Enfield Safeguarding Adults Board

Safeguarding Adults Annual Report 2017-18

www.enfield.gov.uk/safeguardingadults

ENFIELD Council

Enfield Safeguarding Adults Board

Here are some of the organisations working to keep adults at risk safe in Enfield.

NHS Enfield Clinical Commissioning Group

ENFIELD Council

healthwatch Enfield

London Ambulance Service NHS Trust

Barnet, Enfield and Haringey NHS Mental Health NHS Trust

Royal Free London NHS NHS Foundation Trust

North Middlesex University Hospital NHS Trust

CareQuality Commission

National Probation Service

METROPOLITAN POLICE

LFB LONDON FIRE BRIGADE

VS VICTIM SUPPORT

citizens advice

People with Learning Difficulties Making Life Better

over 50s forum

We all have a role to play to help keep people who may be at risk, safe.
If you have concerns, call us and we can act to stop abuse.

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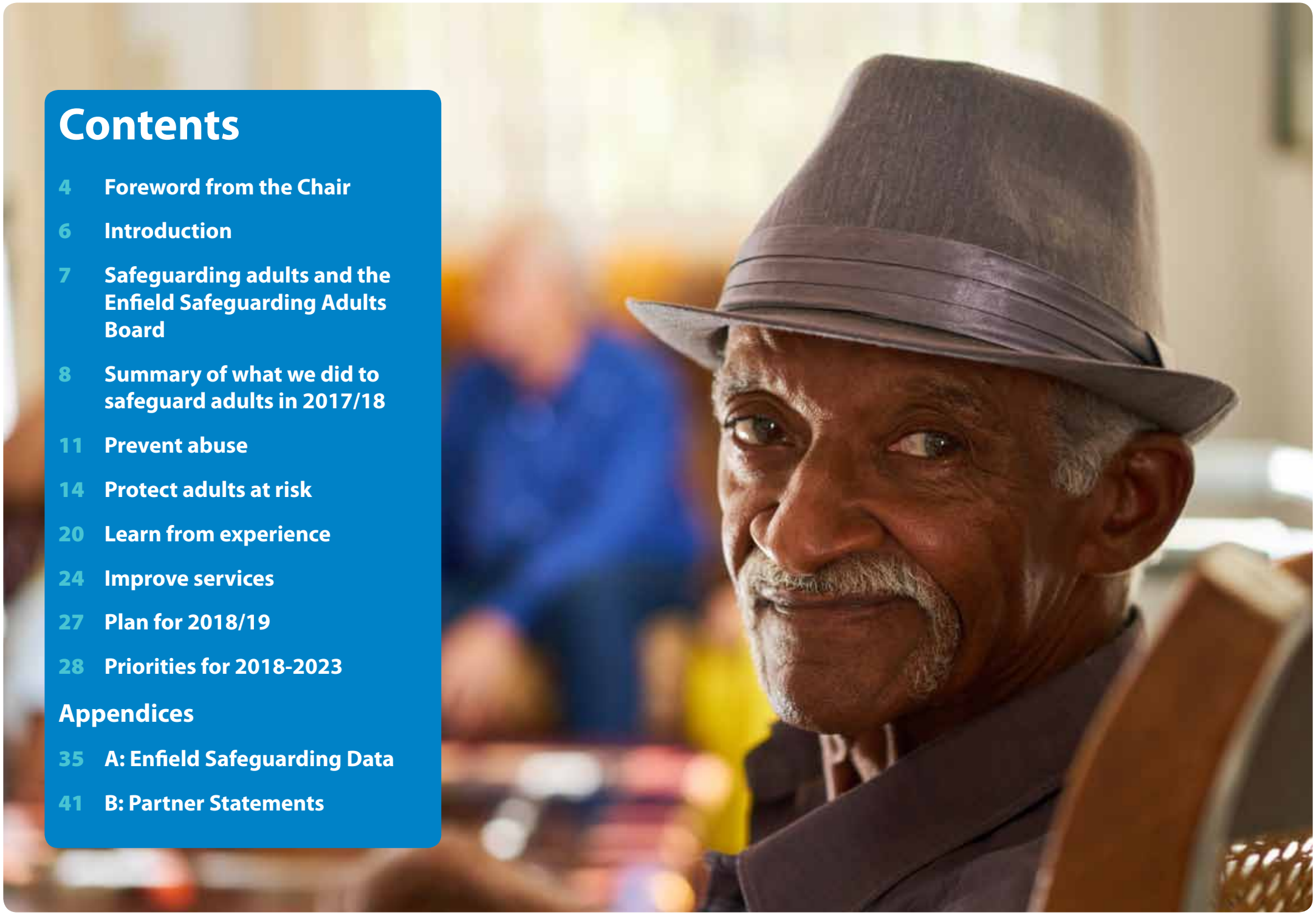

Foreword from the Chair

Christabel Shawcross
Independent Chair of the Enfield Safeguarding Adults Board

As the Independent Chair of the Enfield Safeguarding Adults Board, my role is to make sure the multi-agency partnership is working together well to deliver on Safeguarding Adults Boards' responsibilities and action plan to prevent and protect adults at risk from abuse.

The momentum for the SAB was unfortunately affected by there being no dedicated Board Manager until September. The Head of Safeguarding, Sharon Burgess, and Dawn Adams, the Board Officer worked tirelessly to keep priorities on track, inevitably with some slippage. We were pleased to welcome Bharat Ayer in September who ensures that the Safeguarding Adults Board priorities are kept on track for 2018/19.

2017/18 was a period where we saw a 33% increase in the number of Safeguarding concerns reported. Concerned with the increased number, the Board has checked and been assured that our service users have felt that the outcomes they wanted have been met; so this suggests that the quality of the safeguarding work we do has been maintained. However we cannot be complacent and for 2018/19 will be asking for more detailed case audit information for understanding better the range of outcomes for people.

The increase in Safeguarding Concerns we receive can be seen as a positive rather than a negative as it suggests that there is a greater awareness of what adult abuse is and when to report it amongst partners and in the community. There is still work to be done here and we use comparative data from similar authorities as a bench mark, many also seeing increases. One key priority achieved is the increased focus on qualitative work. I have been delighted with the high level of the work of our Service User, Carer and Patient group who have taken a lead in holding the Board to account on outcomes and making sure we use language and present our work in a way that is more accessible. I was also pleased to encourage the group to take the lead on preparing for the Boards new strategy which needed renewing from April 2018 and is being widely consulted on in 2018/19 for launching in the same year.

There is a continuing focus in Enfield on preventing abuse, a challenge with over 100 care homes as well as registered home care providers. It has been good to see that the Enfield Safeguarding Information Panel and the partners that are part of this work, particularly with health, continue to intervene quickly to stop abuse and harm or prevent it all together. The Panel oversaw 74 different interventions with our providers in the year resulting mainly in improved care for residents or closer monitoring and work

with the Care Quality Commission. We had an increase in cases for Safeguarding Adult Reviews (SARs) resulting in four new ones. Effective learning from a SAR in progress was shown by the work between partners especially with the fire service and housing around preventing fatal fires, particularly the Seminar for Adult Social Care Providers was very well attended, and will have helped to reduce this risk across the borough.

A key priority was to progress work on a themed SAR on Domestic Violence which took longer that anticipated and is concluding in late 2018. This focused work with the mental health trust benefited from vital user feedback underlining the challenge of providing appropriate personalised support, enhancing 'Making Safeguarding Personal principles'.

An important SAR involving several local authorities was published in 2018 concerning sexual abuse allegations involving two residents in a care home with learning disabilities, one as an alleged perpetrator, resulting in the home closing. The extensive learning for all agencies and providers was significant not least the need to ensure people with learning disabilities are afforded the same rights and protections as anyone else when allegations are made.

I have been particularly pleased to help lead the SAB in continuing working beyond borough boundaries and aligning with those in the North Central London area (Barnet, Enfield, Haringey, Camden and Islington) through a challenge event. There is now ongoing commitment to align strategies and share learning to improve staff knowledge and reduce duplication for health partners covering these areas. This will become increasingly important with the continuing impact of austerity and transformation of services to meet these challenges, such as Metropolitan police boundary changes (Enfield with Haringey) and health CCGs.

Further changes within the local authority in 2018 involved the creation of a Peoples Directorate, and together with the new requirements for change for local Children's Safeguarding Boards the opportunity was taken to consider the appointment of a joint Chair for children's and adults safeguarding.

From September 2018, the current LSCB Chair Geraldine Galvin has been appointed and I wish her well in her new role.

I have been privileged to work as Chair to help lead the SAB to prevent abuse of people living in Enfield and have appreciated the strong commitment from all statutory and voluntary partners to both challenge each other and work together effectively to prevent abuse. A particular thank you to all front line staff for their hard work, in often very difficult circumstances, for ensuring Enfield residents are effectively protected when abuse occurs.

These boxes are on most pages, and provide a bit more detail about the subject; usually with information from the Care Act legislation or it's statutory guidance.

Introduction

This report presents the work that the Enfield Safeguarding Adults Board and the organisations that are part of it, have done to keep adults at risk of abuse, safe from neglect and harm.

The report covers the period 1st April 2017 to 31st March 2018.

The style and presentation of this report has been developed by Enfield Safeguarding Adults Board's Service User, Carer and Patient group.

Care Act 2014

The Care Act requires the Board to report on its activities in the past financial year, and its plans for the coming year to keep people who may be at risk of abuse or harm, safe.

Pictured left to right: Christabel Shawcross (Chair of the Enfield Safeguarding Adults Board), Dawn Adams (Safeguarding Adults Board Officer), Robin Standing, Irene Richards (Chair of Service User and Carer sub-group) and Pat Askew

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Safeguarding adults and the Enfield Safeguarding Adults Board

Safeguarding Adults is the work done in an area to protect adults who are, or may be, at risk of abuse or harm.

Safeguarding adults is everyone's business. This means you, your friends and families, your neighbours, as well as the people who work for organisations like Enfield Council, the Police, the NHS and others, have important roles to play to help adults at risk in our community safe from abuse or harm.

The Safeguarding Adults Board brings together organisations that work in Enfield make sure there are good ways of working to keep adults at risk safe.

The work of the Safeguarding Adults Board is organised into one of four areas: Prevent abuse, Protect adults at risk, Learn from Experience, and, Improve Services. Organising the work in these four areas makes it easier to work with our neighbouring local areas across North Central London (includes Enfield, Barnet, Camden, Haringey and Islington).

Care Act 2014

The Enfield Safeguarding Adults Board is a statutory board formed under the Care Act 2014.

The main objective of the Safeguarding Adults Board is to assure itself that there are robust local safeguarding arrangements and partners to help and protect adults in its area.

The Local authority, the Police and the NHS are statutory members of the Board.

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Summary of what we did to safeguard adults in 2017/18

This section presents a summary of the main pieces of work that the Enfield Safeguarding Adults Boards completed or oversaw in 2017/18. This is followed by information presenting work in each of the four priority areas.

Increase in reports about concerns

We are managing an increase in concerns about adult abuse; whilst maintaining quality of our safeguarding work:

- In 2016/17, 1,144 concerns were reported; this increased to 1,616 in 2017/18.
- The improved data presented to the Board confirmed that whilst concerns reported had increased, the local arrangements were still able to responded to them all, and that service users experience was still positive (see page 15).

Fire Prevention

Following a fatal fire incident in the borough, which went on to be a Safeguarding Adults Review, a great deal of work has been undertaken by the Fire Prevention working group, which culminated in a joint Fire Safety Conference between Adult Safeguarding Teams and the London Fire Brigade for Adult Social Care providers.

Nursing home improvements

Enfield Council and Enfield NHS Clinical Commissioning Group have jointly funded a Nurse to work within the Strategic Safeguarding team to focus on issues arising in Nursing homes. We have also developed Quality Circle meetings for Nursing home managers. This group allows managers to share best practice, and for Safeguarding and Quality officers to highlight areas of improvement. This work has helped to improve the quality of care for these residents.

