

ENFIELD SAFEGUARDING ADULTS BOARD

ANNUAL REPORT 2016/17





WORKING IN PARTNERSHIP WITH LOCAL PEOPLE AND



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1. INTRODUCTION FROM THE CHAIR

I am very pleased to be able to introduce the Enfield Safeguarding Adults Board's (SAB) Annual Report for 2016-2017. I was delighted to have been appointed in December 2016 to take on the role of Independent Chair. I bring professional experience and personal commitment to safeguarding adults, having worked as director of adult social care and remain a registered social worker. I believe passionately in the power of partnerships and took the opportunity to meet with all SAB partners. It is evident that there is a strong commitment and drive to cohesively make Enfield a safer place for adults at risk of abuse and neglect. I would particularly like to recognise the work that Marian Harrington has done in the last three years to place the Board in its excellent position to meet the challenges ahead.

This year 2016/17 has been a productive and successful year for adult safeguarding in Enfield, with a continued drive by the partnership to assure that the experience of adults once in contact with services is one of quality and that helps them to be safe. Embedding the new Care Act requirements especially to Make Safeguarding Personal for everyone has been a key target and success.

The positive feedback from quality assurance activities on practice, joined a successful conference on Making Safeguarding Personal and the development of a safeguarding film, exemplifies a partnership committed to keep adults central to all actions taken.

The Board has been keen to influence and work together with a wide range of partners, such as Public Health and the Community Safety Unit, ensuring safeguarding is integral to issues such as suicide prevention and modern slavery. Our aims are not only to provide a robust response when abuse does occur, but ensure that where we can we prevent abuse from happening in the first place. We also want to build on our links with the Safeguarding Children Board to develop a more integrated Think Family Approach and reach out to frontline workers. We want all those who live and work in Enfield to be able to recognise what abuse is and where they can report it, feeling confident that they will be listened to and their concerns taken seriously.

The number of safeguarding concerns raised in Enfield continues to be significant and I am determined that we continue to work with adults and their carers, so their views and wishes influence the work we undertake.

As a Board we recognise that there is a changing landscape with statutory partners, such as health and the police who will be experiencing transformation in their organisational structure, but will continue to provide support and leadership so that safeguarding remains a local priority and with sufficient resources. Facilitating a more joined up approach across North Central London will be a focus, in recognition of the challenges for partners working across boundaries.

Finally another thank you as the SAB Board manager Georgina Diba is after 8 years moving to an important transformation post in Enfield. The Board has been very appreciative of her drive and passion to ensure a high performance by all partners and the challenge and support to all working strategically to protect adults from abuse. We wish her well.

Christabel Shawcross
Independent Chair
Enfield Safeguarding Adults Board

2. ABOUT SAFEGUARDING IN ENFIELD

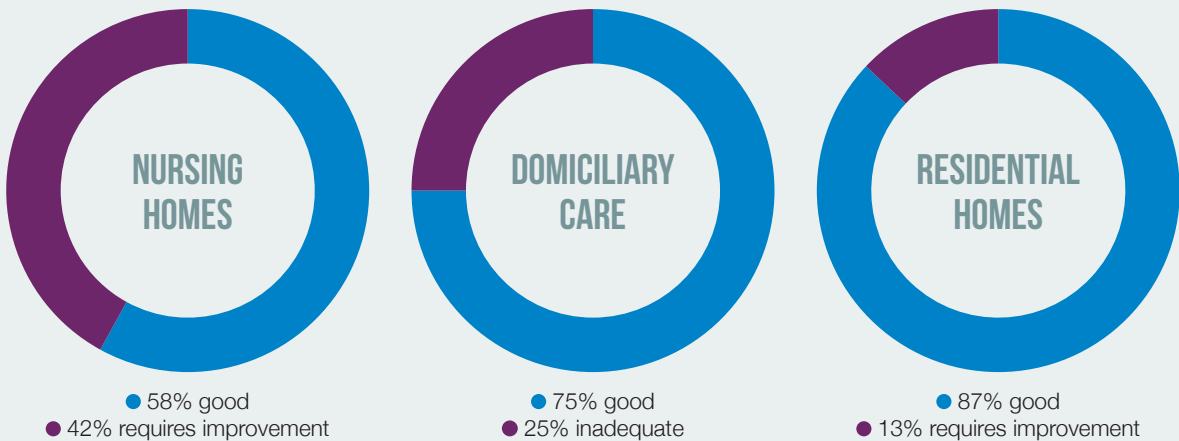
Enfield is one of the northern London boroughs and has some unique demographics which influence how we safeguard adults at risk. The health of local people, as set out in the Joint Strategic Needs Assessments, illustrates an area with contrasting levels of deprivation and affluence.

With the introduction of a Multi-Agency Safeguarding Hub (MASH) in April 2015, our single point of contact to report abuse, we are seeing a significant number of contacts with referrals for adults who have care and support needs. Of these, there were 1,144 number of safeguarding concerns raised to the local authority; more allegations of abuse and neglect are progressing under safeguarding than in previous years.

- **1,147 Applications for Deprivation of Liberty Safeguard**
- **1,144 Safeguarding Concerns Raised**

Enfield has a relatively high proportion of older people living in the Borough, where 12.8% of residents. Around 40,900 people, are aged 65 or over. This figure is the 11th highest in London. Concerns reported to us about adults over the age of 65 years accounted for 49% of all safeguarding raised to the Local Authority. Enfield is also distinguished in having 160 social care providers catering to our residents. This includes nursing, residential and domiciliary care organisations. The Care Quality Commission *State of Care Report, 2015-2016*, notes concern that adult social care sustainability is approaching a tipping point. As such the Board is challenged with the task of collaborating as a partnership to keep adults at risk using services safe from abuse and neglect

Care Quality Commission (CQC) Adult Social Care Ratings for Enfield



Care Quality Commission, March 2017

There are 27,624 residents in Enfield providing at least one hour of unpaid care a week. In addition, 6,194 people of Enfield's population is providing 50 hours or more of unpaid care per week. Concerns where carers are harming or at risk of harming the person they care for continues to be an area the Board wants to make a difference. In the last year, we joined up with the Enfield Carers Centre to raise awareness. We also included an example of a caring role where abuse has occurred in a new safeguarding film. More on this film in section 5.

Importantly safeguarding is about the recovery and resilience of adults at risk of abuse and neglect, enabling their concept of wellbeing to be realised. Through safeguarding practice, we supported 549 adults at risk to have their outcome met or partially met. Outcomes met or partially met: 97%.

Further data relating to safeguarding activity can be found in section 13.



3. YEAR IN SUMMARY

The Safeguarding Adults Board are presenting their Annual Report for 2016-2017. This report sets out what the Board has set out to accomplish over the last year, what it has achieved, and looking forward how we will continue to work together and in partnership with those who use services to enable recovery, resilience and restoration from abuse and neglect.

One year after becoming statutory under the Care Act 2014, the Enfield Safeguarding Adults Board is continuing to demonstrate a desire to improve the wellbeing and safety of those in the borough to be free from abuse and neglect. The Board can evidence it has a strategy and at each Board meeting a review of actions undertaken as part of its business plan. **Making Safeguarding Personal** has been a driver in Enfield for many years, and this year we saw a conference that looked deeper into how methods, such as family group conferencing, can be adapted for use in safeguarding to keep adults experiencing abuse central to all actions taken.

We had several accomplishments this year as a Board. These included assuring that our publicity and communication is fit for purpose, with a **Keep Safe Week** held jointly with safeguarding children and a modern slavery conference. We targeted information, such as on financial abuse and hate crime, to improve reporting in these areas. The Board undertook to assure itself of how individual organisations safeguard, hosting a **North Central London Challenge and Learning** event. Moving forward, the Board will strive for excellence through an audit of its governance and function, using service user and carer oversight for external scrutiny. More information about what we have accomplished can be found in section 5.

The Board aims to influence and contribute to local and national conversations on safeguarding. Locally, the Board welcomes dialogue on issues such as suicide prevention, domestic abuse and learning from our statutory **safeguarding adult reviews**. We are held to account at Board meetings and must demonstrate that any learning has been put in place. Nationally, we took learning from safeguarding adults reviews presented by NHS England and this year we will audit the sustainability of changes we make in response to individual cases. We know that there is more we can do to learn from other areas and await the outcome of a report commissioned by the Association of Directors of Adult Social Services, which draws together reviews nationally. In Enfield, we contribute to national initiatives such as peer reviews, drawing together a revised self-assessment tool for Boards, and sharing our work with other authorities and networks.

Looking forward we have set ourselves some clear priorities for 2017-2018. These priorities have been identified through organisations in Enfield, reviewing themes and trends from data we collect, and from those who use services, carers and patients.

- Focus on prevention and reaching residents in Enfield so everyone can recognise and report abuse
- Identifying more effective ways to work together to achieve the best outcomes for adults at risk
- Assuring the safety of the provider market with targeted activities that focus on quality and safety

The well-established nature of the Enfield Board enables us to reach out and work beyond our boundaries in collaboration with other Boards; learning and sharing ideas which can deliver opportunities for adults at risk in Enfield to live a life free from abuse and where their dignity is respected.

4. ROLE OF THE BOARD

WHO WE ARE

The Safeguarding Adults Board is the partnership of organisations who are responsible for helping adults at risk in Enfield to be supported to live lives free from abuse and neglect. It is about more than being safe and is about a person's wellbeing and their wishes in deciding on any action.

We want to ensure that when abuse occurs an individual is supported to achieve the best outcome for themselves, and importantly we want to work together to prevent abuse from happening in the first place. This report explains how we have done this in the last year and our plans for the future.

OUR AIMS

We set out our aims over a three-year period, from 2015 to 2018, in the Enfield Safeguarding Adults Strategy. We are clear that during this time we intend to work together to ensure that adults who may be 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 an action plan that we review annually and in consultation, ensuring those who use services, carers and local people's views directly influence the work we do.

WHAT WE DO

Partners who form the Safeguarding Adults Board meet quarterly and help to co-ordinate activities and give assurance that systems are working together and in the best way to prevent and respond to the abuse of adults.

The Care Act 2014 and the statutory guidance alongside this, sets out what the Board needs to do. The three core duties are to have a plan each year and sets out how this will be achieved; to publish its annual report; and to conduct reviews in certain cases to identify lessons to be learnt.

RESOURCES AND FUNDING FOR THE BOARD

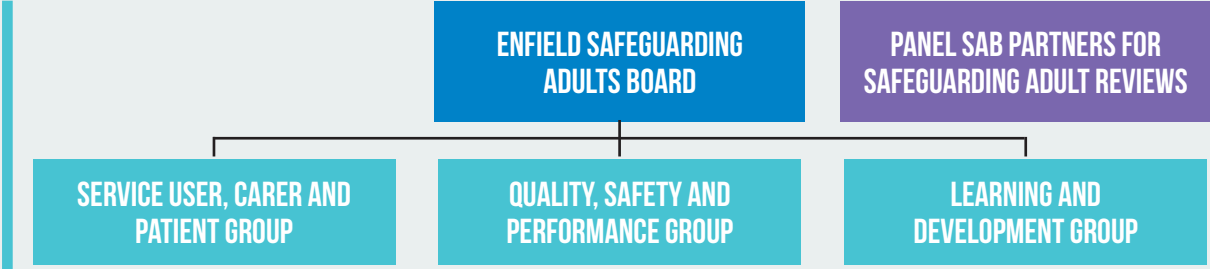
The Board needs both resources and funding to carry out its work. All partners have been able to contribute to the activities which take place, such as giving up staff time to take part in actions, identify leads to attend Board meeting, co-chair groups, and support Safeguarding Adult Reviews. Many partners also take part in events, such as Keep Safe Week where North Middlesex University Hospital held awareness raising stalls with information over three days.

