm hospitals we have continued to build on the strong foundations of safeguarding that were already in place. Our commitment to safeguarding has been demonstrated through the development of a forward looking safeguarding strategy which aims to achieve excellence in practice. Our strategy sets out how we plan to drive forward our safeguarding activities and our reputation over the next 3 years.

Our safeguarding strategy acknowledges the requirement of the Royal Free London NHS Foundation Trust to ensure there is board level focus on the needs of patient safety and that safeguarding is an integral part of the governance framework. To this end we have a newly formed Integrated Safeguarding Committee which reports into the Trust board. In addition we have strengthened our safeguarding team by appointing a head of safeguarding and a lead nurse for safeguarding adults based at Barnet and Chase farm Hospitals. We have also appointed a full –time learning disability nurse.

We recognise that safeguarding is a shared responsibility with a need for effective joint working between partner agencies and professionals. In order to do this we are committed to working closely with others to ensure that all the services we provide have regard to our duty to protect individual human rights, treat individuals with dignity and respect and safeguard against abuse, neglect, discrimination, embarrassment or poor treatment.

As a health care provider we are required to demonstrate that we have strong safeguarding leadership and a commitment to safeguarding at all levels of the organisation. This includes safe recruitment practices, effective safeguarding training for all staff, effective supervision arrangements and the identification of named safeguarding leads. We have ensured that we have a robust safeguarding policy and that staff know how to raise a concern; and that a culture exists where safeguarding really is everybody's business. This means that safeguarding is viewed as an individual responsibility for all our staff as well as an organisation priority.

In order to support our strategy a dynamic work plan has been developed based on 10 key aims:

1. To provide positive assurance that safe and effective processes and systems are in place to effectively safeguard all patients who access services across the Trust
2. To ensure effective systems for prevention, reporting, responding and learning
3. To work in partnership with other agencies to ensure an effective and joined up approach to safeguarding
4. To ensure safeguarding is given a high priority across the organisation
5. To ensure we are a learning and improving organisation
6. To ensure we have a safe and effective workforce in relation to safeguarding
7. To ensure we are continually responsive to changes in the safeguarding landscape, both at a national and local level
8. To ensure we continually drive the safeguarding agenda forward
9. To ensure we improve practice in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards
10. To ensure we are responsive to vulnerable groups such as patients with learning disabilities and patients who disclose domestic abuse

STATEMENT WRITTEN BY:
Deborah Sanders
Director of Nursing

SAFER AND STRONGER COMMUNITIES BOARD

The Enfield Safer and Stronger Communities Board (SSCB) is the statutory Community Safety Partnership locally. The Crime and Disorder Act 1998 as amended by the Police and Justice Act 2006 places a duty on responsible authorities to work together to understand the issues related to crime and community safety in their area and to have an agreed partnership plan to bring about improvements.

The Enfield SSCB have been recognised for strong achievement and good practice both nationally and internationally, contributing to current agendas such as tackling serious and organised crime, counter terrorism and tackling gangs and CSE (child sexual exploitation).

CURRENT POSITION

The Safer and Stronger Communities Board comprises the local authority, the police, the fire brigade, probation services and the clinical commissioning group (CCG). Senior officers from these agencies promote the activity of the Safer and Stronger Communities Board within their own agencies. The lead member for Community Safety is also a member of the SSCB.

There have been significant changes to probation services as a result of the transforming rehabilitation agenda and the probation service has now been split into two different agencies providing the statutory offender management services. These are the National Probation Service (NPS) and the Community Rehabilitation Company (CRC). In London the services of the CRC are being provided by MTCnovo. Both of these agencies are responsible authorities under Section 5 of the Crime and Disorder Act 1998 and are represented on the SSCB.

The SSCB work in partnership with community groups, neighbouring boroughs, central government and the Mayor's Office for Policing and Crime and has representatives from the local Youth Offending Unit, other criminal justice agencies, housing providers and voluntary organisations. It has embedded links with other key groups such as Safeguarding Boards, the Health and Wellbeing Board, Drug Alcohol Action Team (DAAT) and the Enfield Targeted Youth Engagement Board (ETYEB). Regular representation and updates between these boards help us tackle areas of joint concern such as domestic abuse.