Communication

The Service User, Care & Patient Board sub-group, have continued the work to reviewing the language used in our communication and our reports. This was done in preparation for the 2018/19 strategy consultation, and to support future community engagement work.

Learning from our Safeguarding Adults Review

The Safeguarding Adults Review for P was published in March 2018 (see page 21). The lessons learned from this review will reduce the risk of similar incidents happening in Enfield, and will be shared with other areas.

Working with our neighbours

The Board and its partners took part in the North Central London "Challenge and Change" event in November 2017. The event highlighted important areas where we can work together: sharing publicity material, and auditing the same issues at the same time across our areas so we can compare results and learn together.

Working Nationally to improve Locally

Enfield has a strong record of putting service users at the heart of it's safeguarding processes. This approach is called Making Safeguarding Personal (MSP) and we've been part of a national project, with academics, local areas and central government groups to create an audit to measure how well this is being done: an outcomes framework.

Safeguarding Adults Manager Peer Network

A learning group of Safeguarding adults Managers was set-up to make sure teams managing safeguarding concerns were empowered to steer our development work. These forums have also been a great way to share learning, identify areas where more training is needed, and improve issues with our data and systems.

Prevent abuse

This is the work we've done to prevent abuse from happening.

Preventing Fatal Fires

Following a fatal fire incident, a working group was set-up to make changes needed to reduce the risk of future incidents. The working group included the London Fire Brigade, the Council's Safeguarding Adults team and Health and Safety, and NHS Community Nursing team, as part of a group of 12 teams.

Improvements made include:

- Increased awareness of London Fire Brigade's safety guidance and referral pathways for high risk service users, including being aware of the London Fire Brigade Home Safety Visit Line. To request a Free Home Fire Safety Check call 08000 28 44 28, Textphone 020 8536 5914.
- Fire Safety risks assessments reviewed using London Fire Brigade recommendations and a clear escalation processes for high risk service users to mitigate risks
- A joint event between Enfield Adult Safeguarding Teams and the London Fire Brigade for "Adult Service Providers Fire Safety Seminar". It was delivered to 120 delegates from Enfield providers on 24 October 2017. There was positive feedback about the event and the difference it will make for their residents.

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Enfield Safeguarding Information Panel

The Enfield Safeguarding Information Panel brings together the Local Authority's Safeguarding Adults team, the Care Quality Commission (CQC), Enfield NHS Clinical Commissioning Group, Police, London Fire Brigade and others, to share intelligence about quality issues in Enfield's care and support provider organisations: we have 160 CQC registered providers, one of the highest numbers in London.

The panel has a strong Prevention role, co-ordinating, where appropriate, work of agencies with providers to improve issues of poor quality before they escalate to safeguarding concerns. The panel is often cited by the CQC as an example of best practice in London.

The Panel met eight times over the year, and as a result, 74 different actions were undertaken, including out of hours visits, contract monitoring visits, provider concerns meetings and Quality Checker visits.

Responding to Safeguarding Concerns

The majority of concerns reported, do not require a safeguarding enquiry. However, in Enfield we have a commitment to respond to every concern to ensure the adult at risk is safe from abuse or harm.

Despite the increase in concerns this was maintained.

Communication

The language we use in Safeguarding adults can be highly technical. The Service User, Carer and Patient sub-group pointed out that community engagement would be more effective if it was in Plain English. They have been working to improve our reports, website and training material.

The style of this annual report has also been updated through the work of this project.

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Case Study: preventing further abuse

How we worked with Adam*

A safeguarding concern was received by the Adult Safeguarding Team (MASH) citing concerns of neglect. Adam* is an 83-year-old gentleman who suffers from dementia and other health issues. He was found by the London Ambulance Service left in soiled bed linen with other signs of neglect.

Safeguarding work

The case was passed to the Care Management Enquiry Officer. It was then discovered the regular carer who attended to Adam, and provided three calls per day, failed to report Adam's failing health and his reluctance to comply with the support offered from the care agency. There was no indication in the care notes of how Adam was, in terms of his wellbeing, or the home environment. The carer admitted they had failed in their duty of care.

How the safeguarding work helped Adam

The carer was dismissed and reported to Disclosure and Barring Scheme so that they could not seek employment with another care provider. Adam was moved to a Nursing home and is thriving! The care agency is now working on an Improvement Plan with the CQC (who regulate care providers) and the Central Safeguarding team to mitigate any risk of this happening again. The Improvement Plan is proving to be effective.

**Key details have been changed to protect this person's identity.*

Stock library image used.

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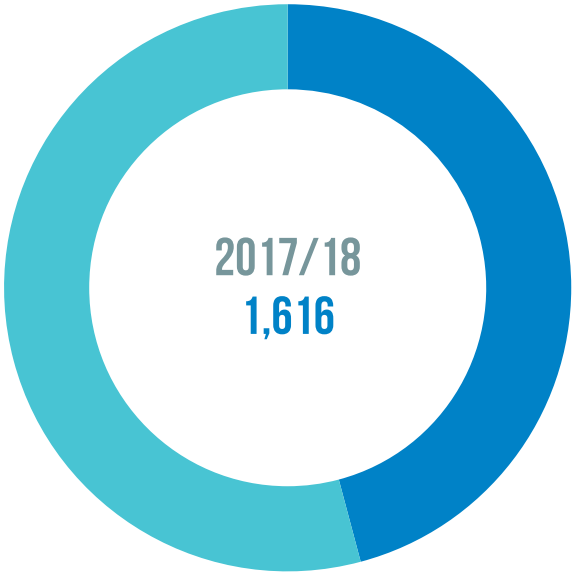
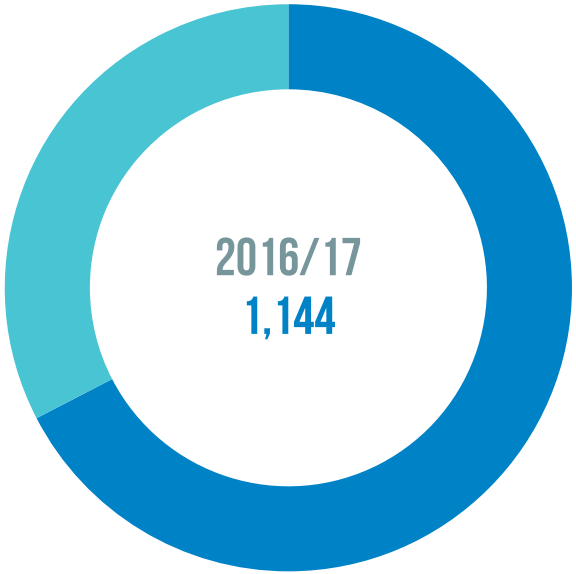
Protect adults at risk

One of the main jobs for the Safeguarding Adults Board is to make sure we have excellent responses to concerns. We do this through looking at our data and audits (checks). Here we present our data, talk about some of the audit projects we have and give an example of how people are affected by our work.

Number of concerns reported

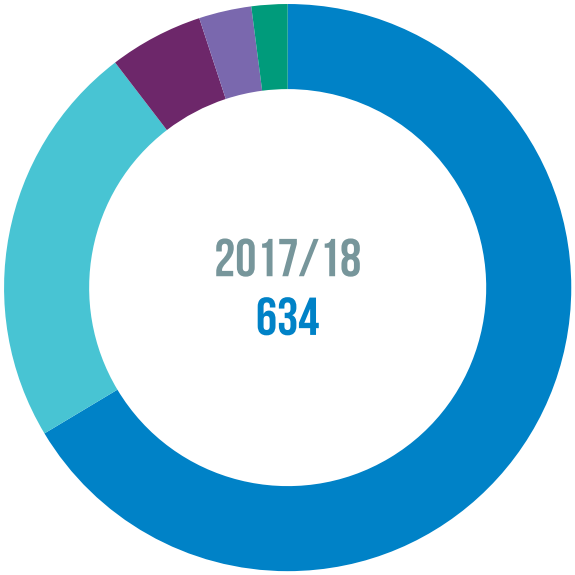


Concerns that led to enquiries	741	45.9%
Concerns that did not lead to enquiries	875	54.1%

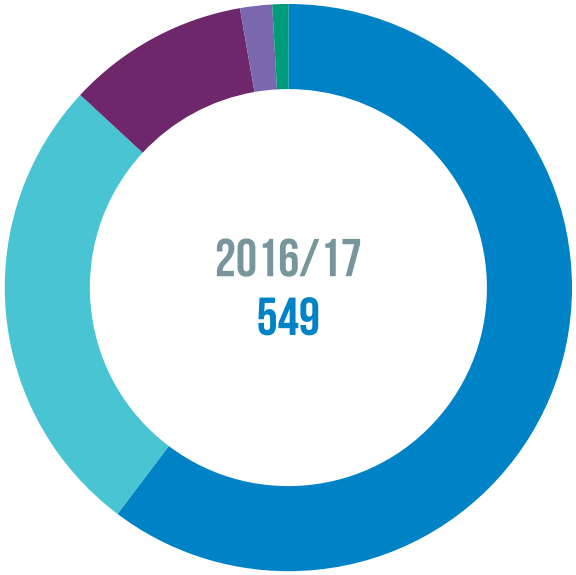


Concerns that led to enquiries	771	67.4%
Concerns that did not lead to enquiries	373	32.6%

Adult at risk's view on weather their desired outcomes were met



Met	421	66.4%
Partially met	147	23.2%
Not applicable	34	5.4%
Not met	19	3.0%
No Safeguarding form	13	2.1%



Met	331	60.3%
Partially met	146	26.6%
Not applicable	57	10.4%
Not met	10	1.8%
No Safeguarding form	5	0.9%

Safeguarding Adults Managers Peer Network

This Network was established so that managers of safeguarding teams could influence the development work for adult safeguarding and provide peer supervision.

The 35 managers meet quarterly, and have identified training needs (legal context of safeguarding), explored specific issues in the borough (self-neglect), and have helped to improve the data and reporting systems.

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Improving our processes with our neighbours

Every year we take part in a "Challenge Event" with our neighbours: Haringey, Barnet, Camden and Islington. Together, with Enfield, we make up an area sometimes referred to as North Central London.

The event, which was held in November 2017 highlighted a number of opportunities to improve and work together. For example, sharing community engagement material, and learning from our reviews.

Making Safeguarding Personal "National Outcomes framework"

Enfield has done some really good work in this area, achieving the Gold standard in 2015 following an evaluation from Bournemouth University.

Alongside a team of academics, central government departments and our local areas, we are part of a national project that has developed an audit tool which will help local areas understand whether their service users really are at the heart of their safeguarding processes or identify where they can make improvements.

