**COVER PAGE**
This draft report maps out the key components of Annual report. Some data/ information is being collected and copy being finalised, but it does express the focus of the report. The report starts on the following page.

The report will be presented at:

Safeguarding Children Partnership Executive meeting on the 13th September 2022

Safeguarding Adults Board on the 14th September 2022

**Local Authority**

Health & Adult Social Care Scrutiny on 15th September 2022

Children & Families Scrutiny on 27th September 2022

Cabinet Meeting on 12th October 2022

Council Meeting on 16th November 2022

**NCL ICB**

To be confirmed

**Police**

To be confirmed

Page 2 - Partners' logos

**Please talk to us**

Safeguarding children, young people and adults at risk is everyone's responsibility. As someone who might live, work or study in Enfield you have a role too. If you are worried about someone or yourself, **please talk to us.** You can get help in any of these ways.

**Children and young people**

**If you or the person you are concerned about is under 18 (a child or young person):**

• Ring the Children Multi-Agency Safeguarding Hub (MASH) Team on **020 8379 5555**, Monday to Friday 9.00am to 5.00pm.
• Call the emergency duty team on **020 8379 1000** at night and weekends, and tell them what is happening.
• For people who work with children and young people, please make your referral using the Children Portal:
**www.enfield.gov.uk/childrensportal**
• You can email at: **ChildrensMash@enfield.gov.uk**
• In an emergency – such as when someone is being hurt or shut out of their home – ring the police on **999**.
You can also ring **ChildLine** on **0800 1111** or visit the ChildLine website: **www.childline.org.uk**

If you don't want to talk to someone you don't know, you can ask an adult that you trust, like a teacher or youth worker or even a friend, to make the phone call for you. When people are working with children they have to follow set procedures, but they will explain to you what they will do and should be able to support you through the process.

**ChildLine**

ChildLine have launched the **'For Me'** app – the app to provides counselling for young people via smartphone and other
mobile devices. For more information and to download the app for free, go to:
www.childline.org.uk/toolbox/for-me

**Adults**

**If you or the person you are concerned about is over 18 (an adult at risk)** you can call anonymously on the Adult Abuse Line:
**020 8379 5212** (Textphone: **18001 020 8379 5212**).
In an emergency always call **999**.
There is also helpful information on the Safeguarding Enfield website. Go to:
**www.enfield.gov.uk/SafeguardingEnfield**

**For all Enfield residents**

Domestic Abuse Freephone helpline

If you have experienced or are currently experiencing being made to feel unsafe by someone close to you, this is domestic abuse. Domestic abuse is not okay and is a crime. There is a specialist team to ensure no one is turned away and support is there for anyone in need.
Call us on **0800 923 9009 (Mon-Fri 9am – 5pm)**

**Email us at callusDAH@enfield.gov.uk**.

We are here to help you.

Modern Slavery Helpline

Modern Slavery is a crime that is hidden from plain sight but, occurs everywhere around us. Modern slavery is happening right here in Enfield and it needs to be stopped. An advice line is available to provide information and support for those that have any concerns or general questions regarding modern slavery. If you would like to discuss your concerns, please contact us on:

**020 3821 1763 (Mon-Fri 10am-2pm),** or you can email us at: **ModernSlavery@enfield.gov.uk**

# Contents page

**Vision statement**

**Our vision:**

**“is for an Enfield community where we can all live free from abuse and harm;**

**a place that does not tolerate abuse;**

**where we all work together to stop abuse happening at all, and**

**where we all know what to do if it does take place.”**

**Foreword by the Chair**

Geraldine Pic…

As the Independent Chair of the Safeguarding Adults Board (SAB) and the 2021-22 Scrutineer of the Safeguarding Children's Partnership (SCP) I am pleased to introduce the 2021-22 Safeguarding Enfield Annual Report.

This report outlines the partnership activities which contribute to keeping Enfield's communities safe. Safeguarding is 'everyone's business' and if you are worried about a child, family, young person or adult at risk, please speak up using the contact information in this report. We can help.

2021/22 represented another challenging year, one where we emerged from the COVID related lockdowns of 2020 and 2021. Partners have responded to the challenges with resilience and, as highlighted in this report, many examples of innovations. The breadth of the work taking place is impressive and highlights the dedication of individuals, team, and agencies to help keep people safe. This is highlighted in the partner updates that can be found in Appendix A.

This was my last year as Chair of Children's Executive group and the new chairing arrangements of the Executive meeting, by a safeguarding partner, are necessary. This change will support the excellent steps already taken by partners to demonstrate equal responsibility for safeguarding children and young people in Enfield.