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

It is within the Safeguarding Adults Board that the wider agenda of community safety is brought to the attention of partners and links made with those adults who may be more at risk to harm, abuse and exploitation. In this year we saw a presentation on Human Trafficking and how partner organisations on the Safeguarding Adults Board can contribute towards tackling this area. Further, we are going to work with the Metropolitan Police Service to develop a Serious and Organised Crime plan which will include this issue.

In addition, we found that Hate Crime against vulnerable adults continues to be underreported and that this is an important issue for the Safeguarding Adults Board. In the coming year we hope to improve on this area through awareness raising and links with the voluntary sector who support many adults at risk to report.

We know from data that domestic violence against adults at risk continues to be highly reported. In particular, there are specific issues faced by older women who have experienced domestic violence and a more tailored approach to support individuals will be developed along with our colleagues in the Council's strategic safeguarding adults service.

KEY ACHIEVEMENTS OF 2014-15 INCLUDE:

- Continued investment in CCTV provision across the borough
- Serious acquisitive crime has shown significant improvement in 2014-15, and has fallen by 22.5% (as at 12th March 2015)
- Continued to support our Safehouse scheme to support the target hardening of vulnerable residents' homes
- Delivered high profile seasonal crime prevention messages around personal safety to appropriate audiences

- We have improved our links and data sharing with health agencies, notably North Middlesex Hospital
- Delivered further Court "Call-ins" sessions to highlight the risks of gang membership and offer support to exit the gang lifestyle
- Better oversight of anti-social behavious cases through the action group (ASBAG) and regular case management meetings
- Further work around Domestic violence including a further 12 months support for Project IRIS working with GPs to identify domestic violence and intervene safely

PRIORITIES IN THIS YEARS' PARTNERSHIP PLAN ARE:

Our Mayor's Office for Policing and Crime (MOPAC) 7 priorities are:

- Burglary
- Criminal Damage
- Robbery
- Theft from a motor vehicle
- Theft of a motor vehicle
- Theft from a person
- Violence with injury

Our SSCB priorities are:

- Tackling serious youth violence
- Tackling domestic abuse and violence against women and girls
- Tackling Anti-Social Behaviour
- Reducing property crimes such as burglary and car crime
- Delivery of the Prevent agenda locally
- Development of a Serious and Organised Crime plan in conjunction with the MPS and local partners

We are also aware of key cross cutting themes that impact on all of the above such as substance misuse, the management of offenders in the community and hate crime. These themes will also be key areas of work for us during 2015-16.

STATEMENT WRITTEN BY:

Andrea Clemons
Head of Community Safety
Enfield Safeguarding Adults Board representative

APPENDIX A PERFORMANCE DATA

This summary report is intended to draw attention to the patterns or trends identified in the safeguarding adults data report for Q4 2014-2015.

The data sets considered for the Safeguarding Adults Board include the following:

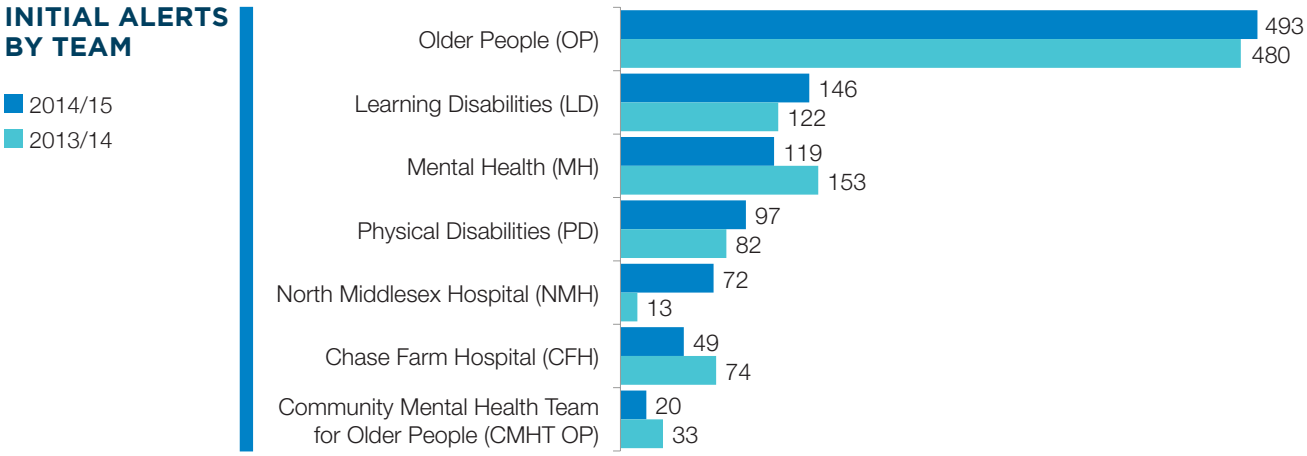
- Total number of alerts
- Number of alerts via team
- Types of alleged abuse
- Place of alleged abuse
- Route of safeguarding referral
- Relationship of the person alleged to have caused harm
- Outcome of alerts in terms of progression under safeguarding adults
- Involvement of a nominated advocate
- Outcome of cases
- Outcome for adult at risk
- Outcome for person alleged to have caused harm

Some of the key patterns or areas of notice identified this quarter are as follows:

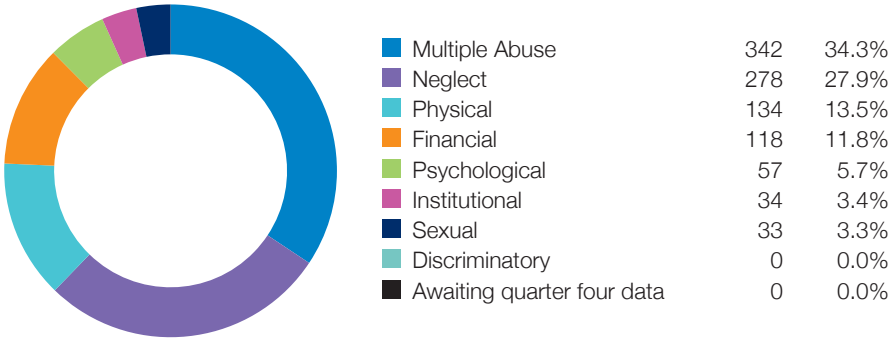
1. During 2014/15 there were **996 alerts** raised to adult social care, compared to 957 in 2013/14 (4% increase). This is a change from the previous trend where the number of alerts reported in 2012/13 had increased by 16% from 2011/12. This trend continued into 2013/14 with a 20% increase in the count of alerts from 2012/13.
2. The **largest referrals increase** across all teams is **North Middlesex Hospital 454%**, (13 alerts in 2013/14 to 72 alerts in 2014/15). The Mental Health team reported a 21% decrease in the number of referrals reported for 18-64s (146 to 116).
3. Most alerts relate to **Multiple Abuse** (34%) with Neglect at (28%). Neglect is higher when compared to 2013/14 which has seen a 22% increase (227 to 278).
4. **40%** referrals are in relation to alleged abuse in the **Adult at Risk's own home** and 26% are in a residential/nursing home. Referrals where the location of abuse is 'Mental health inpatient setting' is lower when compared to 2013/14 (61 to 44).
5. Of the 76 alerts where the location is alleged abuse as 'acute hospital' the count of alerts against each named hospital is confirmed as North Middlesex 45, Chase Farm 19, Barnet 9, Royal Free 2, University College London Hospitals 1.
6. The **largest referral** source continues to be **Hospital Staff at 23%**, followed by Private/ Independent Provider at 19%.
7. **Family members** and **paid staff** continue to be the **highest** proportion of those alleged **to have caused harm**. Other vulnerable Adults make up 8% of those alleged to have caused harm, this is compared to 14% in 2013/14 (69 to 35).
8. The outcome of the initial alert is 73% 'proceed with Safeguarding' and 5% 'require further information gathering' (at the time of reporting).
9. There is an increase in the number of adults at risk whom have a nominated advocate involved 31% (433 to 567) since 2013/14. The type of advocacy is set by the request or requirement of the adult at risk and can include family members, friends, or paid advocates for example.
10. 45% of closed cases were substantiated or partially substantiated (compared to 48% in 2013/14). The outcome in 29% of referrals concludes 'The allegation has not been substantiated' this is an increase from 2013/14 with 24%.
11. 38% of alerts raised during 2014/15 were closed within 7 weeks, this is a decrease when compared to 2013/14 with 48%.
12. The proposed outcome for the adult at risk is recorded as 'no further action' in 53 (33%) of closed alerts, this is an increase when compared to 2013/14 (28%).
13. The main outcome for the Adult alleged to have caused harm is 26% 'no further action' followed by 24% 'action by continued monitoring' this is a change when compared to 2013/14 which reported 26% and 35% respectively.