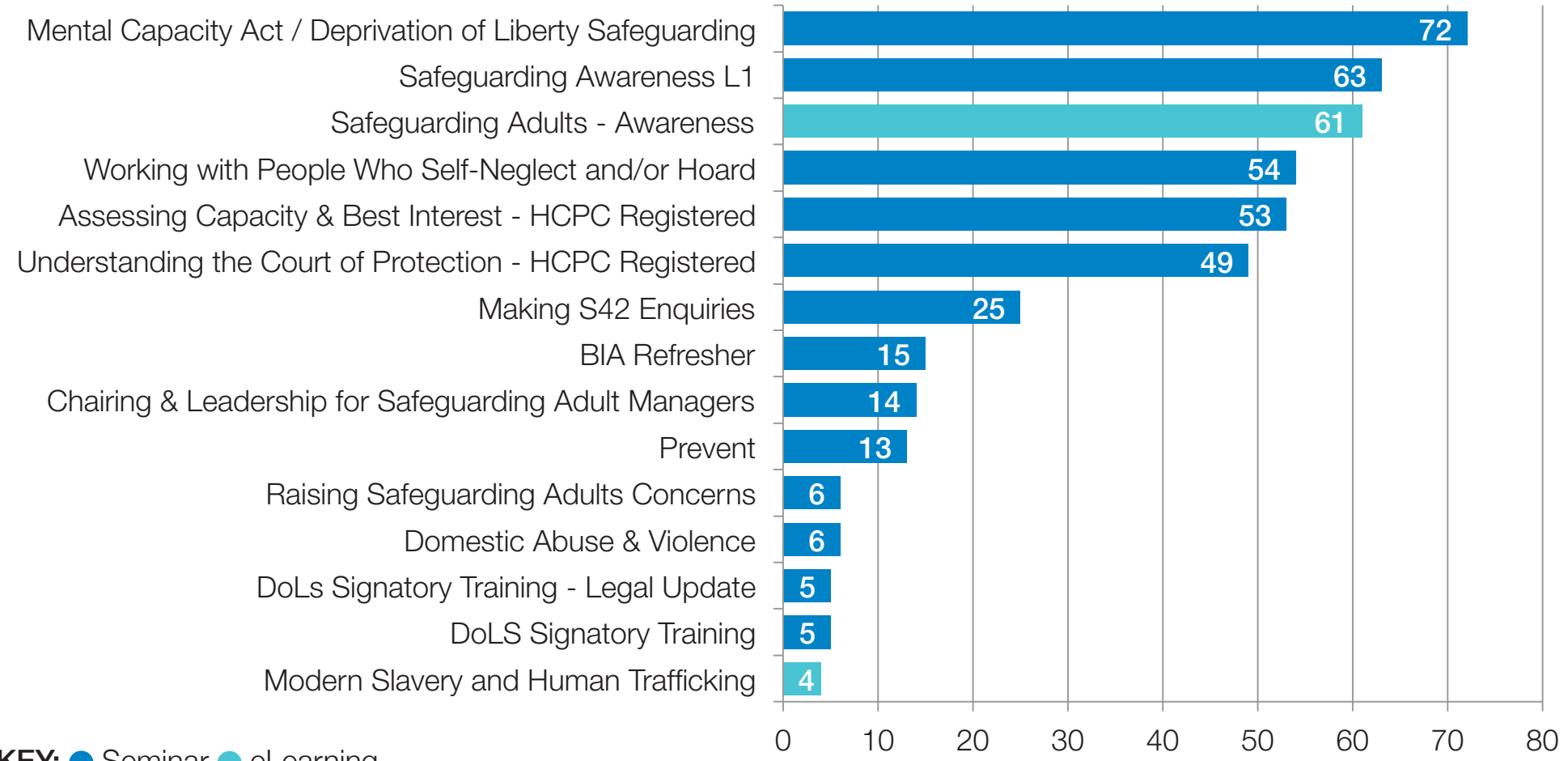
Over 2018/19, we will also be part of the first group of local areas to test the outcomes framework, making sure our local practices remain excellent.

Care Act 2014

Safeguarding Adults duties are detailed in Section 42 of the Care Act and in the accompanying Statutory guidance. Where the following criteria are met for a concern the Local Authority, who is named as the lead agency for safeguarding, must ensure that a Safeguarding Enquiry takes place. The criteria that a concern must meet to require an enquiry are that: it is about a person who is over 18 years of age, with care and support needs, and who is experiencing, or is at risk of, abuse or neglect, and is unable to protect themselves.

Training data for 2017/18

A key part of making sure we have an effective safeguarding response, is by making sure we have effective training. The table here shows the training that's been delivered in the year.



Case Study: protection from financial abuse

How we worked with David

David* is 78-year-old gentleman who suffered a stroke. He presented with significant cognitive problems following the stroke and lacked mental capacity to manage his affairs including finances. He was assessed as a Continuing Healthcare patient and has been placed in a nursing home.

Safeguarding work

A safeguarding concern was raised by a friend concerned about the mismanagement of David's finances and property by someone who claimed to be an informally adopted son. A safeguarding enquiry established by contacting the Land Registry that the Person Alleged To have Caused Harm (PATCH) had fraudulently transferred David's flat to himself with no money changing hands. The timeline also showed

that David had lacked capacity when the property changed hands. The enquiry found that the PATCH had transferred money from David's accounts into his account for personal use, had moved his family into the property, registered himself as the owner of David's car and used other assets.

How the safeguarding work helped David

The Enfield Council Care Management Team has ensured that we worked closely with David and his family and friends to ensure that he is not subject to coercion or undue influence by the PATCH and is protected from any further abuse. David's health has improved considerably and there would be a possibility of his eventually returning to his own home.

We referred David to the Deputyship team (to support him in his financial matters) and the Court has appointed him a Deputy to manage his financial and property affairs. We continue to work closely with the Police and their investigation is ongoing.

**Key details have been changed to protect this person's identity.*

Stock library image used.

Learn from experience

Here, we discuss the various tools the Board uses to understand where things might have been or are going wrong and learn lessons.

What is a Safeguarding Adults Review?

A Safeguarding Adults Review is a process that investigates what has happened in a case and ultimately identifies actions that will reduce the risks of the same incident happening again. The investigations are completed by people who are not involved in the case.

Safeguarding Adults Review referrals in 2017/18

- 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 due to be published in 2018/2019.
- 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 2018/2019.
- One review was agreed in January 2017 following a fatal fire. This review is in progress but actions have already been taken based on lessons learnt. The review is expected to be reported on in 2018/2019.
- One review was agreed in December 2017 in response to the care and treatment to an older woman living by herself. The report is still in progress and will be report to the Safeguarding Adults Board in 2018/2019.
- One review was agreed in December 2017 in response to the systemic financial abuse of service users over a number of years. The report is still in progress.

Care Act 2014

The Care Act places statutory functions on the Board. One of these is in relation to review events and practices when things go wrong.

The Safeguarding Adults Board must conduct a Safeguarding Adult Review (Section 44) should an adult with care and support needs die or experience serious harm, and abuse or neglect is suspected, and where there are concerns about how partners worked together.

Other Safeguarding Adults Review referrals

One referral was considered in February 2018 in response to the care and treatment receive by a man in his own home. The Safeguarding Adults Board needed further information before making a decision on whether the Safeguarding Adults Review process would be used.

Safeguarding Adults Review for P

This was published in March 2018, and the report is available on the Safeguarding Adults Board pages of our website (**www.enfield.gov.uk**).

The Safeguarding Adults review was agreed to examine the way that service providers, Local Authorities and other agencies worked together to provide services to a man P, who was between 18 and 28 years old in the period covered by the review. He is of White British origin and has mild learning disabilities as well difficulties as a result of having experienced a very difficult childhood. P was placed by the London Borough of Hackney in residential services managed by Hillgreen Care Ltd in Haringey and then Enfield. He is believed to have committed a series of sexual assaults over at least a ten-year period.

The Review made a total of 20 areas of recommendations for the attention of the local and national organisations. These topic areas include:

- Supporting people who have been abused
- Compiling an accurate record
- Sharing and receiving information (including Court reports)
- Anticipating additional needs at the point of transitioning into adults services
- Using expert input
- Making safe placements
- Acknowledging risk to others in all placements
- Creating a positive sexual culture in services
- Making risk management plans specific
- Accessing health care including routine and crisis led psychological and psychiatric evaluations.

Please see the report for a full list of recommendations and the organisations they relate to.

Quality Checker projects

Quality Checkers are service users and carers who live in Enfield who work with us and tell us about what's working and what needs improvement.

Over the year, they've been involved in the following projects:

Health and Wellbeing

Quality Checkers interviewed a number of people with social care needs to find out what they daily activities gave them feelings of wellbeing?

Feedback was collated and submitted to the transformation team for future development.

Mystery shopping project

The following services were visited to understand how accessible they were for people with care and support needs: Enfield Leisure Centres; Enfield's webchat service; Enfield's Adult Abuse line.

LGBT Awareness in Residential Care

Produced feedback report and LGBT toolkit, which were shared with partners and providers in Enfield.

Quality Checker quote;

I really enjoy volunteering as a Quality Checker. Small changes can make big differences to those living in residential care and I feel that the work we do makes a real difference in our local community.

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Learning Disability Mortality Reviews

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+) with learning disabilities 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 Safeguarding Adults Board, 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**

Over the 2017/18 financial period, three mortal reviews have been 'signed off', of these, one has been identified as an example of best practice in End of Life Care. Three more reviews for adults are in progress.

A number of improvement areas have emerged from the reviews, and these have been shared with our Safeguarding Adults Board partners, as well as regionally and nationally through the Review process. The lessons include:

- The numbers of safeguarding alerts raised during hospital stays suggest work still needs to be done around the quality of people's acute care.
- There were a number of instances where people with complex health needs did not have a coordinated health action plan.
- There was also a very good example for partnership working and coordinated planning leading to good quality care.
- Communications between services have not been as open as they could be.

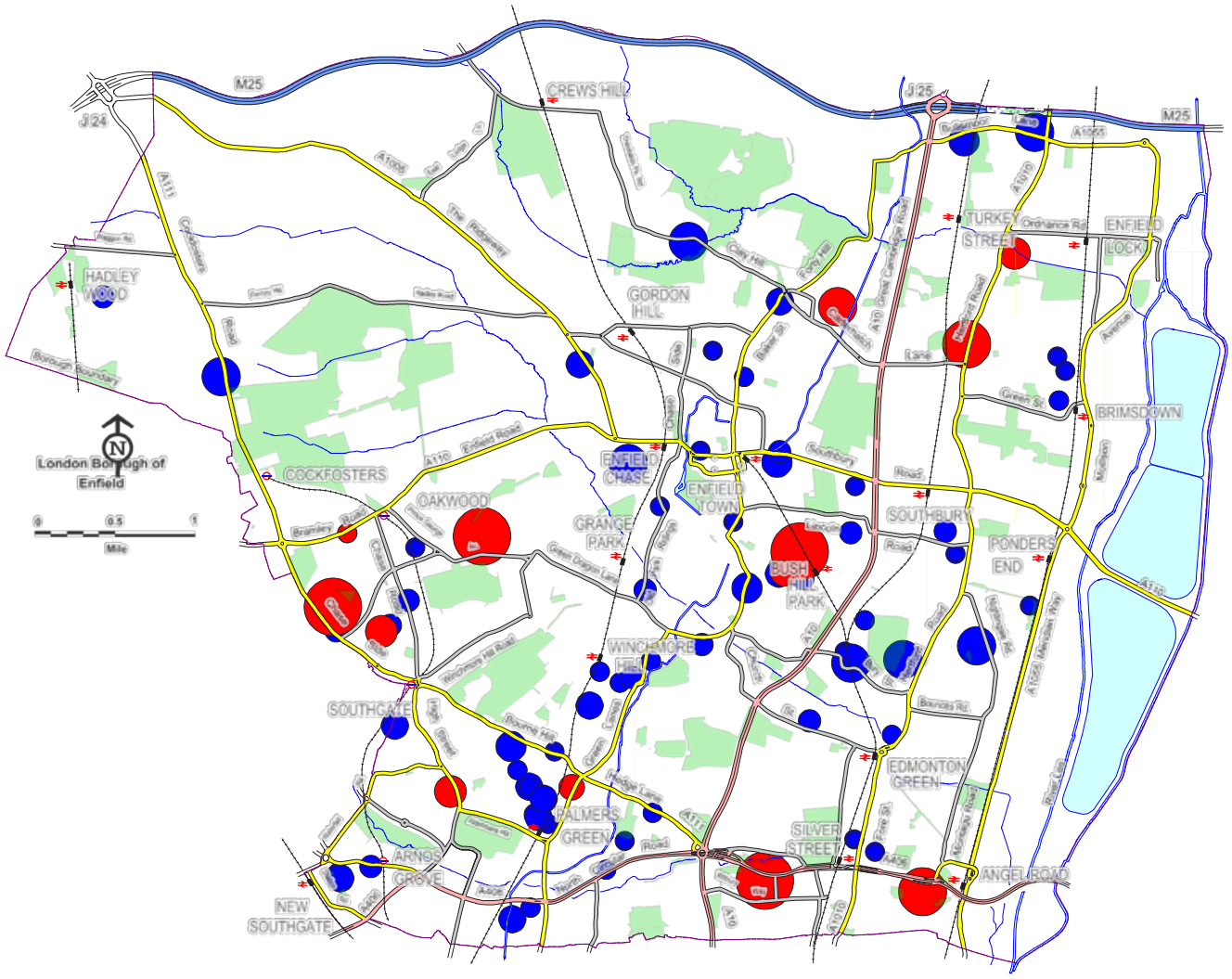
Improve services

We have a number of key processes to improve quality of our the services offered by adult social care providers.