I hope you find this report informative, and I want to encourage all of you send us your thoughts. Tell us what you think, what are we doing well, what do we need to improve on, how else can we communicate better across all the different communities of Enfield. Please email us at: SafeguardingEnfield@enfield.gov.uk

**Geraldine Gavin**

Independent Chair of the Safeguarding Adults Board, and Scrutineer of the Safeguarding Children's Partnership until 31st March 2021

Seb Pic… 

**2022/23 Chair of the Enfield Safeguarding Children Partnership**

As the current chair of the Safeguarding Children Partnership, I'd firstly like to thank Geraldine Gavin, who has chaired the Executive Group since the new arrangements came into force, and chaired the former LSCB in Enfield for many years. Her leadership has helped to create a positive and strong partnership that comes together to seek the best possible outcomes for our children and young people.

As Chair for this year, my focus will be on ensuring the partnership is working well across all our agencies, and in particular schools. I'm keen that we should learn the lessons from our reviews and from national reviews and make meaningful changes that will benefit our children and young people. I look forward to the welcoming our new independent scrutineers for 2022/23 who will assess our partnership arrangements and help us understand what we can do more effectively.

If you have any issues you would like to raise with the partnership's Executive group, please email our Business Unit at : .

I look forward to working with you.

**Detective Superintendent Sebastien Adjei-Addoh, Head of Public Protection, Metropolitan Police Service**

**The Enfield Safeguarding Enfield Partnership**

The Enfield Safeguarding Partnership is made up of the Safeguarding Adults Board and Enfield Safeguarding Children's Partnership and provides a way for the local agencies to work together to safeguard those at risk, and to ensure that the arrangements in place are working effectively.

## Safeguarding Childrens Partnership:

Enfield's Safeguarding Childrens arrangements were agreed and signed by the Safeguarding Partners on 5th June 2019. The arrangements were in place on the 29th September 2019 and the Department of Education were notified.

**Children Act 2004 & the Children and Social Work Act 2017 (Children)**

The Children's Act 2004 and the Children and Social Work Act 2017, state the statutory duties for local authorities and safeguarding partners to work together to safeguard and promote the welfare of children.

**Working Together 2018 (Children)**
The Statutory Safeguarding Partners are the Local Authority, the Police, and the Clinical Commissioning Group.

**The Safeguarding Adults Board (SAB)**

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

**The 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.

**Highlights of what we did in 2021-22**

Adults:

**Modern Slavery** response – Awareness raising work continues with 455 professionals trained, via 17 training sessions. The Modern Slavery helpline received 233 calls over the year.

**Safeguarding Adults concerns** –3638 concerns received in 2021/22, the highest the Enfield Multi-Agency Safeguarding Hub have managed. The number of concerns continue to rise in line with national increases.

**LeDeR reviews** - 16 deaths of people with learning disabilities were notified to the Learning Disability Learning from Lives and Deaths Programme (LeDeR) in 2021/22. After the very high mortality rates recorded during the pandemic, this appears more in line with previous years.

**SMART Living project and PainChek app**– Pain scoring artificial app implemented in nursing home as part of SMART living pilot.

**Safeguarding Community Engagement group** – re-established and focussing on Forced Marriage awareness raising amongst Enfield community members.

Children:

**Josef Local Child Safeguarding Practice Review (LCSPR) was published** – Review into the death of a 17-year-old published –

https://new.enfield.gov.uk/safeguardingenfield/reviews-and-reports/

**Partnership event** – the event in December 2021 attracted over 100 attendees. It covered the Josef review and shared learning from our audit work on Professional Curiosity and Information Sharing, with practitioner guide published –

https://new.enfield.gov.uk/safeguardingenfield/professional-curiosity-practitioners-guide/

**Sexual abuse in educational settings** – following the Everyone Invited testimonials and national responses, we have improved the partnerships links with education and presented key information to the Designated Safeguarding Leads meeting.

**Child Death** - the North Central London team received 30 notifications of Enfield child deaths. The central team reviews each notification and determines the need for a Joint Agency Response (JAR) meeting, where there was an unexpected cause of death. The team have co-ordinated 5 Enfield JAR meetings in the reporting period.

**National reviews** – following the review of the Arthur Labinjo-Hughes and Star Hobson deaths the partnership began an audit on physical abuse; following the Child Q review has led to an Enfield Task and Finish group where we are working with our Safeguarding Ambassadors on culture competence and adultification.

# Prevent abuse

In this section we present the work we've done to prevent abuse from happening.
This can include:
• raising awareness about risks so people can stay safe;
• making sure we've identified the right priorities (consultations); and,
• continue to work in ways that can prevent abuse from happening.

**ADULTS**

**Preventing Abuse in Enfield's Adult Care Providers**

Enfield has 195 CQC registered providers, one of the highest numbers in London.

To manage the risks around Quality and Safeguarding we have a Safeguarding Information Panel to ensure that partners can effectively: share information, identify any risks of harm to those who use services, and prevent any future or additional harm taking place.