During 2016/2017 the Board had a total budget of £58,500 which some partners contributed to. We overspent on this budget due to many Safeguarding Adult Reviews, which required an independent author. The funds were managed by Enfield Council on behalf of the Board to an agreed plan.

We are looking for ways to manage the budget next year and particularly around the spending we have on the Safeguarding Adult Reviews.

GROUPS WHICH SUPPORT BOARD WORK

The Board has several groups which help to complete activities and give the Board additional assurance around how partners work together to keep adults safe. In this section, we set out these groups and what they have done in the last year.



SERVICE USER, CARER AND PATIENT GROUP

There are those in the community, alongside organisations who support adults with care and support needs, who are particularly passionate and dedicated to making Enfield a safe place to live. The Service User, Carer and Patient sub-group of the Board is just that. The group has been running since 2010 and currently meets every two months to provide oversight and challenge to the work undertaken by partners in Enfield to keep people safe. Importantly they have also demonstrated their ability to drive forward and complete projects which are improving outcomes for adults.

In the last year the group has contributed to two significant developments:

- The design and creation of two safeguarding films, which will make understanding the types of abuse and what happens when abuse does occur, more accessible to all communities in Enfield.
- Supported the completion of a piece of work on the experience of Lesbian, Gay, Bisexual and Transgendered individuals in care homes. This work was done in conjunction with the Quality Checkers and resulted in the completion of a toolkit for care providers.

In addition to these key areas, the group continued to give their feedback on how we communicate across Enfield to raise awareness, contributed to discussions on domestic violence and the links with housing, and supported one another to raise issues of safety and wellbeing that have the potential to affect us all.

"the group can help to get different parts of the borough to work together to keep people safe"

"it has been helpful to run cases through the group when there have been safeguarding issues"

"deaf people can be frightened to say when they are worried. This group has been helpful to share information with deaf people"



QUALITY, SAFETY AND PERFORMANCE GROUP

The Board wants to know that services are enhancing the quality of life and wellbeing for adults with care and support needs in its area, alongside keeping people safe. Activities related to this are done by a group that focuses on quality, safety and how we measure this in organisation’s performance.

Over the last year, the group has challenged and shared learning from safeguarding practice through audits and reviewing data we collect. We also helped drive forward a Challenge and Learning event for North Central London Safeguarding Adults Boards. Each organisation on the Board was asked to complete a self-assessment and there is now an action plan being monitored. Importantly, the event helped identify areas where we can share practice and develop projects in partnership with other local Boards.

The group has a very clear focus in the coming year which includes:

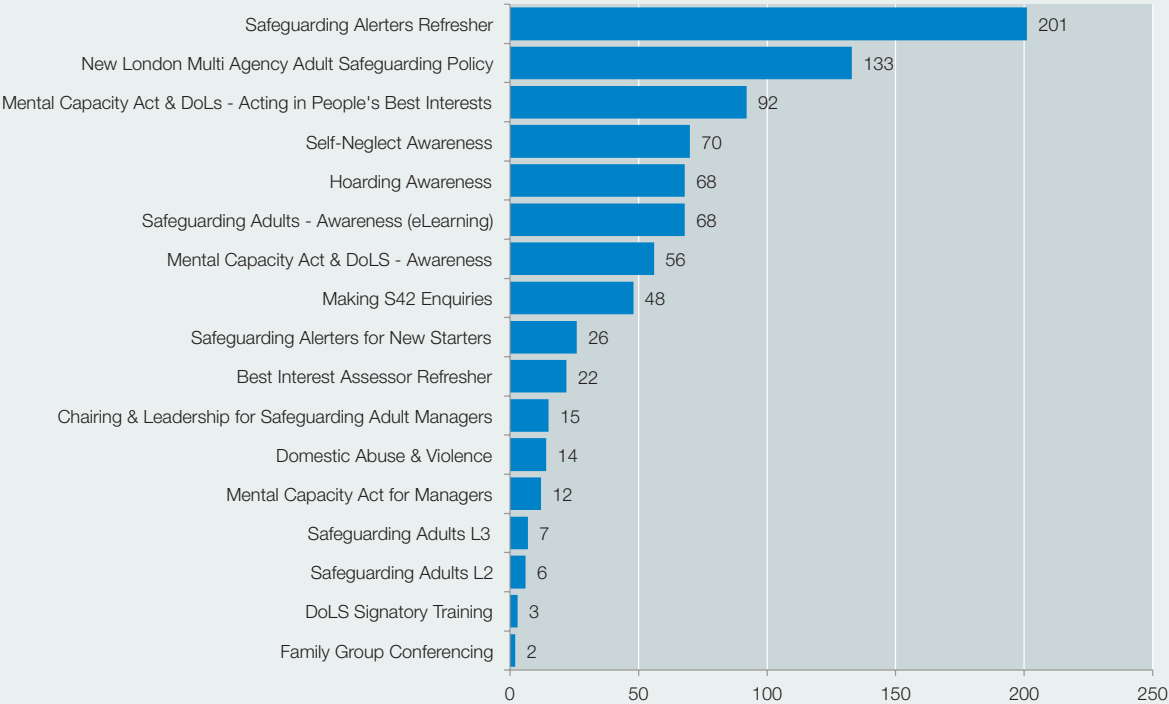
- Developing a way to audit the Board so we can make sure it is effective and efficient
- Review from a system approach how we work together to prevent and detect concerns in our care homes and domiciliary care providers
- Consider how safety for adults can be improved by focusing on holding to account those at risk of abusing

LEARNING AND DEVELOPMENT GROUP

We believe that individuals working with adults should have the right knowledge, skills and confidence to recognise and respond effectively to adult abuse. To help achieve this a joint group with the Safeguarding Children Board is in place to collectively oversee and create the right learning opportunities for safeguarding in Enfield.

For adults, learning and training opportunities are delivered by the Safeguarding Adults Board through Enfield Council’s Corporate Learning and Development Service. In the last year, the following courses were available and a total of **843** people from across the partnership attended. All training was face-to-face apart from an e-learning awareness course.

Total numbers completed on Safeguarding Training 2016-17



In addition, there were several events linked to the Safeguarding Adults Board. This included a conference on **Modern Slavery** during our Keep Safe Week. In partnership with the Safeguarding Children Board we brought together experts in the field to help seventy-two practitioners, managers and councillors from across Enfield to recognise what modern slavery is, the links to internal trafficking and gangs, as well as the support available and how this links to adult and children safeguarding. As an outcome of this we will:

- Identify single point of contacts in the local authority to champion responses to modern slavery
- Write a joint strategy for modern slavery in Enfield with the Safeguarding Children Board
- Provide more learning opportunities in the future for the partnership

Comment from a participant noted it was useful

"being informed about what makes a person more vulnerable to exploitation, and learning how to highlight this and take action".

A second event we held as part of Keep Safe Week was on **Making Safeguarding Personal**. Building on the recognition of Enfield working to gold standard in March 2015, we held a conference to further embed innovative and person centred ways of working. Workshops focused on types of enquiries which can be used, mental capacity and domestic violence, and working with perpetrators. Participants were positive about the conference and it is helping focus our direction in the future. Ongoing training will be offered on self-neglect and working from a person-centred perspective to safeguard in these cases.

Comment from participant moving forward that we will

"concentrate more on enquiries rather than investigation and change the language. What does the service user want – not whether it happened or not".

Partners on the Board also promote learning and development in several ways. These include:

- Targeted presentations to community and voluntary sector groups, and some of their service users, to ensure all communities have access to safeguarding. We have found this year that those being referred under safeguarding are more representative of the Enfield population
- Safeguarding awareness sessions to Parent Champions

Based on the training we deliver and feedback from those who attended, we have considered what we need to offer in the coming year. Additional training will be provided on:

- Working with those who have caused harm (perpetrators)
- Building resilience and recovery for adults
- Family Group Conferencing



5. WHAT WE HAVE ACCOMPLISHED

The Safeguarding Adults Board has an action plan that it reviews at each quarterly meeting. Together the Board monitors its progress and decides what is needed to move activities along. During 2016/17 our accomplishments included:

- **Hosting North Central London Challenge and Learning event for five neighbouring Safeguarding Adults Boards.** This has led to a more joined up approach with several areas where there will be collaboration across North Central London.
- **Targeted awareness sessions taking place because we felt not everyone was represented in the safeguarding adults data; this has included presentations to Enfield Saheli Women's group and Enfield Racial Equality Council.** Our data this year now shows a closer representation to the communities and it means more adults from Black and Minority Ethnic communities are getting access to safeguarding.
- **We targeted information on financial abuse** and this has helped us to start writing procedures for preventing financial abuse.
- **Our training on domestic abuse is inclusive of coercive control and some courses are now in collaboration with safeguarding children.** We are doing this so that more staff have suite of options to offer to victims to enable their safety.
- **Partners in Hospitals, such as Royal Free London which covers the Chase Farm site, have evidenced extensive work on domestic abuse, female genital mutilation, honour based violence and trafficking.** Not only are Independent Domestic Violence Advocates on hospital sites, but there is focused training, awareness activities and conferences on these areas.
- **Developed dehydration cards to assist staff and family members visiting care homes to understand what dehydration is, how to recognise this and what to do.** These cards are going out and our quality checkers will go back into care homes to assess the difference they have made.
- **We created a factsheet on how technology can be used to help people keep safe.** We did this because several service users, carers and local people asked us to do this as part of our annual consultation: "more use of community alarm" as well as information on "alarms and small hidden camera that people can place".

PREVENTION AND QUALITY ASSURANCE

We promised to report on actions from our Strategy action plan, Prevention Strategy 2015-2018 and Quality Assurance Framework 2015-2018. In addition to the points above, we have set out some more activities below and what we are still working on:

We have:

- Scoped locally how we work with perpetrators and are now developing a plan and seeking funding to implement a local perpetrator programme. We want to hold perpetrators to account and break the cycle of abuse.
- Reviewed information presented at each Board related to safeguarding concerns raised and provided challenge and support to ensure this is accurate and gives us a full picture. Thus, we have performance set out in Section 9 of this report.
- Action plans from Safeguarding Adult Reviews which are monitored at the Board so we can evidence that we listened, took the learning, and made changes to help prevent abuse and improve our work together.
- Expanded our focus to include issues such as suicide prevention and how the Board can support this work.
- Held partners on the Board to account at meetings by having each organisation present how they meet the dignity in care standards and effectively safeguard.

We still need to:

- Receive a review by the Police on safeguarding cases referred to them to understand how adults at risk have access to the justice system.
- Work with young carers so that they can recognise adult abuse and have the support to come forward.
- Improve our coordination with community safety officers on the street and their engagement with supported living accommodation.