Enfield has one of the largest number of care providers in London, including 85 care homes.

The map on the here shows the spread of care homes (nursing and residential) we have in the borough.

All registered providers will also be monitored by the Care Quality Commission.



Nursing Homes
number of beds

- 80 to 90 (4)
- 70 to 80 (2)
- 55 to 70 (1)
- 40 to 55 (3)
- 25 to 40 (2)
- 11 to 25 (1)

Residential homes
Number of beds

- 40 to 60 (7)
- 30 to 40 (4)
- 20 to 30 (10)
- 10 to 20 (17)
- 6 to 10 (15)
- 3 to 6 (19)

Provider Concerns Process

Our Provider Concerns process was initiated eight times in the year through our Safeguarding Information Panel.

The process brings together the organisations that are involved with a care provider to discuss concerns and risks, and work with the provider to make improvements for the residents or service users. The process can include a suspension on new placements, or in some cases, particularly if there is a risk of de-registration, an exit strategy.

The Provider Concerns process was developed in Enfield, but now forms part of the Pan-London Safeguarding policy and procedures. The case study overleaf shows how the process had made a difference to one local provider.

The policy can be found on our website here.

The Care Quality Commission rate all of the providers they inspect. The tables below show these ratings for 2017/18, and for the previous year.

2017/18 (ratings at end of March 2018)	Good	Requires improvement	Inadequate	Total %	Total
Community based adult social care services	83%	16%	2%	**100%**	**58**
Residential social care	87%	13%	0%	**100%**	**70**
Residential social care with nursing	75%	25%	0%	**100%**	**12**
Total	**84%**	**15%**	**1%**	**100%**	**140**

2016/17 (ratings at end of March 2017)	Good	Requires improvement	Inadequate	Total %	Total
Community based adult social care services	80%	20%	0%	**100%**	**49**
Residential social care	92%	8%	0%	**100%**	**76**
Residential social care with nursing	58%	42%	0%	**100%**	**12**
Total	**85%**	**15%**	**0%**	**100%**	**137**

Case Study: provider concerns process

A newly registered home care agency in Enfield grew rapidly in line with the demands being made on it from the LBE Adult Social Care teams. The provider had yet to be CQC inspected and this was expected at any time as the first inspection is carried out within the first year of registration. An Initial Provider Concerns meeting was called in response to a series of safeguarding concerns were received about the organisation.

The provider was placed on the Provider Concerns process to receive support to make identified service improvements for the benefit of service users, and in readiness for the providers first CQC inspection. The Project Manager visited the provider and reviewed the ways of working and collected feedback from people receiving the service to shape the action plan for improvements. The provider responded positively to the support being offered and fully engaged with the process resulting in fast and effective service improvements.

The Project Manager and Provider developed an organisational risk assessment and action plan to work through a series of actions and areas for improvements. This approach together with a voluntary suspension on new placements supported the provider to make sustainable changes to ways of working and enabled the provider to develop and maintain management oversight through monitoring and auditing the quality of service being delivered.

Part way through this process the Provider was CQC inspected and received an overall rating of 'requires improvement' however was rated as good for the 'caring' and 'effective' domains. It was widely recognised by the Provider and the Provider Concerns strategy group that without the support of the Provider Concerns process the CQC rating would have been significantly less satisfactory. The Provider Concerns process effectively supported the Provider to improve the quality and safety of the service being delivered and offered the social care market place a Provider equipped with the processes and ways of working to continue to develop and deliver their service in line with the demands of LBE social care customers.

Quality Circle for Nursing Homes

There are 12 Nursing homes in Enfield. To improve and maintain quality standards the managers are regularly brought together to form a Quality Circle. They discuss issues that are impacting on quality, and with the support of Safeguarding and Quality staff work on improvements. The group meet quarterly.

Nurse Assessor

Enfield CCG and Enfield Council jointly fund a nurse assessor, who provides specialist clinical advice as part of Safeguarding concerns, and Provider concerns processes. The Nurse assessor focuses a lot of attention on resolving issues in Nursing homes in the borough.

Plan for 2018/19

The 2018/19 financial year will see the start of the next Safeguarding Adults Strategy. This will be a five year strategy, and it is our opportunity to better understand what residents of Enfield feel are the important issues that need to be addressed if we are to tackle adult abuse effectively.

We will be using the consultation as part of our awareness raising drive; reminding partners and community groups about the adult abuse and how we all have a part to play in preventing it.

The following pages outlines the key actions for the next financial year and how they relate to our overall priorities. You will note that community engagement, and co-production are key themes; as well as using technology and data to better focus the work we do.

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www.enfield.gov.uk/safeguardingadults 020 8379 5212 (Textphone: 18001 020 8379 5212)

Priorities for 2018-2023

Prevent abuse

What	How	Actions for 2018/19	How will we know
Engage with our community, to promote a culture where abuse and neglect are not tolerated	Create a culture in Enfield where our community has a zero tolerance of abuse and neglect and understand how to report any concerns they may have. (We can develop our own marketing materials or use our neighbours tools to help us with this).	Promote safeguarding adults work as part of strategy consultation; evolve Service User Care Group into Community Engagement group.	Attendance and feedback from community engagement activity
Use technology and social media to engage with our community, professionals, providers and voluntary organisations	Improve website and social media presence, so people can stay informed and report concerns; promote developments in assistive technologies and social media options (including video calls).	Rebuild the Safeguarding Adults pages on MyLife and re-work with the Boards' Community Engagement group.	More visits to website, use of social media to report concerns, start to collect feedback on how social media and assistive technologies are helping people through customer audits.
Work to reduce isolation	Online training; community engagement to encourage groups to stay in touch with people who might be isolated.	Analyse consultation feedback and develop this project.	Monitor responses to the isolation question in our social care survey.
Work with people alleged to have caused harm to prevent further abuse	Identifying and working with people who will benefit from support and intervention.	Analyse Person Alleged to Have Caused Harm data to define scope of this long-term project.	Evaluation of the programme by professional, and through customer feedback.

Protect adults at risk

What	How	Actions for 2018/19	How will we know
Make sure our community knows how to recognise and report abuse	Raise awareness about our Adult abuse line, online resources, and different types of abuse through our marketing and community engagement activity.	Engage with Voluntary Sector groups and public – including, Carers Centre, Over 50s forum, Enfield Mental Health Service User group, and 1-2-1; ensure Young carers and young people in Borough considered as part of the awareness raising.	Attendance and feedback from community activity and visits to website.
Make sure professionals are appropriately trained, with a focus on Making Safeguarding Personal	Ensure partners and providers have trained professionals to the required level of safeguarding. Everyone who works with adults at risk should have safeguarding adults basic training, which includes: different types of abuse, including hidden or under reported abuse such as Modern Slavery, Domestic Abuse, Female Genital Mutilation, and details of what to do to report concerns.	Update practice guidance; deliver Modern Day Slavery training and develop policy; develop training from Safeguarding Adults Managers network.	Attendance and feedback from training sessions.
Develop a pack to help people protect themselves from abuse and harm	Paper and online factsheets; information videos; and links to organisations that can help (e.g. for fraud, home security).	Raise awareness of 5 factsheets amongst Adults Social Care users and their carers.	Downloads of factsheets; visits to page.
Develop online tool to make sure everyone knows how to access different services	Update website with new tool; this will also make sure that as partner organisations change, once updated, other agencies will still know who to contact and what everyone does.	This will be a scoping exercise as part of developing the new website portal for Safeguarding Adults on MyLife.	Hits on website, improved referrals, feedback in audits.

Learn from experience

What	How	Actions for 2018/19	How will we know
Check that the way we manage safeguarding concerns is working properly	We have regular checks and an annual independent audit and we will work with our neighbours*. Checks will include: the user experience, applying the Making Safeguarding Personal approach and understanding Deprivation of Liberty Safeguards. We will also work with neighbours to develop consistent London-wide assurance framework, and thresholds.	Work with neighbours on Safeguarding Adults Risk assessment tool and peer "challenge and learn" day.	How will we know: audit reports, and confirmation from partners of the actions they have taken.
Learn lessons from customer feedback	Implement learning from Quality Checkers; ask people who have been through a safeguarding process about their experience and make improvements where necessary.	Develop methods to collate adult at risk feedback as part of safeguarding process using MSP Outcomes framework.	Partners' confirmation of the action they have taken to address issues raised by feedback.
If things go wrong, review what happened and learn lessons	Identified in Care Act, we have to undertake Safeguarding Adults Reviews and learn lessons, and we will also make sure we learn from Children's and Community Safety reviews.	Publish SARs and develop training plans to improve practices, and distil learning to encourage Systems change.	Audits feedback, data.
Learning from our neighbours	We work with our neighbouring boroughs to learn lessons together. We share our lessons from reviews and will work on checks together.	Continue to work closely with Safeguarding Adults Boards of North Central London area – Barnet, Haringey, Islington and Camden.	Annual review and audits to identify improvements to Enfield's safeguarding arrangements based on learning from other borough.

Support services improvements

What	How	Actions for 2018/19	How will we know
Ensure we have effective arrangements in place to intervene when provider quality drops below expected standards. (Provider concerns/improvement)	Support Enfield services to improve, due to quality standards, whenever possible.	Continue with provider concerns and quality assurance work; start project to understand impact of increasing home care providers in Borough.	Number of provider concerns/ improvement processes and key issues addressed.
Ensure partners share information and intelligence about poor quality services	Ensure there are arrangements in place to share information properly about services so that partners can act quickly to respond to unsafe services.	Ensure Safeguarding Information panels take place and improve data that is being analysed.	Regular meetings with partner agencies and evidence of actions.
Online space for providers	Develop online presence to share information, policies and best practice with providers to ensure organisations have tools they need to improve.	With update on website; begin to scope work on provider section.	Take up of resources.
***Consistent policies with neighbouring boroughs**	Make sure Enfield has clear and consistent policies with neighbouring boroughs which represent best practice in all areas.	Safeguarding Adults Risk Assessment Tool - self assessment developed by London ADASS will highlight any gaps in key multi-agency arrangements.	London ADASS self-assessments (which are peer reviewed as part of NCL challenge and learn day).

Case Study: protecting an adult with complex needs

How we worked with Theresa*

Theresa* is a 28-year-old female with mild learning disabilities. She lived in a supported tenancy. She is unemployed and did not participate in any structured activities. Theresa's family are involved in her life but she does not have a good relationship with them. Theresa is addicted to alcohol and illegal drugs. Over the past few years, Theresa has been having unprotected sex in exchange for drugs. This was escalating and she called the Police to assist her on several occasions. There have been many safeguarding concerns raised regarding her being sexually exploited, raped and physically harmed or threatened.

Theresa has had in-depth capacity assessments with psychologists who have determined that she has the capacity to consent to sex and to consent to taking drugs and alcohol. She is fully aware of the potential risks that she places herself in with men and has often called the police when she has felt the situation is out of her control. Theresa has made many reports to the Police of rape but they have never been able to progress as she often changes the details of the account and admits to having consented in exchange for drugs despite not wishing to have sex.