The Panel can initiate actions such as Provider Concerns, Quality Checker visits, Immigration Enforcement visits and
London Fire Brigade visits. The Panel meets every six weeks.

Over 2021-22, the following interventions were implemented:

| Type of Activity (April 2021- March 2022)* | Number of activities |
|---|---|
| Provider Concerns Initial meeting held | 14 |
| Nurse Assessor visits | 8 |
| SIP referrals received | 44 |
| Immigration enforcement visits | 0 |
| Occupational Therapy visits | 0 |
| LBE Quality Assurance visits | 21 |
| CHAT Team visits | 1 |
| LFB safety visits | 0 |
| Quality Checker welfare calls made to family and friend contacts of service users | 231 |
| Quality Assurance 'Out of Hours' visits | 2 |

*Please note, there may be a number of subsequent visits that follow and are not captured in the following information. In addition, for monitoring purposes welfare visits identifies the number of providers worked with.

The SIP actions and interventions were adapted in line with the covid restrictions in place. Essential visits were made to care providers where risks were high, and visits were made with appropriate PPE and robust testing regimes in place.

To see more details on the Quality Checker calls please see page XX

## Infection Prevention and Control measures in Care homes:

Effective infection prevention and control measures are key to mitigating risks of cross infections in our care providers.

The Improvements and Standards manager leads on Infection Prevention and Control to support the boroughs social care providers to implement and maintain robust IPC measures to minimise the risks of cross infection of infectious conditions and to contain and manage identified COVID 'outbreaks'.

This has been extremely valuable during the pandemic and feedback from social care providers has demonstrated that this area of work has been instrumental in managing covid outbreaks and improving IPC measures to prevent repeated outbreaks.

The Improvements and Standards Manager works closely with the Public Health team to monitor levels of infectious conditions in care homes and delivers IPC training to front line workers. During the reporting period;

| **Infection Prevention and Control actions taken from April 2021- March 2022** | | |
|---|---|---|
| IPC training sessions delivered to social care providers | 7 training sessions delivered | 140 front line social care staff attended |
| Organisational learning reviews completed with social care providers that experienced a covid outbreak | 27 reviews completed | recommendations made and common themes identified and escalated for targeted information and advice from PH team |
| Unannounced IPC focused spot checks to social care providers | 47 spot checks made | follow up visit made to monitor services where recommendations have been made |
| IPC equipment provided to social care providers to support good IPC practices | 200 hand sanitisers provided<br>200 UV light hand washing kits provided | All providers contacted with information and advice |

## Safeguarding Community Engagement set-up

The Safeguarding Community Engagement Activity group was re-established after being affected by Covid. Our Lay members Irene Richards and Gill Hawken, are Chair and Depty Chair respectively.The group have agree the Terms of Reference and the Membership. The purpose of the group will be to:

i) Engage with organisations who have community champions or networks, and offer them safeguarding partnership training on specific areas of risk identified by the Safeguarding Adults Board, or Safeguarding Children's Partnership.

ii) Provide oversight of the Safeguarding Ambassador programme

iii) Scrutinise and contribute to newsletters, website, annual reports and strategies.

## Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards process is required by law to make sure that any restrictions to a persons' liberty are independently verified as being in that persons' best interests. This is particularly important where they may lack the capacity to understand the risks they would otherwise face.

| Item | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|
| Application received | 1420 | 1470 | 1539 | 1749 |

Over the past 4 years, we have seen a continuous rise in Deprivation of Liberty Safeguards (DoLS) applications. This has been attributed to a better understanding of the Mental Capacity Act 2005 following training sessions delivered by the DoLS team.

There are changes taking place in the DoLS process. The new process is called the Liberty Protection Safeguards. There will be changes in the roles of health organisations and care providers. A programme of work is underway to ensure that we are prepared for when these changes in the law come into force, which should be in 2023/24.

## Enfield SMART Living pilot – technology in adults social care

Many of us are already using SMART technology in the shape of smart phones, smart televisions, Amazon and Google home hub devices to name a few. We are aiming to increase the exposure of different kinds of SMART technology amongst are Adult Social Care staff, service users and carers, and trial specific applications in care homes. The use of these technologies can improve communication, access to information, enable us to identify issues sooner, and ultimately to help keep people safe.

Over the year, we have:

1. Initiated a programme of awareness raising, which has enabled Adult Social Care staff to loan various SMART devices so that can understand the benefits. This will then promote use of the technology with our service users and carers.

2. We have introduced PainChek, a pain management Artificial Intelligence App, which reliably measures pain, to an Enfield nursing home.

3. Engaged Middlesex University to help us evaluate the impact of our work and identify lessons that we can use to improve how we use and roll-out future versions of the current technology.