COMMUNICATION AND AWARENESS

We believe everyone can recognise abuse and raise a concern. Our role is to support awareness and communication so all communities can help to make the Borough a safer place to live, work and visit.

You asked us to:

- “do more publicity about adult abuse”
- “widespread advertising of contact details of the telephone numbers to report suspicion of adult abuse”
- “a confidential helpline”

The Board has met all actions set out in its Communication Plan:

- Targeted work with adult social care on hate crime and we can now demonstrate there have been 13 reports identified relating to hate crime in this year compared to zero reports in the previous year.
- Held a Keep Safe Week during February 2017 joint with safeguarding children, which targeted information at service users, carers, patients, public and staff.
- Held a safeguarding campaign in which we raised awareness through information boards across the Borough, in newsletters, and posters in public and Council buildings.
- In conjunction with the Service User, Carer and Patient sub-group of the Board the Council developed a film on the types of abuse and what happens when you do report abuse or neglect.

Films can be accessed here: <http://www.enfield.gov.uk/safeguardingadults>

We want to make sure reporting abuse is accessible. In 2010 we set up the Enfield Adult Abuse Line, a single point of contact available 24/7 to report abuse ☎ 020 8379 5212.

We are seeing not only professionals using this number, but self-referrals, and reports by family, friends and neighbours.

6. THE DIFFERENCE TO ADULTS AT RISK OF ABUSE

CASE STUDY A

A woman with learning disabilities living in a care home had an altercation with her mother during a visit. Staff at the care home raised this as safeguarding to the Multi-Agency Safeguarding Hub, who contacted the local authority who placed her in Enfield. A mental capacity assessment was undertaken by her social worker who found she was unable to contribute to the safeguarding process. As a result, a best interest decision was made working together with the local authority who placed her in the Enfield area, and a safeguarding enquiry took place which balanced risk with choice; specifically, this considered how to enable this woman to continue her relationship with her mother but in a way that did not result in physical or emotional harm.

Following the enquiry, the Court of Protection has been approached to ensure safe contact between mother and daughter, respecting their right to family life while minimising the risk of abuse.

CASE STUDY B

An elderly man was referred to the Multi-Agency Safeguarding Hub as there were concerns about self-neglect and the disrepair and clutter in his home environment. Although there were risks involved in living in the home environment, the Adult was very clear he wished to remain living at home and had capacity to make this decision. The MASH Team had to work with partners to minimise these risks and importantly took the time to build a rapport with him. The allocated Social Worker spent time with the Adult, identified small steps towards managing the cleaning and repairs of his home, and sought his views and consent in deciding actions.

Because of the work done in the MASH the Adult agreed to have a blitz clean and his heating and hot water is being repaired. Importantly, there was strong link with the London Fire Brigade and appropriate equipment is in place to minimise the risk of fire. The Adult has agreed to ongoing support from Adult Social Care to focus on his continued wellbeing.

Following the abuse of patients with learning disabilities at Winterbourne View, there has been a national priority to reduce the use of in patient Assessment and Treatment Units, to reduce length of stays for in patients and to develop the right support locally so that people can receive high quality health and social care services in their local communities. This is a key priority for Enfield and at mid-February 2017, there were 5 people receiving inpatient assessment and treatment with a further 4 people receiving a secure forensic service, commissioned by NHS England. These are the lowest numbers in the North Central London Sector. The service is committed to supporting people to live in community living options through robust integrated health and social care support. As a result, 79% of people with learning disabilities in Enfield live in 'settled accommodation' (in their own property or with family). Again, this figure is amongst the highest in London.

7. WORKING WITH CARE AND SUPPORT PROVIDERS

The Board is aware of the number of safeguarding concerns being raised in relation to care and support providers, particularly residential homes, nursing homes and domiciliary care providers. There are several ways the Board works to improve this area and have oversight over the quality of local care and support services.

SAFEGUARDING INFORMATION PANEL

The Safeguarding Information Panel (SIP) is a partnership of organisations (including Care Quality Commission, Police, Clinical Commissioning Group, Immigration Enforcement Agency and Adult Social Care) who share information and early warning signs. This is done so that we can together to identify concerns relating to poor care and safety and work to prevent this through targeted actions. The Panel focuses resources so that we can reduce duplication and importantly keep people who use services safer from abuse and neglect.

Examples of the work we did over the last year:

- Initiated the provider concerns process ten times where safety and quality were in such a poor state that we needed to help keep service users safe
- Had our quality checkers visit ten providers to collect feedback from those who use services
- Our nurse assessor went out on targeted visits to eleven providers to look at areas such as medication and pressure care. We use this as indication of the provider's ability to create a safe environment
- Completed out of hour spot checks unannounced to twenty locations, to see care during nights and weekends
- Asked colleagues in immigration enforcement to conduct checks with four providers, helping to assure those working have the correct documents and clearances
- Three occupational therapy visits focused on safe moving and handling and equipment
- Detailed visits by contract monitoring to eighteen providers.

"The Care Quality Commission (CQC) meets with Enfield Safeguarding Information Panel (SIP) every six weeks. The main purpose of these meetings is to share information about services we have concerns about. Information from these meetings proves very useful to inspectors on an on-going basis. It has helped inform our approach to planning inspections and enabled us to take action when significant concerns are present."

CQC Representative on the Safeguarding Information Panel

Going forward the SIP is looking at additional approaches to integrated quality monitoring which will help triangulate the work being done by partners.

PROVIDER CONCERNS PROCESS

The Provider Concerns Process is led by Enfield Councils Strategic Safeguarding Adults Service but is only possible with the strong support of organisations such as the Care Quality Commission, Enfield Clinical Commissioning Group and many others. A provider concern is triggered when there is an indication that a service has an area or number of areas working below the standard expected and there is a risk to the health and well-being of residents. The provider concerns process can be instigated to both prevent abuse from occurring and improve standards of care, or where abuse has occurred and actions must be taken to protect residents.

The aims of the provider concerns process are to:

- Ensure the safety, dignity and care to those who use the service of the provider;
- Ensure that the customer is at the heart of the process;
- Share information appropriately to enable effective partnership working;
- Facilitate interventions where appropriate to gain assurances that the quality of care is improved;
- Take robust action in instances where a crime has been committed or to protect the wellbeing of those who use services.

"the work undertaken is strong evidence of agencies co-operating and collaborating to improve outcomes for those who use services"

Provider Concerns Chair

Working together means recognising that no single agency can alone respond or improve the quality of care within a provider. Each organisation has its own remit, focus and skills, which together, has the potential to contribute to creating the best possible outcomes within a care provision.

During 2016/17 we worked with 17 providers under our provider concerns process. We found that nursing homes disproportionately came under this process as compared to domiciliary care or residential care homes. Engagement with those who use their services, their families and representatives, is essential and runs through the work we do.

CASE EXAMPLE

Through an internal audit of their services a manager identified concerns about how medication was being provided to individuals, as well as how senior staff check on the quality of care. The manager reported this to Enfield Council and the provider concerns process started. By working together and looking at all parts of the service and how it functions, an improvement plan was developed by the Provider to make the service better. Managers and staff were given the space and time to make these changes. An external auditor was brought in to check that medication was improved and suggested what needs to be in place in the future. The Strategic Safeguarding Adults Service in the Council wrote to all those who used the service for feedback and received positive comments. This identified that the support staff were caring, but the systems and processes needed to be improved. Through the work of the Provider and its staff, these improved significantly and following a Care Quality Commission inspection were rated 'good.'

"I found the process extremely helpful and supportive. The process worked with the team to identify high risk areas, and develop a robust risk assessment to improve standards. Our service was able to obtain commissioned training within short timescale, and high level management support and understanding as a result of the provider concerns process."

Manager of the Care Provider

8. QUALITY ASSURANCE

The Strategic Safeguarding Adults Service in the Council complete practice audits every three months. There are several areas we focus on but how we keep the adult at risk central to decision making and how we support them to achieve their outcomes is always a key area. We also have an external audit every year to give an independent view of our practice.

Our internal audits so far have found:

- Most cases have demonstrated excellent practice, where over 90% of adults in the cases viewed had their outcomes identified at the beginning of the process
- In over three quarters of cases we support the adult to have their outcomes fully met
- We also found that at the end of the safeguarding process people felt safer
- Range of partners now undertaking enquiries, including Health, Providers and the Police.

What we want to focus on going forward:

- That cases do not drift and reasons for delays are recorded
- That for cases which did not progress under safeguarding we still consider how to promote well-being and provide the right information and advice
- That outcomes are reviewed in the middle of the process where possible, as what a person may want can change over time
- About two thirds of people have mental capacity assessments recorded as separate documents and we want to see this number increase.

Our audits make a difference to practice by identifying what areas we need to focus on improving; We share this information with managers and front line staff so together we can find ways to change practice, recording or templates to support the actions we take.

We undertook an additional review of our single point of contact to report abuse, the **Multi-Agency Safeguarding Hub**, in July 2016 this was undertaken by an independent person. The review found in summary:

- The MASH would benefit from renewed and refocused senior strategic interventions, with overview from the Safeguarding Adults Board
- No recommendations about practice; the MASH offered an expert and Care Act compliant triage, information gathering and initial enquiry service to adults at risk
- Recording was of a high standard
- There was significant workload pressure on staff and supervisors trying to maintain excellence with an increasing number of referrals
- Improvements in data collection and management
- Improvements in partnership overall but some work with acute hospitals and mental health partners still needed.



Following several recommendations, the following has been put in place for the service:

- Skill base of staff identified for mental health referrals, with training available and process in place for when we refer on cases
- Identified the support the service needed to manage the concerns coming in
- Training was given to teams which support the MASH
- A clear pathway in place for when we need to escalate concerns within the Police
- Started a review of the resources needed for the service to effectively deliver
- Helped all members of the service access partner system where required
- Have in progress a way to manage issues coming into the MASH which do not indicate abuse or neglect but are about adults who may need additional support or interventions.

Finally during October 2016, the Local Authority commissioned an external audit of 25 cases which progressed under safeguarding, as this independent challenge is welcomed. The auditor will be presenting these findings to adult social care, who will report to the Board on this in the coming year.

QUALITY CHECKER PROJECT

The Quality Checker project recruits, trains and supports a team of service user and carer volunteers to engage with social care clients, to gather meaningful feedback on the quality of the services they receive support from.

Many projects were completed over the year and include:

A. REVIEW OF THE ADULT ABUSE LINE

The Quality Checker volunteers made mystery shopping calls to the dedicated LBE Adult Abuse line. This was done to test the call handler's knowledge and skill in managing allegations of abuse received from members of the public. The calls made covered a wide and varied range of types of abuse and key elements of the call handler's responses were recorded. The findings of all calls were used to develop a comprehensive report highlighting good practices noted and recommendations for improvements as appropriate. The report was shared and welcomed by the Managers of the service. All recommendations for improvement were accepted and implemented. This has directly improved the following;

- Safeguarding information appropriately being escalated to the Multi-Agency Safeguarding Hub
- Improved customer experience for people raising concerns
- Adult Abuse line handlers have refreshed skills to manage incoming calls
- Independent audit of Adult Abuse Line recorded and improvements monitored.