Safeguarding work

Theresa has been assessed under the Mental Health Act and does not meet the threshold for compulsory hospitalisation. She has suffered health issues as a result of these behaviours and does not take

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medical advice. Theresa has an multi-disciplinary team (MDT) around her including community nursing, social work, psychology, psychiatry, drugs and alcohol worker, police and support workers. She is frequently discussed at the Complex Cases Panel. The MDT worked with Enfield's legal team to see if there is any legislation that can be used to safeguard her. We have been advised that the Court of Protection cannot be used as she has capacity and is choosing to make unwise decisions. We have also been advised that using Inherent Jurisdiction is not feasible.

Therefore, we agreed with her consent to move her out of London to a specialist rehabilitation placement. This is a residential placement for people who have Learning Disabilities and substance abuse issues and is a short-term programme. The plan is to move her to a supported living in the new area that she has been placed in and not return her to Enfield to break the link with the men who have been abusing her here.

Update on how Theresa is doing

Theresa has been at the placement for sometime and has made immense progress. She has not used any substances or alcohol, has not been exploited and has not tried to leave the placement. She has been engaging with the other residents, staff and the therapy programme really well. Theresa has become physically fitter and is running every morning as well as attending the gym. She has also joined a football team and plays once a week. Theresa is safe and well and is talking about having hopes and goals for the future.

**Key details have been changed to protect this person's identity.*

Stock library image used.

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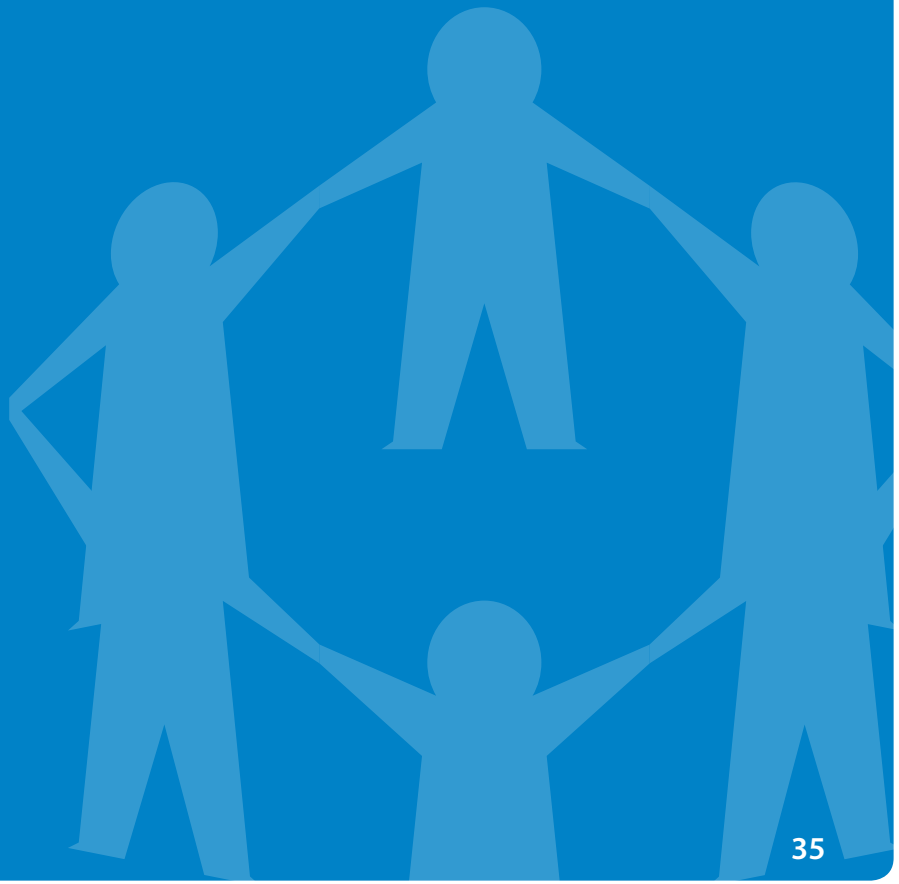
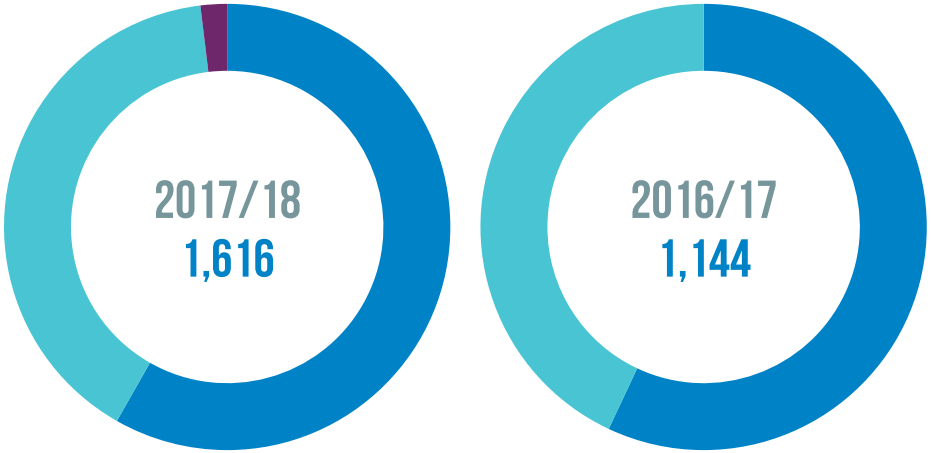
Appendix A
Enfield Safeguarding Data



Protect – assurance data for 2017/18

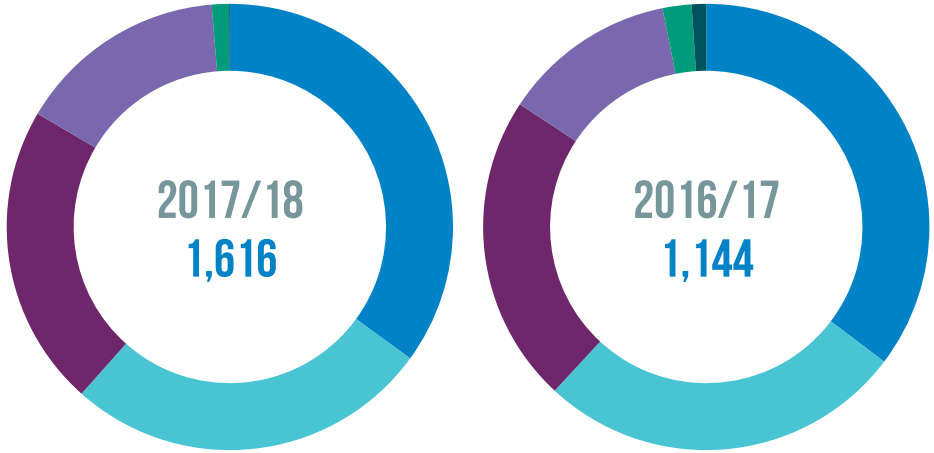
Key data is presented here showing the trends in comparing to the previous financial year.

Gender of concern



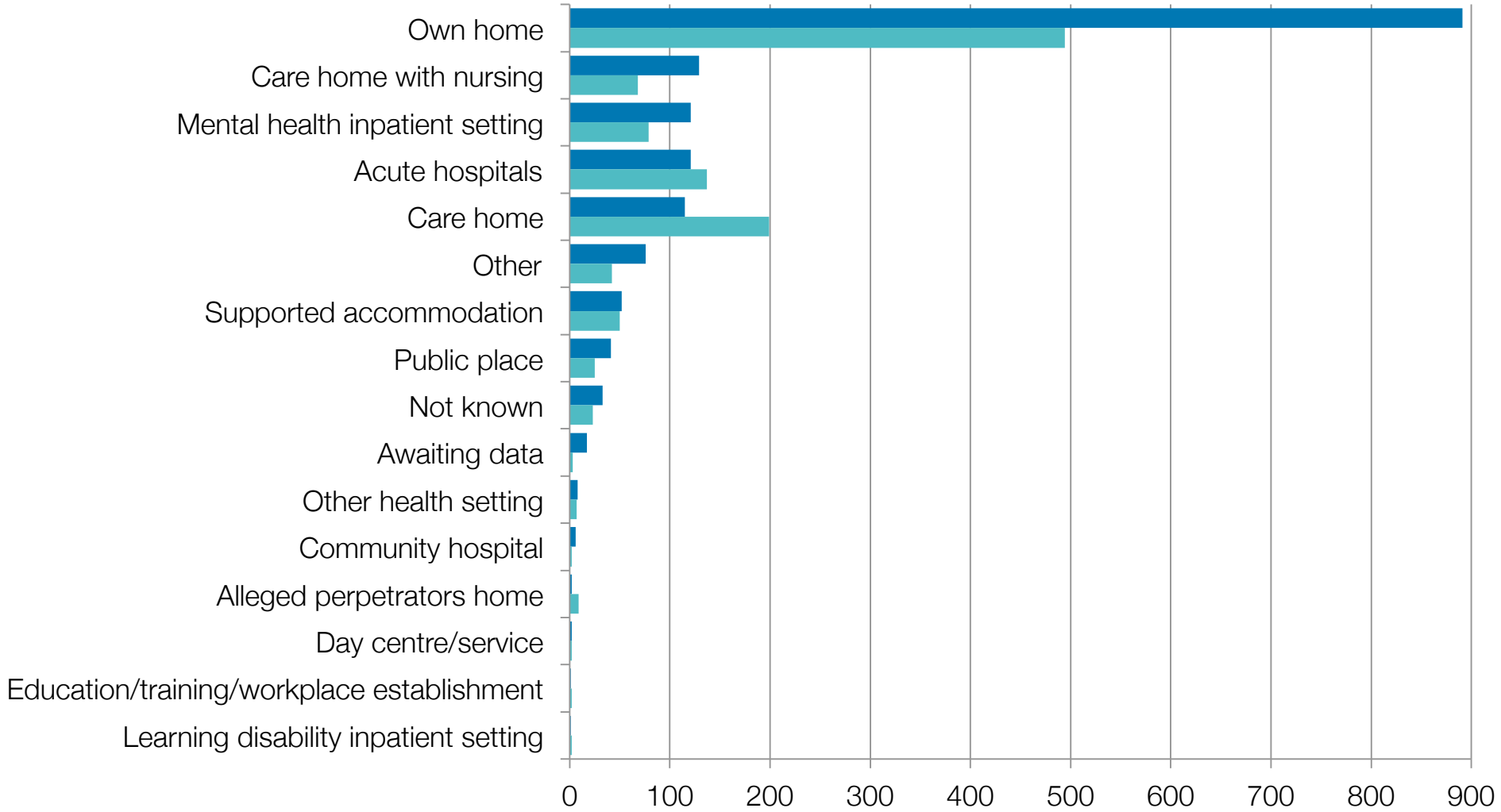
2017/18		2016/17
941 (58.2%)	Female	652 (57.0%)
644 (39.9%)	Male	492 (43.0%)
31 (1.9%)	Not recorded	0 (0.0%)