REFERRALS (ALERTS)

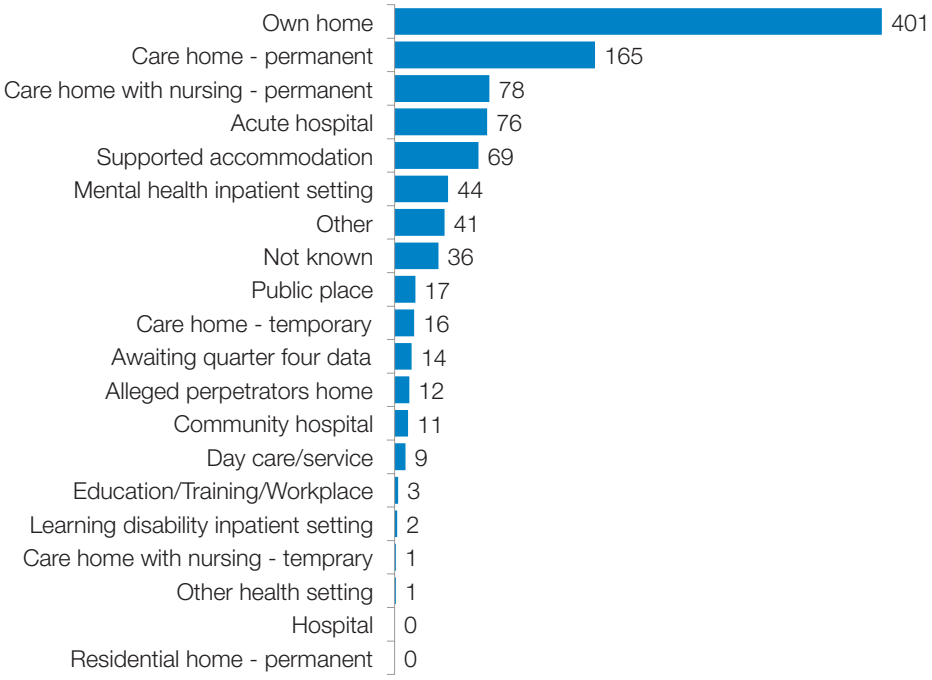
INITIAL ALERTS BY TEAM



TYPES OF ALLEGED ABUSE



PLACE OF ALLEGED ABUSE



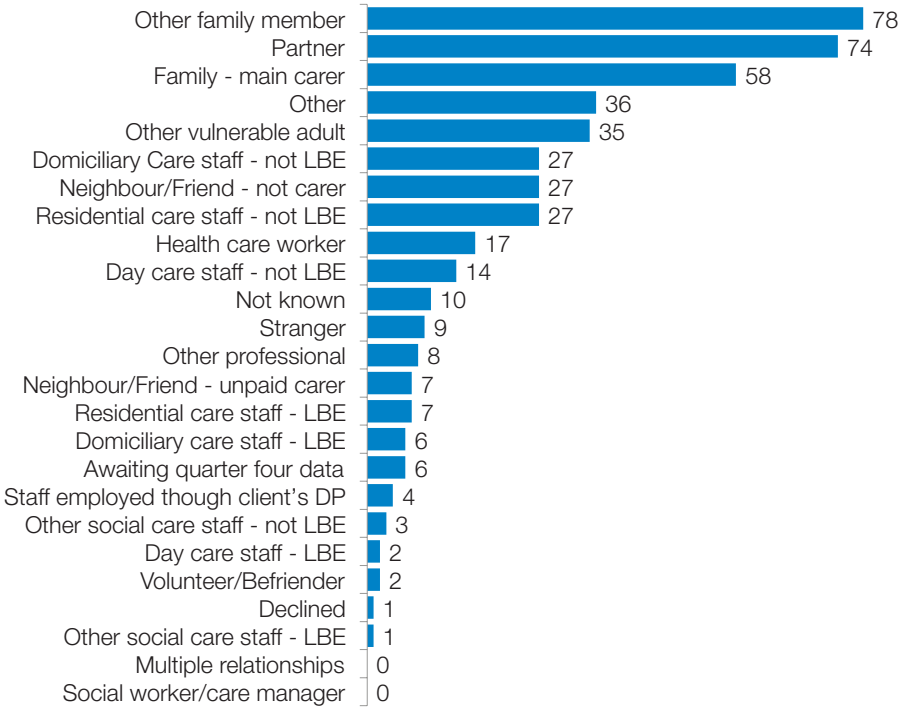
ROUTES OF REFERRAL

Referer	2012/13	2013/14	% change
Hospital staff	225	208	*8.2%*
Private/Independent Provider	188	151	*24.5%*
Community Health Professional	136	95	*43.2%*
LBE - HASC	129	139	*-7.2%*
Relative	57	68	*-16.2%*
LBE not HASC	39	33	*18.2%*
Domiciliary staff	33	27	*22.2%*
Voluntary/Religious	31	11	*181.8%*
Ambulance Service	27	30	*-10.0%*
CQC	23	21	*9.5%*
Self referral	15	13	*15.4%*
Police	14	15	*-6.7%*
General Practitioner	14	11	*27.3%*
Other	12	27	*-55.6%*
Day care staff	12	16	*-25.0%*
Anonymous	12	15	*-20.0%*
Neighbour/Friend	9	9	*0.0%*
Carer	7	7	*0.0%*
Housing/RSL	5	17	*-70.6%*
Awaiting quarter four data	5	5	*0.0%*
Partner	3	0	*0.0%*