B. IMPROVING HYDRATION IN CARE HOMES PROJECT

The Quality Checker project worked in partnership with a multi-disciplinary working group to support good practices that will improve hydration in care homes. The Quality Checker project volunteers conducted visits to twenty care homes and gathered feedback from residents and staff; this included how they support residents to remain hydrated and offer residents choice and control about their preferred foods and drinks. A report was developed to demonstrate the findings of the visits and from this a 'Hydration Toolkit' was designed to be distributed to all care homes in the borough. A hydration card is wallet sized and offers key information to identify and prevent dehydration. The project has made the following improvements:

- Report developed to highlight practices used to support hydration in care homes and good practices shared
- Hydration toolkit developed to ensure providers have accessible information for all staff to prevent dehydration
- Monitoring in place to measure the impact made by distributing the Hydration Toolkit information.

C. THE QUALITY CHECKER PROJECT AND HEALTHWATCH WORKING IN PARTNERSHIP

The Quality Checker Project and Healthwatch are working cohesively to ensure they can maximise the benefits of each projects resources. Co-produced training, awareness raising and volunteer recruitment events are arranged jointly and appropriate information is shared to support the work of both projects. This helps to ensure the service user and carer voice is heard at strategic forums. In addition, the CEO of Healthwatch is the Independent Chair for the Quality Checkers specialist Dignity in Care Panel, helping to make sure the panel operates effectively and reviews of the Council's services are independently scrutinised. Healthwatch and the Quality Checker project will be conducting peer reviews/audits of each other's organisations processes and ways of working. This will further support service development improvement in line with the dignity standards they work to uphold.

9. SAFEGUARDING ADULT REVIEWS

Section 44 of the Care Act 2014 states that a Safeguarding Adults Review (SAR) must be arranged by the Safeguarding Adults Board when an adult in its area dies because of abuse or neglect whether known or suspected, and when there is concern that partner agencies could have worked more effectively to protect the adult. A SAR must also be arranged if an adult has not died but it is known or suspected that the adult has experienced serious abuse or neglect. It may be useful to note that Safeguarding Adult Reviews were previously known as Serious Case Reviews.

The Safeguarding Adults Board had one SAR which concluded during the financial year. This case is set out in more detail below and the learning identified.

In addition to the concluded review, there has also been the following:

- One review was agreed in January 2016 and is a thematic review of domestic abuse and safeguarding. The thematic review started in March 2016 and is being presented in November 2017 to the Safeguarding Adults Board.
- One review was agreed in January 2016 in response to a serious sexual assault. The review is still in progress but actions have already been taken with the provider and several Local Authorities, Clinical Commissioning Groups and other partners to embed changes from immediate lessons learnt.
- One review was agreed in September 2016 in response to how partners provided care and treatment to a man with learning disabilities. This review is in progress and is expected to be reported on in 2017/2018.
- One review was agreed in January 2017 following a fatal fire. This review is in progress and is expected to be reported on in 2017/2018.



There were three additional cases brought to the Safeguarding Adults Board to see if a review should be started. In one case an independent person had already undertaken an enquiry and found lessons to be learnt, so the Panel asked for the recommendations and how they have been put in place to be shared for their overview. In a second case a referral was received which only had identified failings by a single agency and was not about how agencies worked together; this case would continue under a single safeguarding enquiry to assist in coming to a resolution. A third case, regarding a provider, did not meet the criteria for a review but the Board recognised that further investigation would be helpful and requested the Clinical Commissioning Group undertake this.

CONCLUDED SAFEGUARDING ADULT REVIEW

FOLLOWING DEATH OF 'MS K' AN ADULT AT RISK

A multi-agency partnership review was agreed to consider the organisational learning for the agencies involved with Ms K following her death and to undertake this learning on a collaborative basis. Ms K was unknown to any services prior to her death and the reason for this review was to reflect on how as a partnership we could work together to hold person alleged to have caused harm to account once an adult at risk dies.

Five organisations came together and wrote out a chronology on their involvement with Ms K from the day she died and the actions they took together when there were concerns about neglect having contributed to her death. A roundtable event was held and collectively partners agreed what alternative outcomes they wished to achieve and what as single agencies or as a partnership we can do to accomplish these outcomes.

The key learning points are set out below:

- All partners can be empowered to report to the Police where a crime is believed to have been committed.
- Where concerns about abuse or neglect exist the death certificate should be thoughtfully considered before completion. This learning was shared with the General Medical Council as it has national relevance.
- Any partner can escalate concerns to senior managers where they feel an organisation has not taken all actions necessary once a concern is reported.
- Timely sharing of information in safeguarding is key to assessing risk and can assist partners, such as Police or Coroner, to take action against persons alleged to have caused harm.
- Importance of equipping staff with the knowledge to undertake safeguarding in complex cases which may involve a crime. Whether as the referrer, co-ordinator of safeguarding or for Police Officers whom undertake investigations.
- Everyone, including members of the public, need to know how to report concerns about adults at risk.

The Safeguarding Adults Review report is a published document which can be found on the safeguarding adult board pages on www.enfield.gov.uk. The action plan is monitored via the Safeguarding Adults Board.

10. LEARNING DISABILITIES MORTALITY REVIEWS

The Integrated Learning Disabilities Service (ILDS) has traditionally reviewed all deaths of adults with learning disabilities in Enfield. This work has been led by our End of Life Steering Group with oversight from the ILDS Governance Meeting. The Steering Group has developed some excellent end of life planning workbooks for both people with learning disabilities and their carers. The Steering Group has also undertaken some innovative work with care providers on supporting staff with loss and bereavement.

In 206/17 there were 8 deaths of people with learning disabilities. Of this number 4 had end of life plans and died at home as set out in their plan. The remaining 4 people died in hospital without end of life plans in place. The Steering Group produces an end of life report, with the report for 2016/17 being available shortly.

In June 2015, NHS England, the Healthcare Quality Improvement Partnership (HQIP) and the University of Bristol announced the world's first national programme to review and ultimately reduce, premature deaths of people with learning disabilities. This project will be the first comprehensive, national review set up to understand why people with learning disabilities typically die much earlier than average, and to inform a strategy to reduce this inequality.

As from the 1st April 2017, all NHS and Local authority bodies are required to notify and review all deaths of children (4-17) and adults (18+) in their area. A local process in Enfield has been established which builds on our previous best practice in mortality reviews. Learning from the reviews will be collated nationally and locally, with local learning being reported to the SAB, the Local Authority and Clinical Commissioning Group in the Annual End of Life Report. Review training is being provided by NHS England and the ILDS will have 10 trained review staff from across the service. Information on the programme is available at www.bristol.ac.uk/sps/leder/easy-read-information



11. WHAT WE WILL DO NEXT YEAR

The Safeguarding Adults Board have a business plan for each year, which sets out what actions we will take. This can be found in section 11.

While we have a three-year strategy from 2015-2018, we review the specific actions on an annual basis to ensure they remain relevant to any national changes, local themes emerging and importantly from feedback from those who use services, carers and local people. During the review this year the feedback and suggestions provided were:

- To seek assurance that local colleges / universities are supporting adults with care and support needs to report if they have been abused.
- With an increase in reports being recorded as hate crime, for strengthened work between the Multi-Agency Safeguarding Hub and Hate Crime Forum.
- Use the new safeguarding film in training.
- Continue to drive forward publicity and communication for safeguarding, so that everyone in Enfield knows how to recognise and report adult abuse.
- Additional action to be taken to address high reports of concern within care providers.
- Continued focus on raising awareness and for organisations to understand when to report as a concern and when to call Police in emergencies.

In addition to these suggestions we look at the performance information to help identify where we should focus our work. We found this year that there continues to be a high proportion of abuse in care providers and considered this against Care Quality Commission information. As a result, our Quality, Performance and Safety sub group of the Board will do a focused piece of work on what as a partnership we can do to assure ourselves of the safety in the provider market.

We found that some types of abuse are now being recognised more readily than before. This includes hate crime for example, so we will look at individual cases raised to reflect on our response in these cases and identify any organisational learning. Our data presented was also inconsistent and much effort was taken to ensure it presented an accurate reflection of the practice; as a result there will be specific assurance taken in the coming year on consistency of practice and recording across the Local Authority and Mental Health Trust.

Through joint work with the Safeguarding Children Board, Safer Strong Communities Board and partners such as Public Health, the Board is considering a wider scope of issues. This includes modern slavery, preventing suicides and domestic abuse work with perpetrators. We will continue in the coming year to strengthen this joint work and develop a memorandum of understanding, so that we work together in the most efficient way.

12. ACTION PLAN

2017-2018

Objectives set out by the Safeguarding Adults Board are set out below. The actions to achieve these and responsible individuals can be found on the full documents reported at each quarterly Board meeting. These can be accessed on the Safeguarding Adults Board pages at www.enfield.gov.uk

KEY PRIORITY 1: EMPOWERMENT

OUTCOMES	INDICATORS	LEAD/SUB-GROUP
Guidance available to support staff to deal with specific safeguarding issues.	The SAB is assured that guidance is available for staff which reflects the wide spectrum of types of abuse which can be experienced.	Quality, Safety and Performance
Continued improvement in data which identified that adults at risk have appropriate access to advocacy.	Board has assurance that individuals experiencing safeguarding have access to the appropriate advocacy service. Project within London Borough of Enfield Health, Housing and Adult Social Care on advocacy development.	LBE HHASC Service Development
Supporting young carers to understand safeguarding and how to report.	Known young carers are engaged and gaps in services to enable them to report abuse are identified.	LBE HHASC Service Development
Partners working to the ethos of Making Safeguarding Personal.	The SAB is assured partners have active plans to embed Making Safeguarding Personal which take into account regional 'temperature checks' and best practice.	SAB Partners

KEY PRIORITY 2: PROTECTION

OUTCOMES	INDICATORS	LEAD/SUB-GROUP
Adults at risk are supported by the partnership to report abuse and neglect to the extent that they want.	Feedback from adults at risk through face to face interviews or online mechanisms used to give assurance to the SAB.	LBE HHASC Strategic Safeguarding
People at risk of abusing have access to support to prevent abuse or reduce risk of repeat abuse.	The SAB will aim to enable protection of adults at risk through addressing perpetrators of abuse in a clearer and more consistent approach.	LBE HHASC Strategic Safeguarding Adults

KEY PRIORITY 3: PREVENTION

OUTCOMES	INDICATORS	LEAD/SUB-GROUP
Quality and safety in care providers addressed through multi-agency efforts to reduce safeguarding provider concerns.	The SAB is assured that partnership response with providers provides early identification and reduces need for safeguarding interventions.	Quality, Performance and Safety sub-group
Board meeting have partnership data which helps to find themes and trends to enable the Board to take action.	All partners contribute validated data to the Board for quarterly meetings.	SAB Partners Quality, Safety and Performance sub-group
Communities as a whole play their part in identifying abuse and we can evidence calls being made to report it by local people and service users.	The SAB reviews the effectiveness of the communication through performance and data trends and considers new ways to communicate to raise awareness.	Service User, Carer and Patient sub-group