## CHILDRENS

### Early Help for Children and families

Overview of work Early Help services for children and families over 2021/22:

- 1,976 referrals for Early Help were received out of which 880 referrals were accepted and provided with Early Help support. On an average, Early Help was involved with families for 3-6 months.
- In total, Early Help stepped up 91 children into social care due to safeguarding concerns. 187 children and families were stepped down from social care into Early help, ensuring that these families continue to receive support to sustain positive progress.
- Early help quality of practice remains strong within over 85% of audited cases achieving either good or outstanding rating.
- Enfield were set a target of 'turning around' 519 families as part of the Supporting Families Programme. This was overachieved with 538 families successfully supported by the programme.
- Children Centres reached out to 3,044 families, with 1,796 families registering with children centres and accessing a range of services with focus on best start for life. Children Centres provided targeted family support to 223 families and completed 162 Early Help assessment. 97% of infants received face to face new birth visit by the Health Visiting Service.
- Youth Service has continued to deliver a strong youth offer that includes universal services from five youth centres, Summer University, Holiday and Food activities programme, mentoring, detached youth work, outreach work to schools and contextual safeguarding youth work. In June 2021, Council opened a new dedicated Youth Centre in Ponders End. Overall, 4,063 young pe people have accessed youth services. Summer University during school holidays in 2021, delivered 131 structured learning course, providing positive diversionary activities to 848 young people. Inspiring Young Enfield has engaged over 5,000 young people in a range of enriching and learning programmes, providing young people support with well-being, employability skills and staying safe.

Early Help partnership have continued to seek new funding streams and collaborate in leveraging financial resources to sustain and increase our early help offer for children and families. For instance, the following new early help projects were developed and additionally funded to diversify our Early Help offer:

- Successful NCL regional partnership funding bid for Vanguard project, providing therapeutic and youth support interventions for young people at risk of exploitation
- NCL Health Inequalities fun, funding violence reduction social prescribing project Dove for young people
- Additional funding from the VRU to fund the youth project Engage in Wood Green Custody
- DfE Covid recovery funding to develop feasibility study to support development of Family Hubs
- Council funding Early Help pilot Housing project with focus identifying and supporting families with most complex needs and re-housing them from their temporary accommodation
- MOPAC funding additional detached youth workers
- Council capital funding to develop Mobile Youth provision

## Prevention of youth crime and serious youth violence

Enfield Youth Justice Service (YJS) and the partnership demonstrated a strong performance during 2021/22:

- There was a reduction of first-time entrants. There were 73 young people as first-time entrants, which shows a 21% decrease from the previous year of 93. This is attributed to the successful Out of Court Disposal scheme and Early Help delivered by the Council and its partners.
- There was a notable reduction of children receiving custody, which is positive. There were 5 young people in total that received a custodial sentence in 2021/22 in comparison to 13 children in 2020/21. This is attributed to the continued confidence of the courts in the work of the Enfield Youth Justice Service and wider partnership, effectively supporting and safeguarding offending children within the community as well as victims.
- There has been a positive reduction in remand episodes during 2021/22. Cumulatively, there were 35 remand episodes during 2021/22 in comparison to the previous year that saw 45 remand episodes. This represents 22% decrease. Enfield Youth Justice Service continues to ensure that only children that present highest risk to the community and themselves committing the most serious offences are remanded.
- There was a reduction of re-offending for the tracked youth cohort from 2019/20. The re-offending ranged between 26.2%-36.7% in comparison to the re-offending range of 33.9%-51.2% for the 2018/19 tracked youth cohort. This is attributed to the highly effective safeguarding interventions that the service continues to provide to young people.

Youth Justice Partnership developed a range of new preventative initiatives to safeguard and prevent children getting involved in offending, for example:

- Project Dove – through a social prescribing identifying young people at risk of serious youth violence in education and health settings and provide them with early intervention support
- Introduction of contextual safeguarding and detached and outreach youth workers working in schools and local communities, providing information, advice and guidance to young people with focus on diversion and prevention of risky behaviour
- Introduction of community resolutions in August 2021, preventing unnecessary criminalisation of young people for low level offences whilst providing young people with access to early help support.
- Safer Spaces project – identifying spaces where young people feel less safe and developing community safety solutions to increase young people's confidence in safety
- Engage project in Wood Green Custody, providing youth support to the arrested young people presented to the custody with a follow through provision of support into the community post release to meet young people's additional needs with focus on reduction of risky behaviour and further offending.

Youth Justice Service Evidence of impact:

In 2021, the annual youth satisfaction survey highlighted that 95% of young people rated their levels of satisfaction with the service as either good or outstanding.

In 2022, a focus group was held with young people to hear and learn about their journey through the youth justice system, informing the focus of our service improvement plan.

Young people told us they had a positive relationship with their case workers and felt well

informed and supported. Young people have also provided us with further valuable feedback to support improvement of our services – for instance young people continuously told us they would like a better facility for the youth justice service.