Age range of concerns

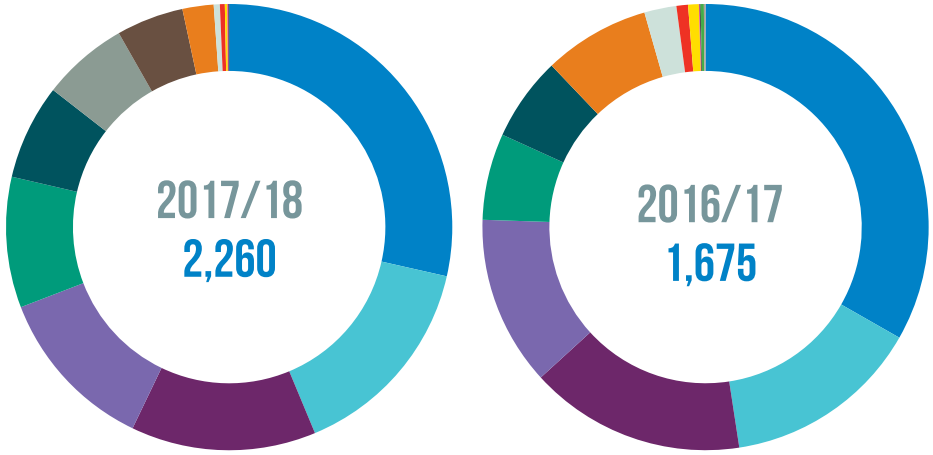


2017/18		2016/17
566 (35.0%)	18-64	404 (35.3%)
429 (26.5%)	85 +	304 (26.6%)
354 (21.9%)	75-84	256 (22.4%)
246 (15.2%)	65-74	144 (12.6%)
20 (1.2%)	Not recorded/not disclosed	24 (2.1%)
1 (0.1%)	Under 18	12 (1.0%)

Location of concern



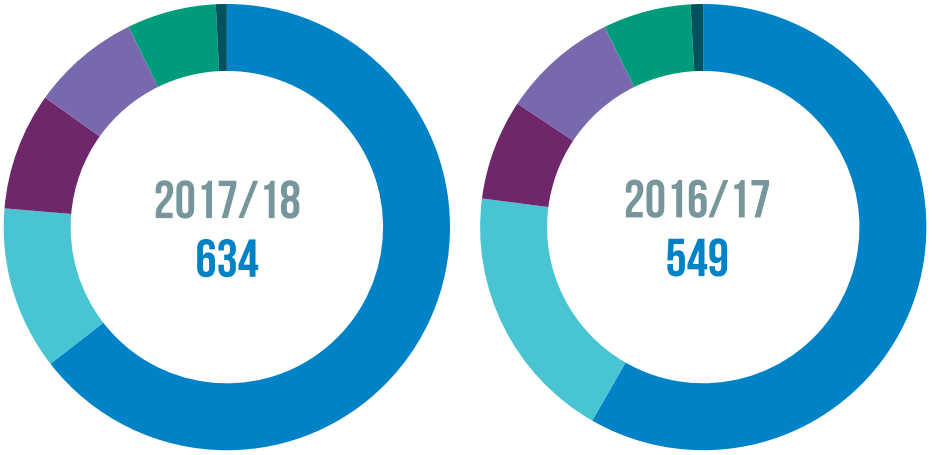
Type of abuse



2017/18		2016/17
645 (28.5%)	Neglect and acts of omission	557 (33.3%)
343 (15.2%)	Emotion/psychological	240 (14.3%)
303 (13.4%)	Physical	262 (15.6%)
272 (12.0%)	Financial/material	206 (12.3%)
214 (9.5%)	Self-neglect or hoarding	105 (6.3%)
156 (6.9%)	Domestic abuse	102 (6.1%)
141 (6.2%)	Pressure Sores	0 (0.0%)
110 (4.9%)	Organisational	129 (7.7%)
51 (2.3%)	Sexual abuse or exploitation	39 (2.3%)
10 (0.4%)	Discriminatory	14 (0.8%)
8 (0.4%)	Hate crime or disability hate crime	13 (0.8%)
4 (0.2%)	Modern slavery of human trafficking	1 (0.1%)
2 (0.1%)	Honour-based violence	1 (0.1%)
1 (0.0%)	Forced marriage	4 (0.2%)
0 (0.0%)	Female genital mutilation	2 (0.1%)

**There can be multiple forms of abuse so numbers do not add up to total number of cases*

Risk outcomes



2017/18		2016/17
409 (64.5%)	Risk reduced	320 (58.3%)
75 (11.8%)	Risk removed	103 (18.8%)
54 (8.5%)	Not applicable	46 (8.4%)
50 (7.9%)	Risk remains	40 (7.3%)
41 (6.5%)	Risk did not exist	35 (6.4%)
5 (0.8%)	No Safeguarding form	5 (0.9%)

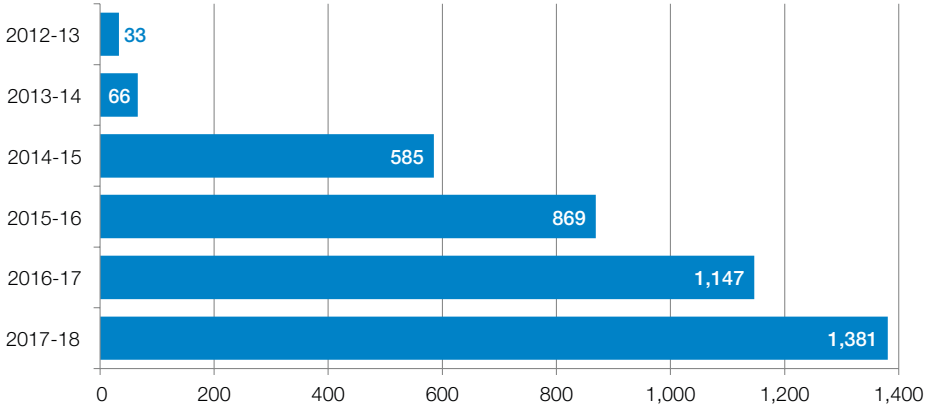
For applicable cases, risk reduced or removed = (409+75)/(634-50-41-5) = 484/538 = 90%

Deprivation of Liberty Safeguards data

There is a growing trend for Deprivation of Liberty Safeguards applications (DoLS).

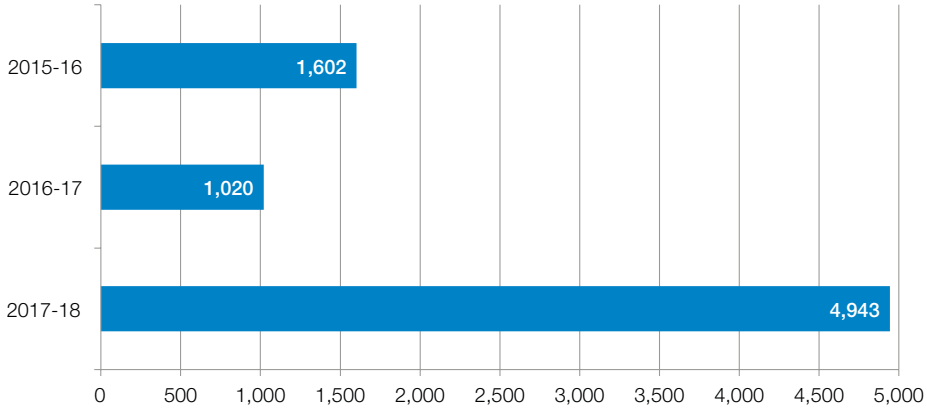
A DoLS is necessary when: 1) a person lacks capacity to make their own decisions; 2) when their care arrangements involve continuous supervision and control; and 3) they are not free to leave their placement.

In these cases it is necessary to follow the legal process to formally deprive the person of their Liberty for their best interests.



Merlins data

The Merlin Database is a recording systems used by the Metropolitan Police to record missing people, children and adults coming to police notice. This system is used to record contract and what, if any, actions have been taken. A Merlin is not always a safeguarding, and we see a growing number of contacts into the Adults Multi-Agency Safeguarding Hub (MASH) in 2017/18.



Appendix B
Partner Statements

Barnet, Enfield and Haringey Mental Health NHS Trust

Overview 2017-18

Barnet, Enfield and Haringey Mental Health NHS Trust remains committed to safeguarding all our service users, their families and carers. We recognise that effective safeguarding is a shared responsibility which relies on strong partnership and multi-agency working. Over the last 12 months we have continued to ensure a robust and proactive commitment to working in partnership with the Safeguarding Adult Board.

Internal governance arrangements

Our aim is to ensure there is a whole organisational approach to safeguarding patients and service users, their families and carers. In order to do this we have developed an Integrated Safeguarding Committee (ISC). The ISC is chaired by the Executive Director of Nursing, Quality and Governance and provides strategic leadership and oversight. The work of the ISC is informed by our Safeguarding Strategy and overarching work plan. The ISC meets each quarter and is accountable to the Trust Quality and Safety Committee. The Executive Director of Nursing, Quality and Governance is the Executive lead for safeguarding and provides bi-monthly safeguarding updates to the Trust Quality and Safety Committee. In addition an annual safeguarding report is provided to the Trust Board. Safeguarding is a standing item for each on the Borough Clinical Governance meetings.

Safeguarding adults work undertaken and key achievements in 2017-18

- The aims and objectives of year 2 of our 3 year work plan have largely been met
- We have led on an innovative domestic abuse pilot project (LINKS) which demonstrates how an independent domestic violence advocate based directly with the mental health team improves responses to service users who disclose domestic abuse.
- We have developed a safeguarding newsletter to ensure staff are regularly updated.
- We have developed a safeguarding adult handbook for all staff.
- We have refreshed our easy read safeguarding information for service users.
- We continue to improve and learn from our safeguarding data collection systems.
- We have developed new polices on the management of safeguarding allegations against staff and we now have new chaperone policy.
- We have designed and rolled out level 3 safeguarding adult training.
- We have reviewed the role and function of the mental health teams safeguarding champions to ensure improved practice and cascade of learning.
- We have improved the way we triangulate information relating to safeguarding alerts, complaints and Datix incident reports.
- We continue to raise the profile of the “Think Family” approach across all services
- We have developed a new safeguarding adult audit strategy aligned to the principles of safeguarding as defined in the Care Act (2015).
- We have consistently maintained Level 1 and 2 safeguarding adult training at the trust target of 90%.

Key Challenges

- Safeguarding practice is complex and varied. The challenge of collecting accurate meaningful data is recognised. Work continues to ensure data is captured and analysed effectively.
- To continue to develop and improve systems to promote effective lessons learnt from reviews such as Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHR’s).
- To respond effectively to the increasing number of SARs and DHR’s
- To ensure consistency of safeguarding adult practice across three boroughs with separate commissioning arrangements and different safeguarding pathways.

- To ensure the challenge of working across three borough Safeguarding Adult Boards and their associated sub-groups is managed effectively.
- To respond to the ever increasing and competing issues across the safeguarding landscape.

Safeguarding adults work planned for 2017-2018

The work of the Integrated Safeguarding Committee is informed by an overarching work plan which underpins the Safeguarding Strategy. The Strategy has five broad aims which form the overall framework of work going forward:

- To ensure safeguarding is everyone's business across the Trust.
- Develop a dataset of information that allows effective monitoring of safeguarding activity and outcomes.
- Develop a culture of learning with robust internal systems to support this.
- Promote early help to prevent abuse from happening in the first place.
- Develop seamless pathways that promote joined up working at every level.

Case Examples

Case Study 1

A safeguarding concern was instigated regarding a service user who was found neglecting herself. Her home was full with clutter and causing congestion in the living spaces and was impacting on the use of her living space. A safeguarding meeting was held that involved partners; local authority, G.P, Fire Service and the Housing Department. This ensured a robust and co-ordinated response across the key partnership to plan the interventions required. A robust multi-agency risk assessment was completed. The victim was referred for psychological intervention, free safety checks. With consent, her flat was cleaned by the Housing department and she was referred for on-going support.

Case Study 2

The case came to the attention of the safeguarding team via the Multi-Agency Risk Assessment Conference (MARAC). A female service user had attacked her husband therefore she was deemed to be the perpetrator of domestic abuse. The multi-disciplinary team had concerns about the characterisation of the service user as a perpetrator and they felt she was being exploited by her husband who routinely attributed incidents and her refusal to comply with his demands to her mental illness. There were also allegations that he often gave her cannabis stating that it was a herbal/ natural cure for her mental illness. This information was shared with MARAC and a safeguarding plan was put in place including:

- Conditions around engaging with Dual Diagnosis services and accessing support and Domestic Violence counselling where to be included as conditions on the CTO.
- An Independent Domestic Violence Advocate (IDVA) was engaged to support the service user for the duration of the in-patient stay as well as for on-going support in the community. The IDVA was asked to address the issues in a culturally sensitive manner as well as support the service user with protection planning and reporting any further I abuse to the Police.