KEY PRIORITY 4: PARTNERSHIP

OUTCOMES	INDICATORS	LEAD/SUB-GROUP
Evidence of service user, carer and patient engagement in Board and partner organisations development.	SAB is assured that adults at risk have a voice in how services are developed and both the Board and partners can evidence this in self-assessments.	Quality, Safety and Performance sub-group Service User, Carer and Patient sub-group
Colleges are confident in raising concerns and we can see this being done through data.	Colleges are able to access appropriate safeguarding training so that they can support adults to raise concerns appropriately.	Learning and Development sub-group
Continued progress with number of hate crimes being recorded under safeguarding.	The Multi-Agency Safeguarding Hub and Hate Crime Forum to strengthen links so that cases referred under safeguarding can be supported by the forum.	(HASC) MASH and Community Safety Unit

KEY PRIORITY 5: ACCOUNTABILITY

OUTCOMES	INDICATORS	LEAD/SUB-GROUP
Board has evidence of how it has been audited against statutory requirements and action plans in place to address gaps.	The SAB will be assured that there are adequate quality assurance processes in place for organisations.	Quality, Safety and Performance sub-group
Learning outcomes from Safeguarding Adults Reviews are sustained within organisations.	The SAB is assured that learning identified in statutory Safeguarding Adults Reviews are followed through, that actions are complete with evidence provided, and that these are sustained.	SAB Officer
We can evidence the number of cases which went to prosecution and access to the justice system for adults at risk.	Board will assure itself via Police colleagues that the decision to proceed under safeguarding and leading to prosecution is transparent.	Enfield Police
Language of professionals to be simplified so that there is an improved access to services (as recommended by Making Safeguarding Personal).	Partners on Board to identify service users to be able to 'mystery shop' their services to audit language.	All SAB Partners

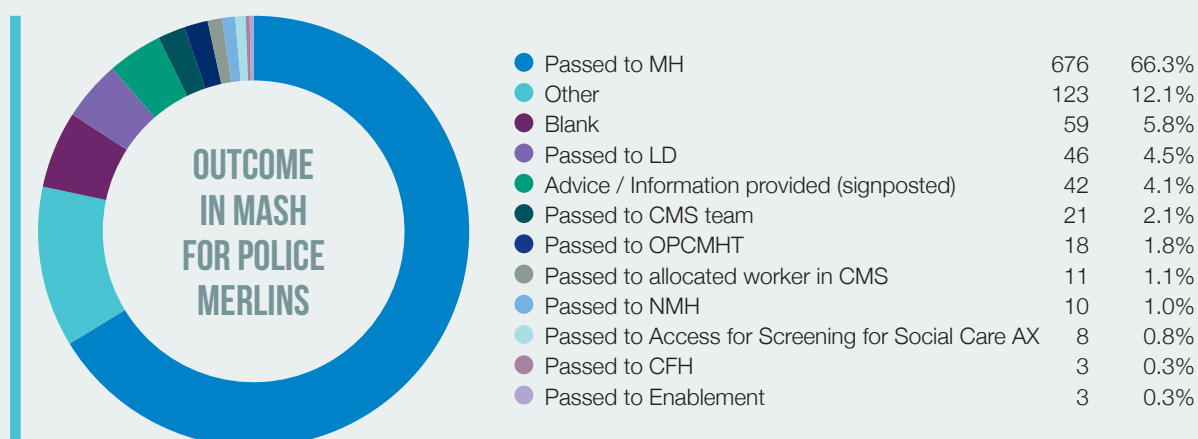
KEY PRIORITY 6: PROPORTIONALITY

OUTCOMES	INDICATORS	LEAD/SUB-GROUP
People at risk of abusing others access support to prevent abuse or reduce repeat victimisation.	Board will facilitate a pathway programme in place for people at risk of harming others.	LBE HHASC Strategic Safeguarding
Feedback from adults at risk confirm that they feel safe and have a positive experience of care and support.	The SAB will seek assurances that safeguarding interventions are appropriate and we embed learning direct from those who have been harmed.	LBE HASC Safeguarding with support BEH MHT for mental health cases under safeguarding

13. PERFORMANCE REPORT 2016-2017

POLICE MERLINS

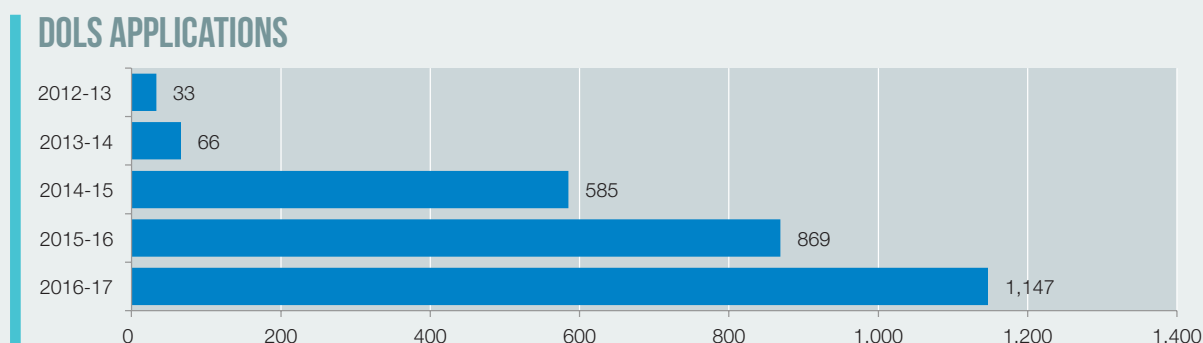
There were 1,020 Police Merlins recorded with MASH during 2016-17 (1,602 in 2015-16). Of these, approximately two thirds (66.3%) are passed to mental health, which is a rise on last year (56.3%).



A Merlin is not always safeguarding; The Merlin Database is the recording system the Metropolitan Police utilise to record missing people, and children and adults coming to police notice. This system is used to record contact and what, if any action has taken place. Officers and police staff are trained to identify vulnerability through the use of the MPS Vulnerability Assessment Framework.

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

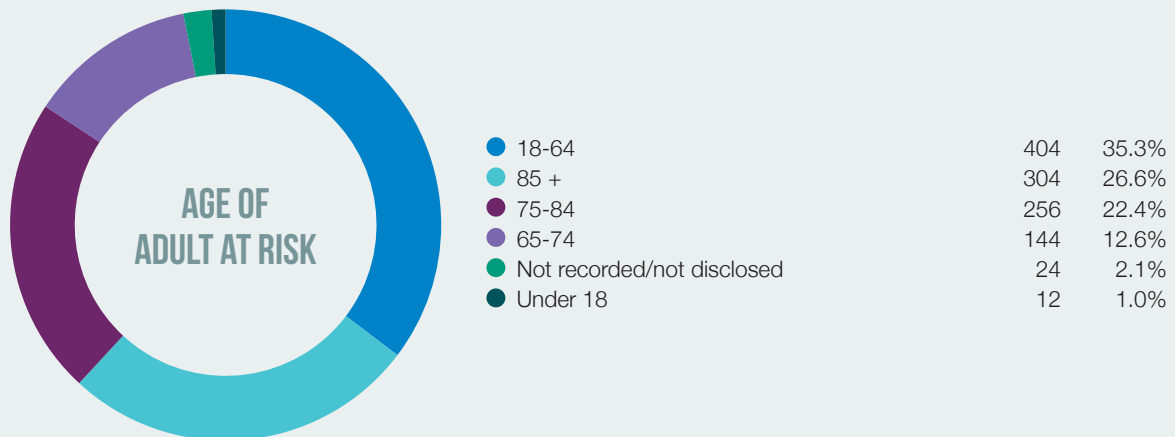
According to our Covalent system, there were 1,147 DoLS cases in 2016-17, of which 1,061 (92.5%) have been completed. This reflects a growing trend in DoLS cases as can be seen below.



SAFEGUARDING CASES

There were 1,144 total safeguarding concerns raised to Council: a slight fall on 2015-16 (1,244). Of these:

- **652** were female
- **12** were under 18 years of age, although 304 were aged 85+
- **281** safeguarding cases did not meet Section 42 criteria
- **78** cases required further information gathering
- **2** cases were passed to mental health colleagues
- **771** cases met the section 42 criteria

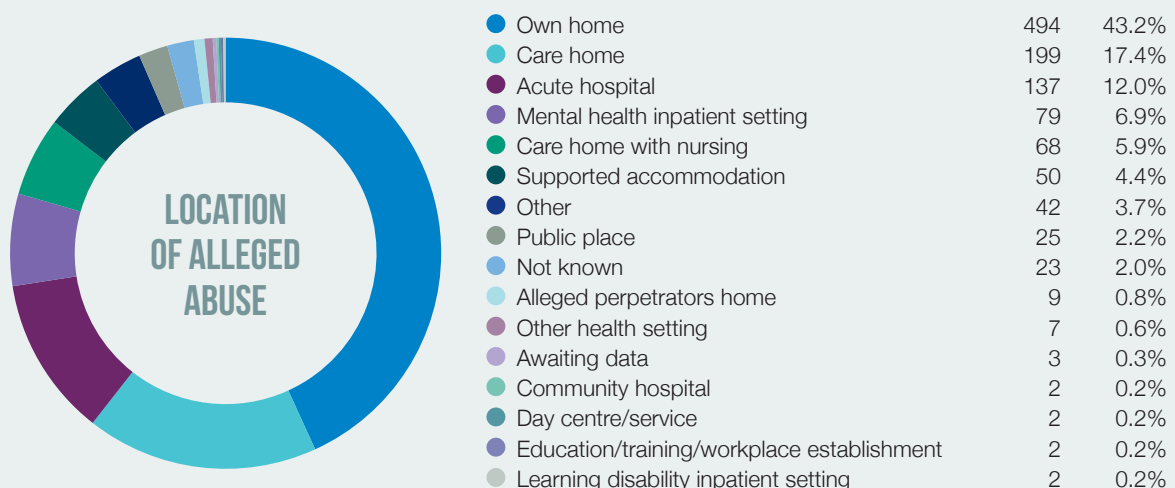


There are a significant number of groups and persons who have raised concerns, with the three organisations or persons who raised the most safeguarding concerns being:

- Hospitals: **259**
- Residential care homes: **116**
- Social care staff: **100**

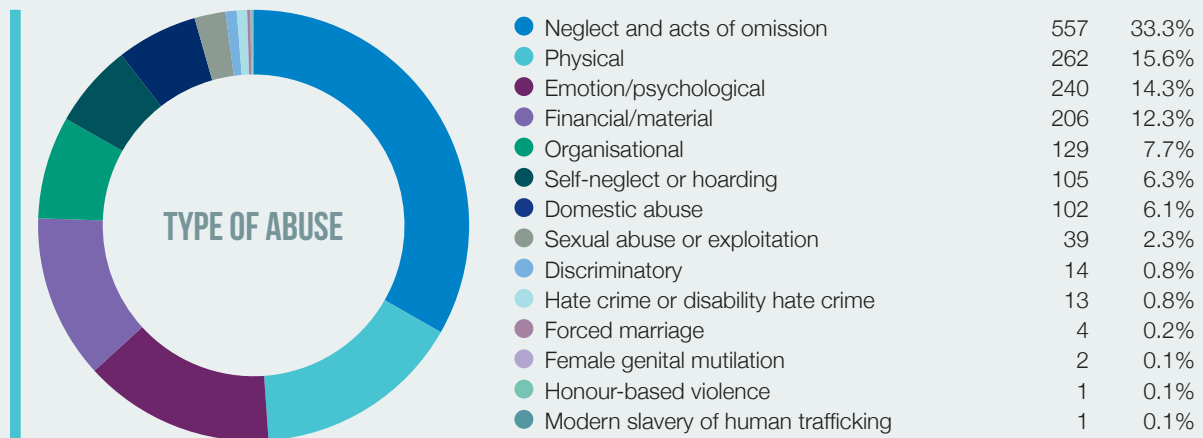
LOCATION OF ALLEGED ABUSE

The most common location for the alleged abuse to occur is in the home (494). This is more than the next three highest categories combined – care homes (267), acute hospital (137) and mental health inpatient setting (79) and also represents an increased proportion of cases when compared to last year (43% this year against 37% in 2015-16).