Mental Health staff - joint teams	0	32	*-100.0%*
Council staff	0	7	*-100.0%*
Education provider	0	0	*0.0%*
Financial Institution - Bank	0	0	*0.0%*
Guardian/Office of Public Guardian	0	0	*0.0%*
Other service users	0	0	*0.0%*
PCT	0	0	*0.0%*
Public	0	0	*0.0%*
Social Services staff - not LBE	0	0	*0.0%*
Total	**996**	**957**	***4.1%***

INFORMATION ABOUT THE PERSON ALLEGED TO HAVE CAUSED HARMS

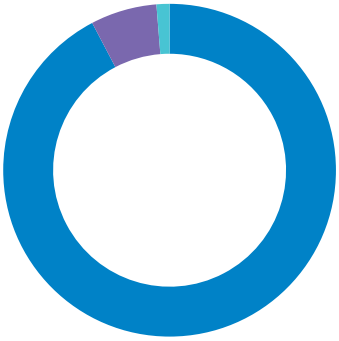
Relationship to Adult at Risk of those alleged to have caused harm. Only for those alerts where the type of alleged perpetrator is an individual.

PERSON ALLEGED TO HAVE CAUSED HARMS RELATIONSHIP TO ADULT AT RISK



OUTCOMES OF ALERTS

OUTCOME OF INITIAL ALERT



Proceed with Safeguarding	731	92.3%
Further information gathering required	51	6.4%
Awaiting quarter four data	10	1.3%

NOMINATED ADVOCATE INVOLVED?