In response, we will be re-locating the Youth Justice Service from Claverings into a new state of the art building in Thomas Hardy House in Enfield Town by the end of 2022.

Youth Justice Service Priorities for 2022/23

Youth Justice Service and wider partner have identified the following key strategic priorities that are reflected within the statutory Youth Justice Plan 2022/23:

- Prevent first time entrants, reduce re-offending and custody whist keeping the public safe in the context of recovery from the pandemic.
- Continue to drive service delivery improvements in response to our quality assurance findings
- Promote a child first approach across the youth justice system and effectively safeguard children, whilst promoting their welfare and best outcomes
- Drive system improvement by building on our organisational effectiveness, governance work, partnership and leadership to delivery high quality youth justice services.
- Develop and implement a disproportionality action plan across the youth justice system informed by understanding of local needs.
- Focus on prevention of serious youth violence in line with our public health approach.

## Community Safety

- The number of Serious Youth Violence victims in Enfield increased by 32.3% in the year to March 2022. 352 victims were recorded in the borough compared with 266 victims in the year to March 2021, an increase of 86 more victims. This year is still 41.8% lower than pre-pandemic year end March 2021 (499).

- Our aim to reduce SYV is underpinned by a public health approach focused on early Intervention partnership and commissioned work. New initiatives have included a violence reduction social prescribing project, funding for project Vanguard secured to increase therapeutic support for young people at risk of SYV and exploitation, contextual safeguarding youth work, team around the school pilot, safer spaces project and outreach mentoring in A&E.

- 31 Prevent referrals resulted in 16 cases being discussed in Channel panel. Home Office funded projects have been delivered and completed, these included projects focusing on improving safeguarding practices in unregulated spaces and projects aimed at increasing awareness of radicalisation amongst professionals working in domestic abuse space.

- The Prevent team delivered 17 training events to 249 staff including foster carers. In addition, 31 training events were delivered to schools with 1,002 attendees receiving training. 29 workshops/assembly events were delivered, raising awareness and educating 2,124 students.

- There was a 13.7% decrease in domestic abuse violence with injury (DA VWI) offences. Community Safety continues to commission perpetrator programme, IDVA service and has been working with housing towards the DA Housing Alliance Accreditation.

**Joint Services for Disabled Children**

- The Joint Service for Disabled Children comprises of the specialist social work service, preschool support home visiting service, early years keyworker service and a specialist short breaks and family support service. Services are delivered in house 7 days per week at Cheviots, specialist play, and home care providers are commissioned, and families can also access a personal budget to arrange the support that best meets their child and family's needs.

- The services and support are designed to provide fun activities for the child, an opportunity to meet with their friends or be supported to access community activities and provide a break for the parent from their caring responsibilities to support family life.

- At the end of March 2021, 344 children were receiving a service from JSDC. There were 254 new referrals for short breaks, this is an increase on last year (150). 159 of those children and young people had a diagnosis of Autism.

- In Enfield, there is a well-established mechanism in place for co-production, consultation, and engagement with parents/carers. The JSDC has worked in partnership with Our Voice Parent Carer Forum, Enfield National Autistic Society and Carer 2 Carer. Parents and carers play an integral part in decision making processes are fully engaged in shaping, developing, implementing, and evaluating services and pathways for support.

- Parent representatives attend strategic groups and workstreams and participate in all discussions relating to commissioning of new providers, development of the Local Offer and SEND provision in the borough. They are equal partners in the work we do.

## Work in Schools

The details below highlight the work the Education department has been doing with schools in the borough:

- New role created – Senior School Improvement Advisor Safeguarding & Inclusion – February 2022. This role means working in close liaison with other agencies in particular Children and Families Services, Human Resources, Police, and National Health Service for the benefit of and always promoting safeguarding of children.
- Leaders took part in a ten session Professional Learning programme during 2021-22, including local, national and international expertise, e.g. Unconscious Bias and Anti-Racism as a response to the Black Lives Matter movement.
- Governors took part in training course, e.g. Unconscious Bias and Anti-Racism, during 2021-22.
- Whole service Safeguarding training took place in September 2020 and is arranged for September 2022.
- Leadership team made aware of changes to Keeping Children Safe In Education September 2022 through in-house training.
- Designated Safeguarding Lead training arranged termly so that schools can ensure they are meeting their statutory needs. These were broken down into mainstream settings

and special schools during 2021-22, and for 2022-23 will be again broken down into mainstream and those that work with pupils with Special Education Needs & Disability (SEND) due to the growing number of pupils with Educational Health Care Plans (EHCPs) in mainstream schools.