TYPE OF ABUSE

Neglect and acts of omission is by far the most common form of alleged abuse (557 allegations), more than double the next category (Physical abuse – 262). In fact, over 75% of all allegations relate to just four categories (Neglect and acts of omission; Physical; Emotion/psychological and Financial/material).



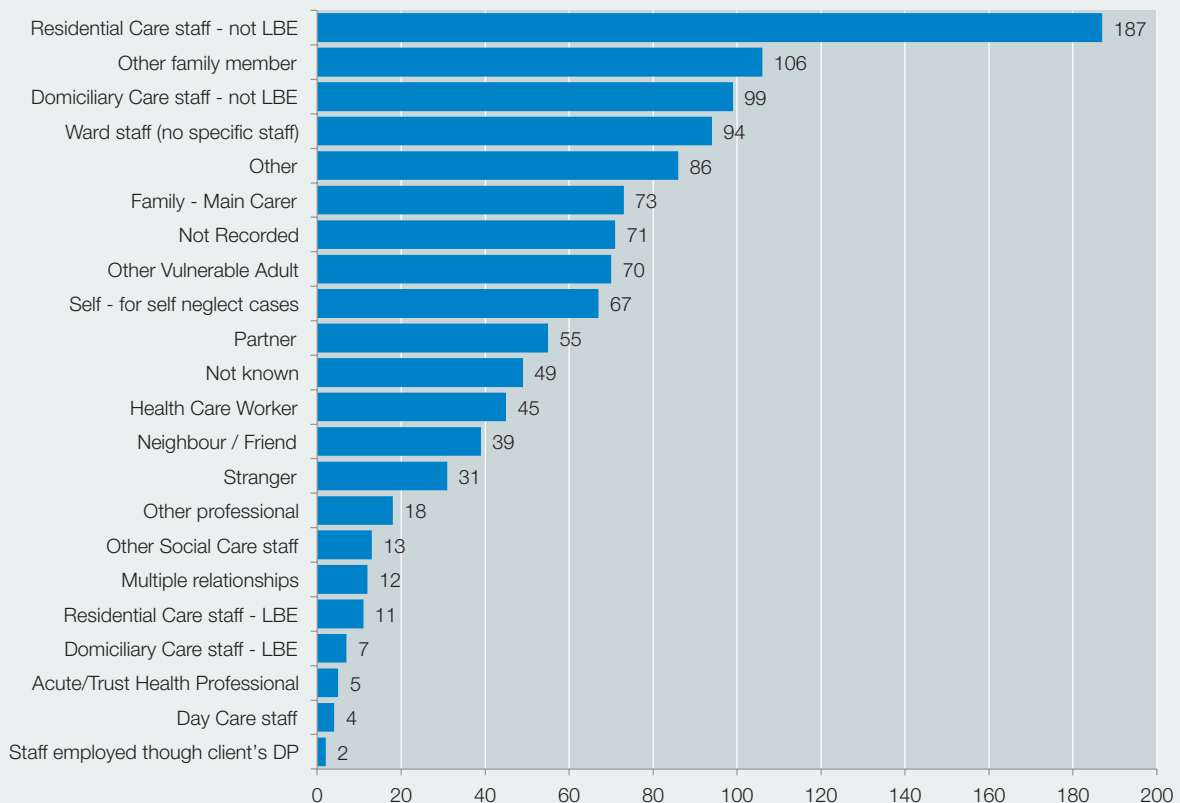
*There can be more than one form of abuse so numbers do not add up to all 1,144 cases.

RELATIONSHIP TO ADULT AT RISK

When looking at the alleged perpetrator and their relationship to the vulnerable adult, there are a wide number of possible relationships. The three most common, which together represent over one in three of all alleged perpetrators, are:

- Residential Care staff – not LBE: **187 cases**
- Domiciliary Care staff – not LBE: **106 cases**
- Other family member (not main carer): **106 cases**

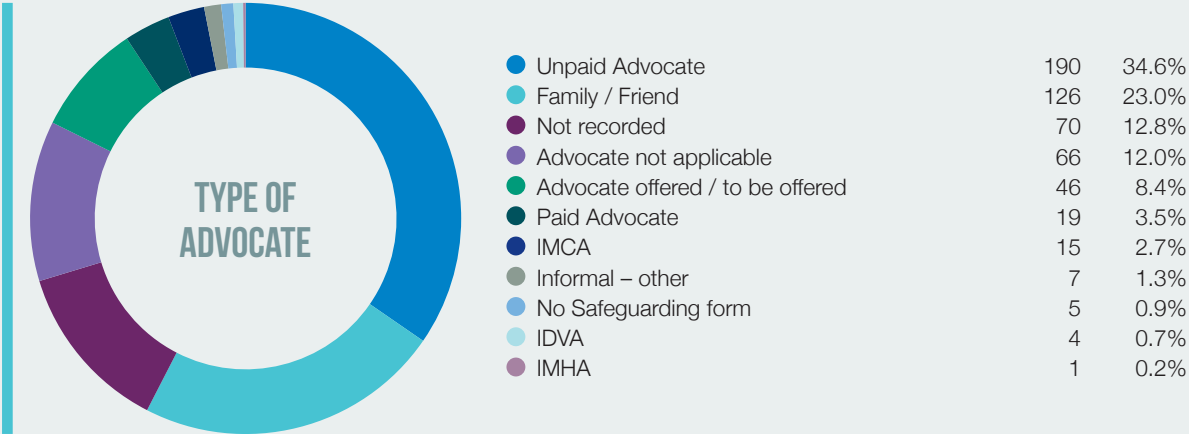
RELATIONSHIP TO ADULT AT RISK



OUTCOMES FOR S42 CRITERIA MET AND COMPLETE CASES: 549 RECORDS

Of the 1,144 safeguarding concerns raised, 549 have both met the S42 criteria and been completed. These cases are analysed below.

Of these 549 cases, 190 (34.6%) had an unpaid advocate and a further 123 (23%), Family/Friend was the advocate. Together with those cases where the type of advocate was not recorded (12.8%) or not applicable (12%), these represent over 80% of all the types of advocate.



OUTCOME FOR PATCH

The three most common outcomes for the PATCH (Person Alleged To have Caused Harm) are:

- Continued monitoring: **161 cases**
- No further action: **127 cases**
- Not known: **82 cases**

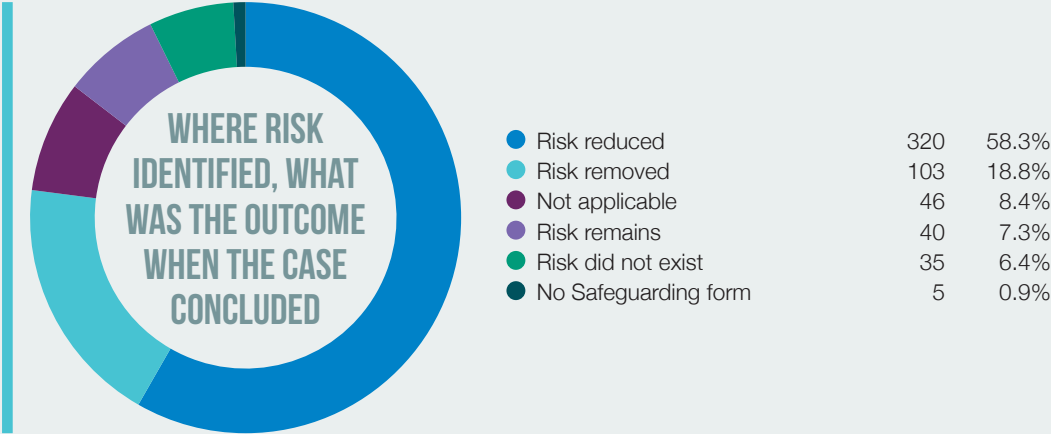
Together these represent over two thirds (67.3%) of all outcomes for the alleged perpetrator.



RISK OUTCOMES

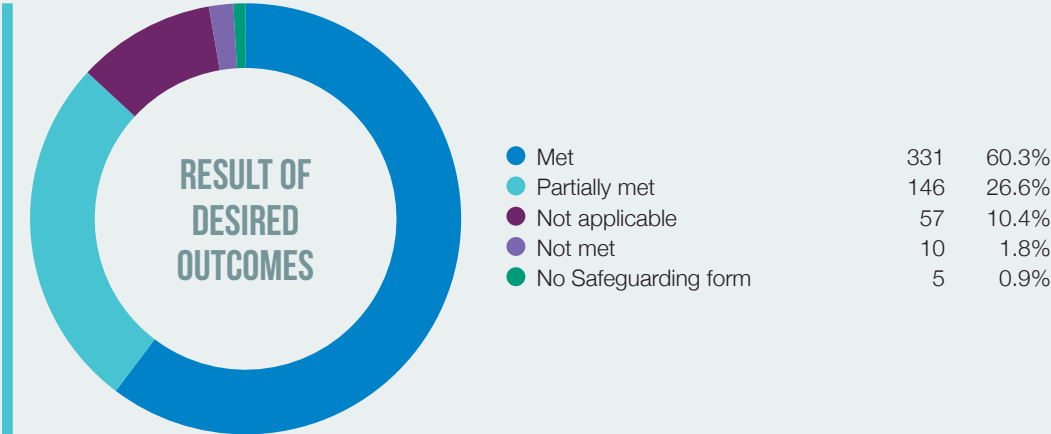
When looking at where a risk was identified, what was the outcome when the case concluded; it is clear that we are successfully reducing risk.

Where applicable, and where a risk existed, over 9 in 10 cases (90.4%) saw the risk reduced (68.4%) or removed (22%).



EVALUATION BY ADULT AT RISK — WERE THE DESIRED OUTCOMES MET?

Where applicable, 97% of adults at risk said their desired outcomes had been met (67.3%) or partially met (29.7%), which is an extremely positive result.



14. PARTNER STATEMENTS

BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST

OVERVIEW 2016-17

Barnet, Enfield and Haringey Mental Health NHS Trust remains committed to safeguarding all our service users, their families and carers. Our Safeguarding Strategy and associated three year work plan reflects our commitment and drive to ensure effective safeguarding is a shared responsibility both at a local level and with partner agencies. We strive to continually improve systems and processes; and to develop a clear strategic approach to safeguarding across all our services. Our commitment to safeguarding is reflected at Executive Board Level and the Executive Director of Nursing, Quality and Governance is Chair of our Integrated Safeguarding Committee.