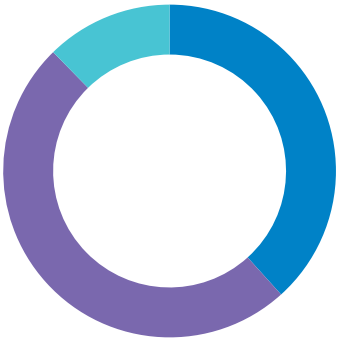
	2014/15	2013/14	% change
Yes	567	433	*30.9%*
No	48	264	*-81.8%*
Not applicable	110	31	*254.8%*
Awaiting quarter four data	6	5	*20.0%*
Total	**731**	**733**	*-0.3%*

OUTCOMES OF CLOSED CASES

OUTCOME OF THE SAFEGUARDING ADULT INQUIRY/ INVESTIGATION

Substantiated	49	31.8%
Not substantiated	44	28.6%
Inconclusive	29	18.8%
Partially substantiated	20	13.0%
No further action	12	7.8%

DAYS FROM ALERT TO INQUIRY CLOSED



Within 7 weeks	59	38.3%
More than 7 weeks	76	49.4%
Awaiting quarter four data	19	12.3%

OUTCOME PROPOSED FOR ADULT AT RISK

Data Measured	2014/15	2013/14	% change
Community Care Assessment and Services	6	11	*-45.5%*
Increased Monitoring	37	57	*-35.1%*
Restriction/Management of access to AP	3	4	*-25.0%*
Moved to increase / Different Care	8	23	*-65.2%*
Review of Self Directed Support	3	1	*200.0%*
Management of Access to Finances	3	4	*-25.0%*
Application to change appointee-ship	0	2	*-100.0%*
Continuing care placement required to meet patients cultural needs	0	2	*-100.0%*
Removed from Property or Service	9	10	*-10.0%*
No Further Action	53	63	*-15.9%*
Other Outcome	9	25	*-64.0%*
Awaiting quarter four data	16	18	*-11.1%*
Application to Court of Protection	2	3	*-33.3%*
Referral to Counselling /Training	3	1	*200.0%*
Referral to MARAC	2	2	*0.0%*
Total AAR Outcomes	**154**	**226**	***-31.9%***

OUTCOME PROPOSED FOR PERSONS ALLEGED TO HAVE CAUSED HARM

Data Measured	2014/15	2013/14	% change
Action by CQC	0	3	*-100.0%*
Action by Contract Compliance	6	9	*-33.3%*
Action by Continued Monitoring	38	78	*-51.3%*
Community Care Assessment	0	1	*-100.0%*
Counselling/Training/Treatment	12	6	*100.0%*
Criminal Prosecution/Formal Caution	1	2	*-50.0%*
Disciplinary Action	6	15	*-60.0%*
Exonoration	7	4	*75.0%*
Management of Access	7	8	*-12.5%*
Police Action	1	2	*-50.0%*
Removal from Property or Service	5	8	*-37.5%*
No Further Action	42	59	*-28.8%*
Other (specified)	0	0	*0.0%*
Awaiting quarter four data	17	20	*-15.0%*
Not Known	12	9	*33.3%*
Referral to Registration Body	0	2	*-100.0%*
Total AP Outcomes	**154**	**226**	***-31.9%***

APPENDIX B
OUR SUMMARY ACTION PLAN

KEY PRIORITY 1: EMPOWERMENT

PEOPLE BEING SUPPORTED AND ENCOURAGED TO MAKE THEIR OWN DECISIONS AND INFORMED CONSENT

- The Partnership will develop strategies for management of self neglect, hoarding and honour based violence and domestic abuse which enables adults to have choice and control.
- The Board will assure itself that adults at risk are involved strategically in safeguarding and through to involvement in individual cases.
- We will ensure children and young people are aware of adults at risk and who they can speak to if they have concerns.
- Board partners to provide assurances that they can achieve requirements of 'Making Safeguarding Personal'.