- All Early Carer Teachers were able to join borough run safeguarding training within their first half term.
- A new Professional Learning training offer for Designated Safeguarding Lead Supervision set up for 2022-23.
- Designated Safeguarding Lead Network for schools started last year and to be embedded in 2022-23 with an increase in sessions.
- Designated Safeguarding Lead training questionnaire completed May 2022 and used to support Designated Safeguarding Leads with knowledge and skills for their role.
- The Senior School Improvement Advisors visit to schools included questions about safeguarding and the culture in the school. All Senior School Improvement Advisors help to ensure school staff and others working in education are promoting the welfare of the children in their settings.
- Senior School Improvement Advisors for Safeguarding & Inclusion able to complete safeguarding reviews in school as requested/needed.
- Senior School Improvement Advisors for Safeguarding & Inclusion offers guidance on specific safeguarding issues to schools.
- Advice and guidance to educational establishments, early years settings and childminders on safeguarding and child protection concerns, including allegations against staff.
- Trauma Informed Practice in Schools (TIPS) was promoted via taster sessions and shared at Leadership Day in July 2022.
- Senior School Improvement Advisors for Safeguarding & Inclusion has had full E-TIPS training to support with signposting and sharing good practice.
- Senior School Improvement Advisors for Safeguarding & Inclusion is a Mental Health First Aider for adults.
- Strengthening Wellbeing, Emotional health, Relationships and Readiness for Learning (SWERRL)/Behaviour Support Service (BSS) continue to support vulnerable pupils in school.
- Example safeguarding self-audit shared.
- Disseminate best practice regarding safeguarding by drawing on latest safeguarding guidance and research.
- Finalised the Inclusion Charter for launching in September 2022.

## Protect people at risk

One of the main tasks for the Safeguarding Partnership is to make sure we have excellent responses to concerns. We do this through having clear policies, good training, looking at our data and audits (checks). This year a significant part of this work involved responding to emerging risks due to COVID-19. Here we present some of our key responses, policies, talk about our training and present some high-level data. More details information can be found in the appendices.

### Adults

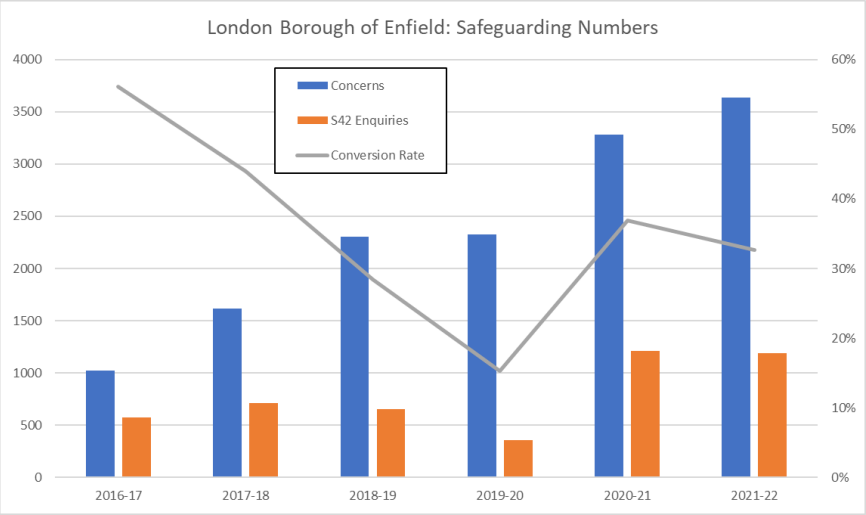
[in box]
**Care Act 2014 (Adults)**
Safeguarding Adults duties are detailed in Section 42 of the Care Act and in the accompanying Statutory guidance. Where the following criteria are met for a concern the Local Authority, who is named as the lead agency for safeguarding, must ensure that a Safeguarding 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.

### Adult Multi-Agency Safeguarding Hub (MASH)

| | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 |
|---|---|---|---|---|---|
| **Concerns received by the Adults MASH** | **1616** | **2307** | **2326** | **3278** | **3638** |
| **Concerns that led to enquiries** | **741** | **656** | **356*** | **1217** | **1190** |

*Only includes Statutory Section 42 (2)

**[note for loui- place holder graph, ]**




Since the conception of the Adult MASH, there has been a commitment that all concerns will be responded to. This can include information and advice, sign-posting to other services, assessments

for care and support services, or for a social worker to work with the adult to manage the risks of abuse they face.

2021/22 saw the upward trend in safeguarding concerns continue. Concerns relating to self-neglect remain high, as well as those occurring in people's own homes.

Enfield were part of a National Insights projects, led by the Association of Directors of Adults Social Services, to understand safeguarding concern trends since the pandemic began. Initial analysis shows that the types and numbers of concerns received in Enfield are in line with what has been experienced nationally.
The Enfield teams were asked for feedback around Safeguarding Adults cases during as part of this project. Our Locality teams and MASH noted an increase in work with homeless people and that they were being asked to assess people that they felt would not previously have been asked to assess. This is likely to be a result of the establishment of the Rough Sleepers Multi-Agency Risk Assessment Meeting (MARAM) – however, this continues to be a very positive example of interagency and departmental co-operation.