The London Multi-Agency Safeguarding Adults Policy and Procedure has been substantially revised and was launched in February 2016. It has been adopted across London and our Trust Safeguarding Adults at Risk Policy has been updated in line with the procedures, ensuring the Care Act 2014 principles and Making Safeguarding Personal (MSP) approach is reflected. We have worked hard to raise awareness of safeguarding, particularly in regard to new categories of abuse such as self-neglect, hoarding and modern slavery.

The London Multi-Agency Safeguarding Adults Policy and Procedure has been substantially revised and was launched in February 2016. It has been adopted across London and our Trust Safeguarding Adults at Risk Policy has been updated in line with the procedures, ensuring the Care Act 2014 principles and Making Safeguarding Personal (MSP) approach is reflected. We have worked hard to raise awareness of safeguarding, particularly in regard to new categories of abuse such as self-neglect, hoarding and modern slavery.

SAFEGUARDING ADULTS WORK UNDERTAKEN AND KEY ACHIEVEMENTS IN 2016-17

- We have been successful in securing funding from NHS England to pilot a domestic abuse project which aims to demonstrate the need for Independent Domestic Violence Advisors in mental health settings.
- Domestic Violence and abuse training is provided for all staff at Corporate Induction and this is reflected in our referrals to domestic abuse agencies which continue to rise.
- We have improved oversight of data relating to safeguarding activity across the Trust enabling greater oversight and shared learning.
- We have updated and refreshed our safeguarding patient information leaflet using an easy read format.
- We have developed a supportive safeguarding information packs for staff.
- We have worked closely with the patient safety team and patient experience to ensure a triangulated approach to safeguarding.
- We have raised the profile of PREVENT across the organisation and Healthwrap3 training is included for all staff at their Corporate Induction.
- We have worked closely with the local Channel Panels to ensure information regarding concerns relating to potential radicalisation are shared effectively.
- We have mapped our level 3 safeguarding adult training requirement against the Intercollegiate Document for Safeguarding Adults 2016 and offered to all mental health teams.
- Level 1 and 2 safeguarding adult training of 85% or above consistently achieved.
- Effective partnership working across the three boroughs of Barnet, Enfield and Haringey has continued.

KEY CHALLENGES

The difficulties of collecting accurate meaningful data are recognised and we continue to work with partner agencies to overcome these challenges.

STATEMENT WRITTEN BY:

Ruth Vines, Head of Safeguarding on behalf of Mary Sexton, Executive Director of Nursing, Quality and Governance

ENFIELD CARERS CENTRE

ECC supports all carers, wherever they are on their caring journey. We provide a safe, confidential space for carers to help them deal with whatever they're going through. We also offer a holistic range of services such as: peer support groups, counselling, training and information workshops, carers social and leisure breaks.

Family and unpaid carers provide a vital role that is often unrecognised and unappreciated. It was recently estimated that carers save the UK economy over £132billion (Carers UK Valuing Carers Report 2016). Enfield Carers Centre (ECC) believes that carers have a right to enjoy a life outside caring and be well supported while they care for their loved one(s). We also understand that carers don't necessarily choose their caring role and sometimes caring responsibilities bring with them unwanted emotions and unexpected stress that can negatively impact on a carer's life. We recognise that carers can sometimes be victims of difficult and challenging behaviour from their loved one and conversely, sadly pushed to the end of their tether when insufficient support is available to them or their cared for person.

ACHIEVEMENTS DURING 2016-17

- Active member of Enfield Safeguarding Board
- Reviewed and updated ECC Safeguarding Policy
- Circulation of Carers Keep Safe Guide
- Carer-specific event during Keep Safe Week in February 2017
- Completion of self-assessment of safeguarding
- Attendance at North Central London Challenge and Learning Event
- All Staff attended a safeguarding training session
- Raised safeguarding concerns as appropriate/brought to our attention by or on behalf of carers

ACTIVITIES PLANNED DURING 2017-18

- Embedding of carer related safeguarding training videos onto ECC website
- Refresher safeguarding training for all ECC staff
- Ongoing commitment to continue raising awareness of safeguarding issues among carers
- Carers' Safeguarding Event during Keep Safe Week 2018

STATEMENT WRITTEN BY:

Pamela Burke, Chief Executive, Enfield Carers Centre

ENFIELD BOROUGH POLICE

Enfield Borough Police is committed to making Enfield a safer place to live, work and visit. As a statutory partner on the Enfield Safeguarding Adults Board we continue to work together with partners, communities and local people to prevent harm, abuse and neglect to those at risk. We continue to work in partnership with organisations to prevent offences that target the most vulnerable such as artifice burglary and financial crime.

Senior Police continue to attend the Safeguarding Adult Board on a regular basis and co-chair the Quality, Safety and Performance sub-group. We look forward to continuing this partnership and contributing effectively to ensure that organisations are safeguarding effectively.

ACHIEVEMENTS OVER 2016/17

Enfield Borough Police remain proud to be a partner on the Multi-Agency Safeguarding Hub where we continue to develop our processes to gain greater focus and research into reported adult safeguarding matters. Ethical and proportionate information sharing ensures a partnership led approach to problem-solving, maximising adult safety and the prevention of crime and abuse.

- Focus continues for our front line staff to identify and record safeguarding matters on the MPS Merlin system which is the primary notification channel to strategic partners of risk identified.
- Enhanced ties between police safeguarding units and other crime units such as the Gangs and the Major Crime Unit has been developed.
- Safeguarding training continues to be mandatory for all officers to assist with the identification of safeguarding matters and recording procedures.
- Where cases have been referred for consideration as Safeguarding Adults Reviews, Enfield Police have supported and contributed openly and transparently with all such enquiries in the objective of ensuring best practise identified and areas of development recognised and improved.

ACTIVITIES PLANNED FOR 2017/18

Enfield Borough Police will continue to have safeguarding as a priority across all of the policing activities that we undertake. This be led by Detective Superintendent Tony Kelly who has recently joined Enfield Police and comes with an extensive background of Safeguarding and Public Protection.

- Police will participate at DI and DS level in awareness training on the Mental Capacity Act and Safeguarding with the Local Authority.
- We will continue to develop and contribute to the Multi Agency Safeguarding Hub, with the aim being to capture as many safeguarding adult concerns and referring to appropriate services as possible.
- We will strive to engage with all communities across the Borough to build trust and confidence in the services provided, whilst highlighting the importance of victim care and crime prevention.

STATEMENT WRITTEN BY:

Alison Cole, Detective Chief Inspector, Enfield Police

HEALTH, HOUSING AND ADULT SOCIAL CARE, ENFIELD COUNCIL

Every community has a part to play in recognising and reporting adult abuse. Enfield Council as lead for adult safeguarding is working in partnership to help secure freedom from abuse and neglect for those in the Borough. In collaboration with service users, carer, residents and our partner organisations, we want to stop abuse from happening in the first place.

Enfield Council has lead under the Care Act 2014 for making enquiries or causing others to do so when it believes an adult is experiencing, or at risk of, abuse or neglect. This means that when we are aware of a concern we make contact with the person being abused to establish together what action should be take and by who. Our audits have confirmed that we have sound safeguarding practice, with points of learning to ensure we never remain complacent. “Despite pressure in adult social care with an increasing number of concerns progressing under safeguarding, I can see front line staff and managers continuing to strive for excellence. They are a testament to a profession who want to enable people to achieve the best possible outcomes and wellbeing.” Head of Safeguarding Adults and Quality.

In addition to managing single concerns about individuals, we take the lead on Provider Concerns. This is a process to manage serious safety and care issues in organisations through an enabling approach, while holding providers to account to improve. During the year we worked with seventeen providers and with the support from partners feel confident we are helping those who use services to be safe from abuse and neglect.

First and foremost we aim to work in co-production with those who use services and carers. We demonstrated this through our commitments and ongoing support to the Quality Checker project. Through the dedicated service user and carer volunteers we facilitated checks on services and helped to monitor the changes were put in place.

Some of our accomplishments this year included:

- Joint work with the Clinical Commissioning Group to launch the Deprivation of Liberty Safeguards and Mental Capacity Act Policy with care providers
- Leading the Making Safeguarding Personal conference so that we can continue to provide a person centred approach with innovative approaches to enquiries
- A commitment to Safeguarding Adult Reviews and embedding the learning, which we evidence to the Board
- Improved data collection which focuses on wellbeing, meeting outcomes and whether the person feels safer as a result.

We believe strongly in integration, not only as it can create a more efficient partnership, but above all it is about improving the care and support services an adult at risk experiences. Our focus going forward is on the recovery and resilience of adults at risk of or experiencing abuse and the partnership approach to enable this.

STATEMENT WRITTEN BY:

Bindi Nagra, Assistant Director, Health, Housing and Adult Social Care

HEALTHWATCH ENFIELD

Healthwatch Enfield was established in 2013 to act as the statutory, independent consumer champion for health and social care services in the borough to:

- provide information and signposting to help the local population to navigate the complex systems of health and social care
- develop a local evidence base of public opinion on health and social care
- seek opportunities for local voices of seldom heard communities to be heard at strategic fora and seek improvements to service delivery.

Our role is to amplify the voice of local people on issues that affect those who use health and care services. We actively seek views from all sections of local communities and try to ensure that our priorities take account of the issues raised with us. We believe that patients and local residents:

- should be a key aspect of any approach to quality
- should be listened to and heard
- need information and increased awareness of safeguarding issues.

We are pleased to see that Safeguarding Adults Board have been placed on a statutory footing and that Healthwatch is a member of the Board; this allows us to provide challenge and inject the issues raised by local people into how safeguarding is developed.

Healthwatch Enfield directly contributed to the development of the Safeguarding Adult Board's three-year strategy 2015-2018 as well as the 2017/18 SAB Action Plan. We welcomed the focus on advocacy and asked for additional clarity on performance indicators.

OUR CONTRIBUTION TO SAFEGUARDING 2016/2017

In terms of safeguarding, Healthwatch has:

- supported the work of the Safeguarding Adults Board, to ensure that the patient's/ local people's voice is central to service planning and any case reviews
- had representation on the SAB's Quality Performance and Safety (QPS) group
- ensured that our Board, staff and volunteers are trained to understand and follow up any safeguarding concerns identified by us or raised with us in our work locally
- supported awareness-raising about safeguarding issues amongst our community partners and communities as part of other engagement activities.

A Healthwatch representative also attended the North Central London Challenge and Learning event for Safeguarding Adults Boards. This enabled us to provide positive support for the voice of patients and local peoples to be raised amongst senior members across partner organisations.

Going forward, Healthwatch Enfield intends to continue to support the Board and contribute towards this important area of protecting some of the most vulnerable people from abuse and harm.

STATEMENT WRITTEN BY:

Parin Bahl, Volunteer

LONDON FIRE BRIGADE — ENFIELD BOROUGH

We believe that all residents have the right to be treated fairly, with dignity and respect, and to feel safe from abuse. Through our strong commitment to safeguarding and a keen desire to work in partnership, the London Fire Brigade is acting to ensure abuse and neglect are identified and reported, while preventing harm and minimising the risk.