EMPOWERMENT OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- Guidance available that supports staff to deal with specific safeguarding issues with adult at risk central to interventions and support.
- Evidence of service user, carer and patient engagement at strategic board level, in partner organisation safeguarding development, and through to the safeguarding adults process.
- Data show that children and young people have information, understanding and feel able to report concerns.
- All partners are working to the ethos of Making Safeguarding Personal and have action plans that demonstrate deliverance.

KEY PRIORITY 2: PROTECTION

SUPPORT AND REPRESENTATION FOR THOSE IN GREATEST NEED

- Safeguarding Adults Board will meets its statutory requirement as set out by the Care Act 2014.
- The Board will clarify the surveillance and community alarm options for adults at risk and their representatives and have assurances this in within legal parameters.
- Partners on the Board will facilitate intervention on the issue of dehydration and hold providers to account for implementation.

PROTECTION OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- There is a Safeguarding Care Act Implementation Group which reports and is accountable to the Board.
- Surveillance or community alarm options are set out and we are able to report back on uptake.
- Through quality checks we can evidence that dehydration interventions are being appropriately implemented by care providers.

KEY PRIORITY 3: PREVENTION

IT IS BETTER TO TAKE ACTION BEFORE HARM OCCURS

- Our local health economies will be monitored and have indicators that ensure people are kept safe from abuse.
- Board will have partnership data through an integrated performance report from the Police, Local Authority and CCG.
- The Board will develop and deliver on creating pathways of support for those isolated and at increased risk of abuse and exploitation.

PREVENTION OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- Partnership demonstrates through Board and Quality Assurance Groups that we are acting on data to prevent harm.

- Board meetings have partnership data report which informs trend and theme analysis to support performance risk prediction.
- Partnership approach to identifying isolated individuals who we can evidence are able to access support from across services.

KEY PRIORITY 4: **PROPORTIONALITY**

THE LEAST INTRUSIVE RESPONSE APPROPRIATE TO THE RISK PRESENTED

- The Board will support strategic discussions around the Multi-Agency Safeguarding Hub (MASH) for adults at risk, to ensure information sharing and cooperation in line with the Care Act.
- We will seek service user feedback from those who have been harmed to improve practice.
- Board will facilitate pathway programme in place for people at risk of harming others.

PROPORTIONALITY OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- Our recording can inform practice and provide aggregated outcomes for the SAB.
- Feedback from adults at risk confirm that they feel safe and have a positive experience of care and support.
- People at risk of harming others access support to prevent harm or prevent repeat abuse.

KEY PRIORITY 5: **PARTNERSHIP**

LOCAL SOLUTIONS THROUGH SERVICES WORKING WITH THEIR COMMUNITIES COMMUNITIES HAVE A PART TO PLAY IN PREVENTING, DETECTING AND REPORTING NEGLECT AND ABUSE

- Develop a quality assurance framework for the Board to embed learning culture across the partnership.
- Partners will provide assurance to the Board that their service provision is in line with the Dignity Standards.
- We will strengthen the partnership between Board and the voluntary sector.

PARTNERSHIP OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- The Board has set out how it will quality assure itself and partners, with a timetable in place and activities underway.
- We can look at the strategic plans of partners on the SAB and find evidence of safeguarding adults.
- Voluntary sector report feeling more engaged with safeguarding through the SAB and evidence of more joined up activities as reported in the annual report.

KEY PRIORITY 6: **ACCOUNTABILITY**

ACCOUNTABILITY AND TRANSPARENCY IN DELIVERING SAFEGUARDING

- Board will set out its arrangements for peer review and self-audits.
- Board will assure itself that decision to proceed under safeguarding and decisions to prosecute are transparent.
- Carry out Safeguarding Adults Reviews (SAR) were there is a statutory obligation and ensure learning is widely disseminated.

ACCOUNTABILITY OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- Board has evidence of how it has been audited against statutory requirements and action plans in place to address gaps.
- We can evidence number cases which went to prosecution and access to justice system.
- SAR included in annual report and wider learning across the partnership with action plans in plan.

HHASC442

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Safeguarding Adults
Health, Housing and Adult Social Care

June 2015

ENFIELD Council