Our Mental Health teams have noted an increase in people presenting (with mental health concerns substantial enough to require secondary health services input) for the first time since the first lockdown and this continues to increase. Anecdotally, alcohol and substance misuse services suggest the same. This is also evident in the concerns that we have received in terms of anecdotal evidence from the teams conducting the Section 42 Enquiries.

All teams felt that self-neglect cases are more complex and time-consuming than other types of cases in terms of length of involvement, need for complex review and so on. Self -neglect is now the highest 'type' of abuse that we see in the concerns raised.

| | 2021-22 | | 2020-21 | 2019-20 | 2018-19 |
|---|---|---|---|---|---|
| **Type of Abuse** | **Yes** | **%** | **%** | **%** | **%** |
| Self-Neglect or Hoarding | 890 | 20.7% | 20.3% | 17.3% | 18.8% |
| Neglect and Acts of Omission | 864 | 20.1% | 18.0% | 21.7% | 22.7% |
| Physical abuse | 590 | 13.7% | 14.0% | 11.9% | 12.3% |
| Emotional / Psychological Abuse | 571 | 13.3% | 13.8% | 14.0% | 12.7% |
| Domestic Abuse | 452 | 10.5% | 11.3% | 5.7% | 5.6% |
| Financial or Material Abuse | 441 | 10.2% | 9.7% | 10.1% | 11.1% |
| Sexual Abuse or Exploitation | 182 | 4.2% | 3.7% | 6.9% | 7.7% |
| Organisational Abuse | 138 | 3.2% | 3.7% | 3.0% | 2.5% |
| Pressure Sores | 103 | 2.4% | 3.4% | 8.0% | 5.5% |
| Modern Slavery | 37 | 0.9% | 0.5% | 0.4% | 0.3% |
| Discriminatory Abuse | 23 | 0.5% | 0.7% | 0.2% | 0.2% |
| Hate Crime or Disability Hate Crime | 11 | 0.3% | 0.5% | 0.6% | 0.5% |
| Honour Based Violence | 3 | 0.1% | 0.3% | 0.1% | 0.0% |
| Forced Marriage | 3 | 0.1% | 0.1% | 0.0% | 0.1% |
| Female Genital Mutilation | 0 | 0.0% | 0.1% | 0.0% | 0.0% |
| **Total** | **4,308** | | | | |

Note: there can multiple types of abuse in a safeguarding concern

**Location of Abuse:**

**2021-22**

| Location of Abuse | Count | % |
|---|---|---|
| Own Home | 2,152 | 59.2% |
| Other | 284 | 7.8% |
| Care Home - Residential | 231 | 6.3% |
| Blank | 217 | 6.0% |
| Care Home - Nursing | 174 | 4.8% |
| In the community | 162 | 4.5% |
| Hospital - Acute | 147 | 4.0% |
| Hospital - Mental Health | 144 | 4.0% |
| In a community service | 66 | 1.8% |
| Hospital - Community | 61 | 1.7% |
| **Grand Total** | **3,638** | |

2020-21

| Row Labels | Count of Unique ID | %age |
|---|---|---|
| Own Home | 1917 | 58.5% |
| Care Home | 252 | 7.7% |
| Other | 245 | 7.5% |
| Hospital | 217 | 6.6% |
| Blank | 186 | 5.7% |
| In the community (excluding community services) | 172 | 5.2% |
| Hospital - Mental Health | 154 | 4.7% |
| In a community service | 135 | 4.1% |
| **Grand Total** | **3278** | |

| 2019-20 | Count of Unique ID | %age |
|---|---|---|
| Own Home | 1019 | 43.8 |
| Blank | 711 | 30.6 |
| Care Home | 255 | 11 |
| Hospital - Mental Health | 86 | 3.7 |
| Hospital | 70 | 3 |
| Other | 61 | 2.6 |
| In the community (excluding community services) | 50 | 2.1 |
| Not known | 39 | 1.7 |
| In a community service | 35 | 1.5% |
| | 2326 | |

**Risk outcomes for completed enquiries:**

**The table below compares risk outcomes from previous years:**

| Where risk identified, what was the outcome? | 2021-22 | 2021-22 | 2020-21 | 2019-20 | 2018-19 |
|---|---|---|---|---|---|
| | **Total** | **%** | **%** | **%** | **%** |
| **Risk reduced** | **744** | 62.5% | **70.9** | **53.8%** | **59.0%** |
| **Risk removed** | **258** | 21.7% | **20.2** | **24.2%** | **15.7%** |
| **Risk remains** | **114** | 9.6% | **7.8** | **6.7%** | **9.3%** |
| **Risk did not exist** | **56** | 4.7% | **1.0** | **9.2%** | **6.9%** |
| **Not Applicable** | **18** | 1.5% | **0.1** | **6.3%** | **6.7%** |
| **Total** | **1190** | | | | |

## Modern Slavery

Enfield's Modern Slavery Team comprising Local Authority and Police staff. The multi-agency team has been raising awareness and responding to intelligence.