Our primary aim is to reduce the risk of harm from fire to those most vulnerable within the community. We do this not only be home fire safety visits, but working with partners on the Safeguarding Adults Board to identify those at highest risk and provide the advice and support to improve safety.

Our safeguarding responsibilities include regular attendance at the Safeguarding Adults Board, to provide support and challenge to the partnership so that we can be assured we are effectively responding to the abuse and neglect of adults at risk. The Borough Commander for the Enfield Borough LFB currently sits on the Board, as well as having lead officers contribute to the sub-groups which enable the Board to carry out its duties. We have maintained an active participation in the Safeguarding Adults Board and are proud to be part of a strong partnership that collaborates to improve outcomes for those most vulnerable.

KEY ACHIEVEMENTS 2016-2017

- Attending safeguarding meetings to contribute to the safety planning with partners and adults at risk
- Completing home fire safety visits for those undergoing a section 42 enquiry, so that we can work together to find ways to minimise the risk of fire
- Exceeding our home fire safety assessment target, so that we know that more people in the community have fire safety advice and working fire alarms
- Presenting at the Quality, Safety and Performance sub group of the Board, to help highlight and develop the partnership approach

THE DIFFERENCE WE HAVE MADE TO AN ADULT AT RISK

The London Fire Brigade worked with an gentleman who was bed bound but smoked, placing him at risk of fire. Fire retardant bedding was provided and when this was not being appropriately used and safeguarding partners were in touch, the LFB did another home visit. Additional guidance was provided to the client and new fire retardant bedding, alongside several recommendations to the partnership to help safeguard this client. This included for example a fire suppression system and balancing the rights of the individual with this need to prevent harm.

PRIORITIES 2017-2018

We will continue to prioritise the fire prevention and safety across all areas of Enfield. This includes awareness to local partners and organisations on the risk of fire due to hoarding and the partnership response needed to work with adults in this area. We have a strong commitment to Making Safeguarding Personal, and will continue to provide an individualised response in safeguarding cases to enable adults to achieve their outcomes.

STATEMENT WRITTEN BY:

Steve West, Borough Commander for Enfield

NHS ENFIELD CLINICAL COMMISSIONING GROUP

INTRODUCTION: WHAT TYPE OF BODY IS NHS ENFIELD CCG?

NHS Enfield CCG is a clinically-led statutory NHS body which is responsible for planning and commissioning health care services for the Enfield area.

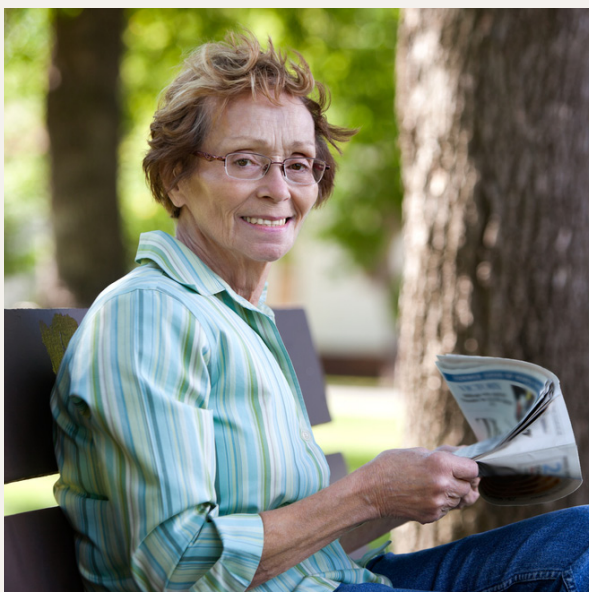
NHS Enfield CCG is supported by NHSE England London region which has three roles in relation to the CCG. The first is assurance: NHS England has a responsibility to assure themselves that the CCG is fit for purpose, and is improving health outcomes. Secondly, NHS England supports the development of the CCG. Finally, NHS England is a direct and supporting commissioner, responsible for specialised services and primary care.

NHS Enfield CCG has key responsibilities towards safeguarding which are set out in the NHS Safeguarding Assurance and Accountability Framework (2015) to ensure that the services they commission have safeguarding systems and processes in place to safeguard and promote the welfare of adults and to protect those at risk from abuse.

HOW HAS NHS ENFIELD FULFILLED ITS SAFEGUARDING RESPONSIBILITIES THIS YEAR?

Safeguarding adults has remained a very high priority for both commissioners and providers of NHS services during 2016/17. NHS Enfield (the CCG) operates within the NHS Standard Contract. The wording in the Contract regarding safeguarding arrangements was strengthened in 2015/16. Specific requirements were included to comply with relevant law and updated guidance, along with clearer provisions on staff training and audit. The CCG has worked to develop and review Provider contracts with the CCG so that they include all necessary safeguarding elements as per the NHS Standard Contract section 32. Work has also been completed to update the policies for safe recruitment and on managing allegations against people who work with the adult public following the Myles Bradbury case in Cambridge University Hospitals.

The CCG's safeguarding leads are up to date with their safeguarding training and have access to appropriate supervision. They provide supervision for named safeguarding staff in provider organisations. Safeguarding adults' training forms part of the mandatory training programme for all staff employed by the CCG. Additionally, the CCG has established a GP Forum on safeguarding which has helped to implement recommendations from Domestic Homicide reviews and safeguarding adults' reviews.



A Primary Care Safeguarding Conference was held in 2016 in order to engage GPs and Primary Care Staff to enable them to embed their knowledge in safeguarding matters. We are delighted to say we have a Named GP for safeguarding Adults who is working in the MASH and providing advice and clinical guidance in order to facilitate adult safeguarding referrals. We have a Nurse assessor in our Nursing Homes who is able to investigate provider concerns quickly and ensure that the Nursing Homes are safe for us to commission.

The CCG has developed a Mental Capacity Act and Deprivations of Liberty Policy jointly with Enfield Local Authority for all Nursing homes in Enfield.

The safeguarding team at the CCG has endeavoured to ensure that the CCG and the health economy learns from Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews . The CCG has engaged in a SAR and 5 Domestic Homicide Reviews over the past year; The Named GP for Adults at risk completed an Independent Management Report for primary care services provided in Enfield. The CCG Adult Safeguarding Lead has acted as Safeguarding Adult Review and Domestic Homicide Review panel members. This representation has enabled the CCG to support the Board in its statutory duties and help the CCG to address the challenge of enabling SAR learning to be embedded across the health economy.

The CCG has received regular monitoring reports from providers on adult safeguarding within their services including evidence of training compliance.

WHAT PLANS DOES ENFIELD CCG HAVE TO IMPROVE SAFEGUARDING PRACTICE FURTHER?

- The CCG has engaged a clinical expert from Buckinghamshire New University to work with the Safeguarding team both in the CCG and with the Local Authority in developing a pressure ulcer protocol. This will be rolled out in collaboration with the Nursing Homes in Enfield.
- A conference to enhance safeguarding knowledge amongst stakeholders is planned for July 2017.
- We will continue to use the GP Forum to discuss safeguarding updates and to prioritise the dissemination of learning from SARs and DHRs.
- We will establish the use of the Pressure Ulcer Policy in Nursing Homes.
- We are developing the learning from disability deaths review protocols in the CCG and staff will access appropriate training in order to be able to comment authoritatively on reviews in line with the new LeDer Statutory Responsibilities.

STATEMENT WRITTEN BY:

Julie Dalphinis, Adult Safeguarding Lead, NHS Enfield Clinical Commissioning Group

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. We recognise that safeguarding is a responsibility for everyone, and therefore seek to ensure that safeguarding is a priority throughout the organisation.

We have a project to raise awareness and understanding of Hate Crime, and hold regular workshops for staff, carers and people with learning difficulties. We have launched a DVD and booklets to raise awareness on Hate Crime so people can recognise and report it.

To ensure our members are safeguarded against any abuse, we work with the Integrated Learning Disabilities Team.

One-to-One (Enfield) has 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.

STATEMENT WRITTEN BY:

Nusrath Jaku, Volunteer Co-ordinator

THE ROYAL FREE NHS FOUNDATION TRUST

The Royal Free NHS Foundation Trust (RFL) has continued to build on the strong foundations of safeguarding that were already in place. Our safeguarding strategy sets out how we plan to drive forward our safeguarding activities and our reputation over the next 3 years. It acknowledges the requirements to ensure there is board level focus on the needs of patient safety and that safeguarding is an integral part of the governance framework.

In August 2016, NHS Improvement accredited the RFL to lead groups or chains of NHS providers, to be a Vanguard Trust, one of four acute trusts chosen in the UK. Discussions are currently in progress between the RFL and North Middlesex University Hospital NHS Trust (NMUH) to identify how the two organisations can work together for the benefit of their patients and the local communities.

SAFEGUARDING ADULTS WORK UNDERTAKEN AND KEY ACHIEVEMENTS IN 2015/16

We have consolidated our team with the appointment of two Adult Safeguarding Advisors and the successful applicants have now started their roles, one in Barnet and Chase Farm and one in the Royal Free Hampstead.

We developed an electronic flagging system for the nursing handover sheet at each site to increase awareness. These symbols will remain on the system if patients are re-admitted again. The symbols for someone coming into the organisation with a Learning Disability, DoLS or a Safeguarding Concern will look like this.



Referral rates have increased from April 2016 and March 2017 by another 9% for 2016 – 2017:

- **470** Safeguarding alerts raised at the Royal Free Hospital
- **483** Alerts for Barnet Hospital and Chase Farm Hospital (increase of 25 %)

We believe the increase in referrals can be attributed to the permanent appointment of the Barnet and Chase Farm Adult Safeguarding Advisor.

We have also increased the number of DoLS applications across all sites in the past year.

There were **168** applications across the trust in 2015/ 2016, this has increased by 58% to 265 for 2016/2017.

In terms of training, our figures are consistently in the 80% range for delivering MCA/DoLS and Safeguarding adults. We have developed a level 3 training schedule to comply with the “Safeguarding Adults: Roles and Competence for health care staff – Intercollegiate Document” which is expected in 2017.

We held a very successful conference called ‘Tackling Domestic Abuse’ which was attended by 153 candidates many from our local partners organisations.

The Royal Free London NHS Foundation Trust initially signed up to be a pilot site for The Learning Disability Mortality review programme.



Our two liaison nurses are reviewers for the programme and are members of the Pan London Steering Group.

We have published a newsletter from the integrated safeguarding team, this will be available every six months and we use it to introduce the team, educate and promote on any key themes and to update on local and national developments in safeguarding.

We have supported Enfield with a Domestic Homicide Review and continue to be active partners in the Board and Sub Groups.

KEY CHALLENGES AND PRIORITY FOR 2017/18

- Deliver the PREVENT agenda across the Trust
- Develop and deliver safeguarding adult supervision
- Develop a supervision policy
- Develop a Restraint policy
- Develop and deliver level 3 safeguarding adult training

STATEMENT WRITTEN BY:

Dee Blaikie, Adult Safeguarding Lead

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**Strategic Safeguarding Adults Service
Health, Housing and Adult Social Care**

July 2017