Statement written by:

Ruth Vines
Head of Safeguarding

on behalf of Linda McQuaid, Interim Director of Nursing, Quality and Governance and Executive Lead for Safeguarding.

NHS Enfield Clinical Commissioning Group

What type of body is NHS Enfield Clinical Commissioning Group?

NHS Enfield Clinical Commissioning Group (CCG) is a clinically-led statutory NHS body which is responsible for planning and commissioning health care services for the London Borough of Enfield. Safeguarding adults is a key part of the CCG's approach to commissioning and, together with a focus on quality and patient experience, is integral to its working arrangements.

The CCG is compliant with its statutory safeguarding responsibilities and has a Safeguarding Adult lead in post. The CCG has also employed a Named GP for safeguarding adults at risk for two sessions per week.

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 2017/18.

In 2017/18, the CCG continued to regularly review Provider services and independent healthcare providers using a variety of assurance tools, including a quarterly metrics report on training compliance, audit and safeguarding referrals. In 2017/18, the CCG attended provider internal safeguarding adults committees. Each internal committee provides an update on safeguarding arrangements within the organisation highlighting quarterly achievements, risks and challenges.

In 2017/18, the CCG safeguarding team undertook an audit of safeguarding arrangements with GP practices. Following analysis of the findings, each practice was graded and given an action plan to ensure they were compliant with safeguarding arrangements.

In 2017/18, the joint CCG/LA nurse assessor worked with Nursing Homes to ensure action plans developed following investigations were complete as well as ensuring the standards of nursing care were driven up in the homes. The Nurse Assessor worked collaboratively to ensure organisations identified as having provider concerns were supported.

In 2017/18, an additional CCG nurse assessor supported the Multi-Agency Safeguarding Hub (MASH) team in assessing cases and is providing a health perspective on safeguarding referrals into the MASH. The CCG Named GP for Adults at risk continued to spend a session per week with colleagues in the MASH team.

In 2017/18, the CCG safeguarding team arranged training for assessors on the Learning Disability Mortality Review (LeDeR) programme. The CCG safeguarding team has joined the Integrated Learning Disability team in its mortality review group and is contributing to reviews.

On the 6th of July 2017, the CCG Safeguarding team held a safeguarding conference for children and adults at Forty Hall. Over 150 health practitioners attended and heard presentations on Mental Capacity and Deprivation of Liberty Safeguards, Prevent, Modern Slavery and Domestic Violence.

In 2017/18, the CCG safeguarding team arranged a number of infection control training sessions for Care Homes and Nursing Home staff. The training was delivered in conjunction with Public Health England and Public Health Enfield with 116 staff trained.

What plans does Enfield CCG have to improve safeguarding practice further?

The CCG is committed to working with partner agencies to ensure the safety, health and well-being of the local people in 2018/19. Enfield CCG has engaged with Passport in Leadership Training for Care Home managers across North Central London (NCL) to increase the leadership capacity, capability and confidence of nurse leaders in the care home sector.

Priorities and work plan summary 2018/19

- To continue embedding safeguarding adults at risk and Prevent training.
- Ongoing monitoring of provider organisations arrangements.

- Develop a cohesive strategy for Care and Nursing Homes across the NCL Partners.
- To work with the Local Authority in monitoring and reporting pressure ulcers using the borough wide and the Department of Health and Social Care protocols.
- Ensure the lessons for learning from reviews is embedded.
- Oversee the introduction of an Independent Domestic Violence Advocate, in Accident and Emergency Department at the North Middlesex University Hospital (NMUH) following a successful joint CCG/LA bid.

Enfield Carers Centre

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 situations they are facing. We also offer a holistic range of services such as: peer support groups, carers assessments, 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). (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 2017-18

- Active member of Enfield Safeguarding Board
- Reviewed the ECC Safeguarding Policy
- Circulation and display of Carers Keep Safe Guide during Keep Safe Week 2018
- Raised safeguarding concerns as appropriate/ brought to our attention by or on behalf of carers
- Attendance at Enfield Safeguarding Board Away Day event

Activities planned during 2018-19

- Embedding of Enfield Council's 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 2019

Statement written by:

Pamela Burke
Chief Executive, Enfield Carers Centre

Health and Adult Social Care, Enfield Council

Enfield Council, as lead for adult safeguarding, works with Safeguarding partners and our communities to help create freedom from abuse and neglect for our residents. We want to stop abuse from happening at all, and we hope this Annual Report shows the important work being done to make this a reality. Enfield Council is the 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 of neglect. This means that when we are aware of a concern, we contact the Adult at Risk or their advocate to establish together what actions should be taken and by whom.

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 issue in organisations through an enabling approach, while holding providers to account to improve. During the year, the work across Nursing Homes in particular has been very encouraging, with 75% of these homes achieving a "Good" CQC inspection rating at the end of March 2018.

Our audits have confirmed that we have sound safeguarding practice, with points of learning to ensure we never become complacent. We are working with independent auditors, our neighbouring areas, and on national projects, to make sure the way continually learn and improve the way we manage our safeguarding adults work: whether it's a concern about an individual; a provider concern or supporting the work of our Safeguarding Adults Board.

Some of our accomplishments this year included

"Year on year, we are seeing increases in the number of concerns being reported. While this does mean we have more to work to manage, it is also a sign that our safeguarding partners and members of our community are getting better at spotting the signs of adult abuse and feel more confident reporting it. This can only be a good thing for adults who may be at risk of abuse in the borough."

Head of Safeguarding Adults & Quality

We believe very strongly in the value of co-production. The Quality Checker program shows how powerful the service user voice can be in improving services. To build on the lessons we've learned through this work, we are also co-producing our Safeguarding Adults development work with people who are doing the Safeguarding adults work, through the Safeguarding Adults Manager network. This is a peer supervision and support group where we discuss opportunities to improve, highlight current and potential risks, and work together to improve systems.

Some of our accomplishments this year included:

- Maintaining our commitment to responding to all contacts received into our Multi-agency Safeguarding Hub, even though contacts have increased significantly; our Service User feedback has also suggested that consistently high proportions of people feel their outcomes have been met (fully or partially).
- Joint work with the London Fire Brigade to address Fatal Fire risks in the Borough, including a Fire Safety Seminar for Adult Social Care providers, which was attended by 120 delegates.
- A commitment to Safeguarding Adult Reviews and embedding the learning, which we evidence to the Board.
- Improving our Safeguarding Adults data, which means that in future years we will be able to develop much more sophisticated ways of understanding where key risks are and how well we are doing.

We believe strongly that Safeguarding really is everyone's business; and that to create a society that does not tolerate abuse we need to generate a much greater awareness of adult abuse in our community. While we are seeing improvements in referrals from professionals, there is still a lot of work to do in Enfield community groups. We are confident the excellent partnership at the Safeguarding Adults Board, will be the springboard to help create the wider culture change necessary to prevent adult abuse.

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. Our roles and responsibilities include:

- Obtaining the views of local people regarding their need for, and experiences of, local health and care services and importantly to make these views known.
- Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local health and care services.
- Enabling local people to monitor the standard of provision of local health and care services and whether and how local care services could and ought to be improved.
- Providing advice and information about access to local health and care services so choices can be made about these.
- Producing reports and recommendations about how local health and care services could or ought to be improved. These should be directed to commissioners and providers of care services and people responsible for managing or scrutinising local care services and shared with Healthwatch England.
- Formulating views on the standard of provision and whether and how the local health and care services could and ought to be improved; and sharing these views with Healthwatch England.
- Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about particular issues.
- Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

Healthwatch has been able to support the Safeguarding Board and highlight issues raised with us locally or through our work with local care and health organisations. We are also able to raise relevant issues at a number of strategic boards; this allows us to provide challenge and inject the issues raised by local people into the development and delivery of local strategies. We contributed to the development of the Safeguarding Adult Board's three-year strategy 2015-2018 and will be involved in the development of a new strategy over the next year. We welcome the recognition that more has to be done to improve engagement and understanding of safeguarding across all communities.

Our contribution to safeguarding 2017/2018

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 in any case reviews
- 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.

We attended the North Central London Challenge and Learning event for Safeguarding Adults Boards. This enabled us to reinforce the issue of engagement and involvement of local people and communities in service development and delivery across partner organisations.

Statement written by:

Parin Bahl
Chair

London Ambulance Service (LAS) NHS Trust

2017-18 has been another busy year for the London Ambulance Service NHS Trust. We have seen an increase in incidents and an increase in safeguarding concerns raised by our staff. Safeguarding is a priority for the Trust and we have this year recruited a full time administrator to assist with the increased workload.

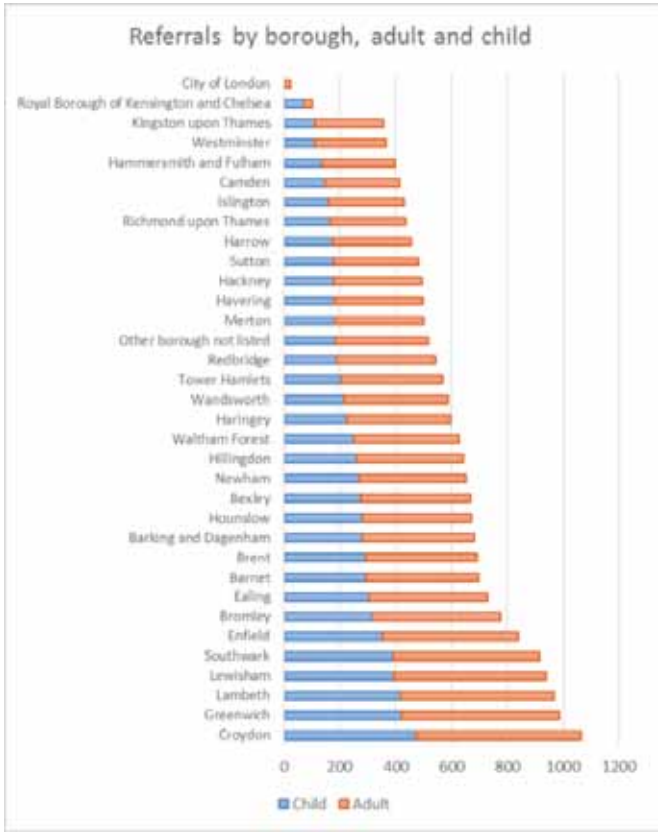
During the year we have introduced two new policies, Safeguarding Supervision and Chaperone policy. We continue to provide annual safeguarding training to clinical staff which this year was delivered via e learning and reflected learning from Safeguarding Adult Reviews, Serious Case Reviews or audits undertaken.

The Trust has undertaken a number of quality audits throughout the year these include:

- Auditing knowledge and retention of staff learning
- Quality of concerns/referrals raised
- Quality of training delivery
- Modern slavery referrals
- Child sexual abuse and child sexual exploitation
- Adult sexual abuse
- Child female genital mutilation

Full LAS safeguarding governance and assurance can be found in our annual report for 2017/18 which will be published on our website when agreed.

The following graph shows the referrals numbers for Adults and Children for London Ambulance Service by Borough.



North Middlesex University Hospital NHS Trust

Overview 2017-18

North Middlesex University Hospital NHS Trust's Board takes the issue of safeguarding extremely seriously and receives annual reports on both safeguarding children and safeguarding adults. The Trust 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.

The Trust has an established Safeguarding Adults Group which has representation from our inter professional and inter agency groups. It meets bi-monthly and provides the strategic direction to safeguarding adult activities across the Trust and ensures that all safeguarding commitments and responsibilities are met.

During 2017/18 the Trust has worked with partner organisations to safeguard some of the people who are most at risk of abuse, harm and neglect. This enables the Trust to work with partners, communities and local people to prevent abuse and ensure a robust and transparent response when abuse of an adult at risk occurs.

The Director of Nursing is the Executive Lead for Safeguarding Adults and represents the Trust at the Enfield local multi-agency safeguarding adult board meetings.

Partnership working during 2017-18

In June 2018, the Trust recruited a new Safeguarding Adult Lead, having covered the post for six months with interim appointments, following the retirement of the previous post holder. The Safeguarding Lead manages a centralised safeguarding email inbox to enable partners to send safeguarding concerns direct to the Safeguarding Adult Team. All concerns or enquiries are then forwarded to the relevant Local Authority Safeguarding Adult Teams. The Trust works in partnership with the multi-agency Enfield MASH team to comply with requirements for following up Safeguarding Adult alerts.

Trust staff attend Safeguarding Adult Strategy Meetings and Case Conferences as required. Recommendations from Case Conference Investigations are fed back to the relevant ward managers and matrons and the Trust has introduced monthly 'Lessons Learned Events' for Ward Managers and Matrons and other members of the multi-disciplinary team to enable reflection of recommendations from safeguarding adult enquiries.

The Trust is represented at Enfield Safeguarding Adult Board subgroups by the Safeguarding Adult Lead and Deputy Director of Nursing. The Trust is also represented at NHS England Safeguarding Network meetings by the Safeguarding Adult Lead.

North Middlesex University Hospital has the following governance in place to ensure safeguarding adults is embedded within the organisation:

- **Executive Lead** – Deborah Wheeler, Director of Nursing & Midwifery
- **Deputy Executive Lead** – Elizabeth Wynne, Deputy Director of Nursing
- **Safeguarding Lead** – Sarah Pope (commenced in post on 2 June 2018)

The Trust has an up to date Safeguarding Adults Policy that sets out responsibilities, reporting and investigating procedures for the protection of adults at risk. This policy supports and encourages staff to report any concerns that they may have about possible abuse to a person at risk, whilst that person is receiving treatment or care at the hospital.

Adult Safeguarding enquiries are coordinated by Adult Social Services and the Trust is a partner agency of the Enfield and Haringey Safeguarding Adult Boards. The Trust is represented on both these boards by the Deputy Director of Nursing and the Safeguarding Lead.

The Trust is also represented at both the Enfield and Haringey Safeguarding Adult Board subgroups by the Safeguarding Adult Lead.

The Trust is represented at NHS England Safeguarding Network meetings by the Safeguarding Adult Lead.

Safeguarding adults work undertaken and key achievements in 2017-18

To include specific examples of work undertaken:

- Training compliance is increasing to Level 1 84% and Level 2 is 87% in April 2018.
- MCA and DoLS training continues to be poorly attended and levels are 73%. MCA and DoLS is included in Level 2 safeguarding training but not in great detail. The safeguarding lead is doing some focused training over coming months.
- There had been a backlog of Enfield Safeguarding alerts raised against the Trust, which had not previously been reported to the Trust. All cases are progressing and the backlog is cleared.
- There is a monthly safeguarding meeting with attendance from all departments and partner agencies. The meeting looks at all safeguarding adult concerns identified by staff to ensure correct processes have been followed. An escalation plan is in place and triangulation of concerns enables us to liaise with local authority.
- Harm free panels for falls and pressure ulcers takes place weekly to give assurance plans are in place and prevention of further deterioration. Safeguarding Lead attends meeting to identify vulnerable patients early.
- Prevent Training takes place on hospital induction and regular roll out of training is offered to all staff.
- Attendance at SAR Panels and subsequent action plans to share the learning.

Key challenges

- Keeping up with changes to Mental Health Act and DoLS legislation.
- Staff fully compliant with mandatory training.
- Training for volunteers.

Safeguarding adults work planned for 2018-19

- Roll out of sustained PREVENT training to comply with statutory obligations under the Counter Terrorism and Security Act 2015.
- Continue to embed the use of MCA in the organisation.
- Development of a centralised monitoring system for DoLS to ensure full compliance.
- Continue to embed identification of patients deprived of their liberty and legal responsibilities.
- Continue training programme for DoLS.
- Audit DoLS compliance with Senior Nurses on visible leadership programme.
- Continued development of robust data collection system to monitor more activity in relation to safeguarding and utilise this data to target specific practice.

Details of internal arrangements for providing staff (and others) with safeguarding adults training

- Safeguarding training is part of the Trust induction programme.
- 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. Bespoke training is targeted to nurses at band 6 and above.
- A brief overview of Domestic abuse has been added to the cooperate induction training and will continue to be delivered in 2017/2018.
- Bespoke training sessions around use of MCA and DoLS.
- Roll out of PREVENT WRAP 3 training across the organisation to comply with statutory obligations under the counter Terrorism and Security Act 2015.
- We are currently 63% compliant.

One-to-One (Enfield)

One-to-One (Enfield) is a charitable organisation that works with adults with learning difficulties. As an organisation we are 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 work with our members to raise their awareness and understanding of abuse including Hate Crime. Our organisation is user led and with members' engagement and participation we have launched a DVD and booklets to explain about abuse and hate crime, to enable people to recognise and report it.

To ensure our members are safeguarded against any abuse, we work with the Integrated Learning Disabilities Team and ensure that concerns and incidents are reported immediately.

One-to-One (Enfield) has a positive relationship between members and their carers, staff, volunteers and other partner organisations such as Residential Homes for people with learning difficulties. This encourages people to be open about concerns and develops learning from each other. There are continuous training and development opportunities for staff and volunteers to help us keep abreast of any developments.

Statement written by:

Nusrath Jaku
Volunteer Manager

Enfield Borough Police

As publicly announced in February 2018 the Metropolitan Police Service is undergoing significant changes. These changes are vital to ensure the communities of London receive the very best service. The Basic Command Unit (BCU) programme with be implemented this financial year between Enfield and Haringey Police. The new BCU will be named 'North Area'. The Strategic leads will be responsible for both geographical areas. This provides opportunities for shared best practice, streamlining of processes and improved service through collaborative problem solving across boundaries. North Area BCU is committed to making the community a safe place to live, work and visit by working together with partners, communities and local people to protect the most vulnerable.

Senior officers will continue to attend the Safeguarding Adult Board 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 2017/18

Enfield Borough Police remain committed to the continued success of the Multi-Agency Safeguarding Hub where close collaboration ensures a partnership led approach to problem-solving thus maximising the ability to Safeguard vulnerable adults.

- Focus continues for our front line staff to correctly identify and record safeguarding matters on the MPS Merlin system, which is the primary pathway to strategic partners for any risks identified.
- Enhanced ties between police safeguarding units and other crime units such as the Gangs and the Major Crime Unit continues.
- 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 with the objective of ensuring best practise identified and areas of development recognised and improved.

Activities planned for 2018/19

North Area BCU will have a Safeguarding strand. This will allow the collaboration and oversight of a number of police units with Safeguarding vulnerable members of the community at its core. North Area BCU Safeguarding will be led by Detective Superintendent Tony Kelly who has an extensive background in Safeguarding and Public Protection.

- We will continue to engage with all communities across Enfield to build trust and confidence. Specific work will be undertaken to identify and target under reporting within community groups that have protected characteristics. This will be done to improve service to those who for whatever reason do not report instances to Police or services.
- We will continue to develop and contribute to the Multi-Agency Safeguarding Hub, with the aim of ensuring safeguarding adult concerns are referred to appropriate services in a timely manner.
- We commit to ensuring that no opportunity to Safeguard the vulnerable is missed, and that it is clearly understood that Safeguarding is everyone's responsibility.

Statement written by:

Detective Chief Inspector Adam Ghaboos
Safeguarding Enfield Police

Royal Free London NHS Foundation Trust

The Royal Free London NHS Foundation Trust is committed to safeguarding and understands that to safeguard effectively we must work collaboratively with partner agencies and professionals.

We work closely with others to ensure that all of 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. We acknowledge the balance between an individual's rights and choices and the need to protect those at risk.

Internal governance arrangement

We have a three year strategy that informs our three year work plan. The progress of this work plan is monitored by the Integrated Safeguarding Committee (ISC). The ISC meets quarterly and is chaired by the RFL Group Chief Nurse who is the executive board lead for safeguarding. The ISC is attended by the CCG safeguarding leads and monitors all safeguarding activity, Safeguarding Adult Reviews, Serious Incidents, allegations against staff, complaints, training compliance as well as responding to requests from Safeguarding Adult Boards and national priorities.

The ISC reports internally via the trust governance structure and produces an annual report for the Clinical standards and Innovations committee and the full Trust board.

A member of the safeguarding team sits on the weekly serious incident review panel.

Safeguarding adults work undertaken and key achievements in 2017-2018

Policy development – completed and implemented

- Safeguarding Policy. (Integrated Adult and Children)
- Safeguarding Supervision Policy

We have adopted a 'think family' approach to all our actions and policies and is evident in the three year work plan. Members of the safeguarding team are involved in a pilot project to improve the awareness and identification of early help and intervention to families and individuals in need. The pilot has been accepted as a project for quality improvement training provided by IHI and supported by the Trust. Using this opportunity the project group is supporting the development of early help and intervention across the Trust.

Referral rates: stable between April 2017 and March 2018,

- **401** alerts at the Royal Free Hospital (decrease of 17% on last year)
- **504** alerts for Barnet Hospital and Chase Farm Hospital (increase of 4% on last year)

The adult safeguarding team supported patients from 30 different Boroughs or Counties which shows the range of patients we admit with concerns and the complexity of the care plans that we are required to support.

We have refined our Safeguarding Alert reporting and screening in this past year and we are working with the local authorities to ensure that our processes are aligned. We have reduced the administrative burden for staff raising concerns and improved our information sharing with the relevant local authority teams, particularly relating to pressure ulcers where we are broadly following the new the DOH Safeguarding Adults Protocol, Pressure Ulcers and the interface with a Safeguarding Enquiry which was ratified in January.

The training figures are consistently in the 80% range for delivering MCA/DoLS and Safeguarding adults and we have worked diligently to raise awareness of PREVENT.

Key challenges and priority for 2018-2019 are to:

- Work stream to progress MSP principles
- Deliver the PREVENT agenda across the Trust
- Expand the breath of safeguarding adult supervision
- Develop and deliver level 3 safeguarding adult training
- Continue to improve compliance with application for DoLS

Statement written by:

Dee Blaikie
Adult Safeguarding Lead

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.

Current position

The Safer and Stronger Communities Board comprises the local authority, the police, the London fire brigade, probation services, (including the Community Rehabilitation Company) and the clinical commissioning group (CCG). Senior officers from these agencies support and promote the activity of the Safer and Stronger Communities Board within their own agencies. The Board is jointly chaired by the Basic Command Unit Chief Supt and the Chief Executive of the Council. The lead Elected Member for Community Safety is also a member of the SSCB.

The SSCB is the lead forum for monitoring the partnership response to crime an anti -social behaviour and members receive briefings on policy changes opportunities and risks

Key priorities agreed by the SSCB for the period 2017-2021:

- Tackling Violent Crime in all its forms
- Keeping young people safe and reducing their risks from crime
- Reducing Burglary and keeping people safe at home
- Promoting cohesion and tackling hate crime
- Dealing with Anti-Social Behaviour

These priorities are developed through a strategic assessment of crime and disorder to help the Board meet its duties to understand the local crime picture and work in partnership to do something to improve it.

The SSCB receives updates from a number of groups, including the Drug and Alcohol Action Team meeting and safeguarding boards to ensure that we are appropriately sharing information and opportunities to improve Community Safety for local residents and those who work in or visit the Borough.

Statement written by:

Andrea Clemons
Head of Community Safety
Enfield Safeguarding Adults Board representative

Strategic Safeguarding Adults Service
Health and Adult Social Care

October 2018

ENFIELD Council