Between 1st April 2021 and 31st March 2022, the team have delivered 17 awareness training sessions to 455 delegates in a variety of teams across Enfield, including GPs, Schools, Social care to name a few. From the feedback received, the sessions have been positively received:

*"I thought the delivery was excellent from two knowledgeable members of staff*"

The hard work and dedication of the Modern Slavery Team has been recognised across the local safeguarding partnership. The team have been described by the Central Crime Police team as the 'Gold standard' borough with the view of training other boroughs of how to approach modern slavery and exploitation cases.

The team identify trends in conjunction with Police and focus targeted resources in areas of need to tackle the criminal element of modern slavery in the borough.

The team continues to run a helpline to support the public and professionals in relation to modern slavery. During 1st April 2021 and 31st March 2022 there have been 233 calls to the helpline from various sources such as Police, members of the public etc.

[the following in a box as a case study]

**[**Enfield's Adult Multi-Agency Safeguarding Hub (MASH) receive all individual safeguarding concerns where there is a suspicion/ allegation of Modern Slavery.

We pride ourselves in ensuring all MASH staff are aware of how to recognise Modern Slavery and have Social Workers who `specialise` in this form of abuse. When Modern Slavery is suspected, we use creative and timely ways to intervene and make safe contact with the individual(s) and ensure that we have necessary resources in order for their voice to be heard in relation to their views and

outcomes, whilst considering any influences of coercive control; this could be with the support of a GPs, Hospitals, interpreting and domestic abuse services, to name a few.

In addition to this, where necessary, Police will be used to support in more risky engagements with individuals and we have been awarded Gold standard in collaborative working with our local Police.

MASH have worked with survivors of Modern Slavery on a number of cases by ensuring their outcomes are met and they are safeguarded until long term support is in place.

*"I was scared initially but I now realise that this was not normal or right, and I thank you for all your help. You have saved my life".*

**]**

## High Risk Advisory Panel

A 'High Risk Advisory Panel' was set up for adults safeguarding cases. This is chaired by our Head of Safeguarding and bringing together senior multi-disciplinary colleagues for cases where there has been a lack of progress using usual processes.

Many of the cases so far referred have involved some level of self-neglect or non-compliance so mental capacity is a key area for discussion. This builds on pre-existing meetings such as the ILDS Complex Cases panel.

Several Safeguarding Adults Board partners have been involved which has been been essential in moving very complex cases forward.

## Hoarding multi-agency database:

A Hoarding Co-ordinator was appointed for 5 weeks to work on a database of properties in the borough where there are concerns about hoarding. This allows agencies, including the London Fire Brigage, to work together from an earlier point to support adults who have problems in their home environment.

## Gambling problems amongst adult social care service user:

Adult Social Care have started a project with GamCare to pilot regularly asking service users about problem gambling. This should help us to understand how much of a problem this is for our service users – the project has also involved training staff to work with those who have issues with gambling.

## Community Do Not Attempt CPRs

Practices around community Do Not Attempt CPR orders were checked by a joint project between the NHS Clinical Commissioning Group and Adult Social Care, funded by the NHS Clinical Commissioning Group. GP practices were asked to confirm their practices following concerns raised in the media and by our lay member. Work is on-going and improvements being worked on with the newly formed NHS Integrated Care Board.

## Transitional Safeguarding

Adults Social Care and Children and Family Services have identified a need to support young adult residents aged 18 to 25 in achieving positive outcomes, these young adults may have been known to Children's Services as vulnerable children or have come to the notice of Adult Social Care post 18. This group may have received some support as a child, but when turning 18 are often unable to access equivalent or ongoing support as adults unless they have been assessed as having eligible needs for care and support under the Care Act (2014). There are gaps in legislation to safeguard this group and the need for change has been highlighted nationally.

In Enfield, a working group has been formed to consider the best options. Using feedback from colleagues, gathering local data, and looking at other authority models who have already adopted new ways of working, it has been recognised that there is currently a gap for this group of young people in the service. Upon reaching 18 they have no support in place but may still need a degree of help to ensure that they are able to achieve better outcomes in life.

The working group has identified that these young people need the right support at the right time and is best delivered independently from the Local Authority with a provider who has a good track record of engaging with young people, and has the experience, skill set and community links.

The key aims are to:

- promote individual wellbeing
- work in a strengths-based way with a focus on goals
- facilitate development strategies of life skills
- identify and utilise community resources
- connect young adults to their communities
- ensure young adults are involved in influencing the service and support they receive

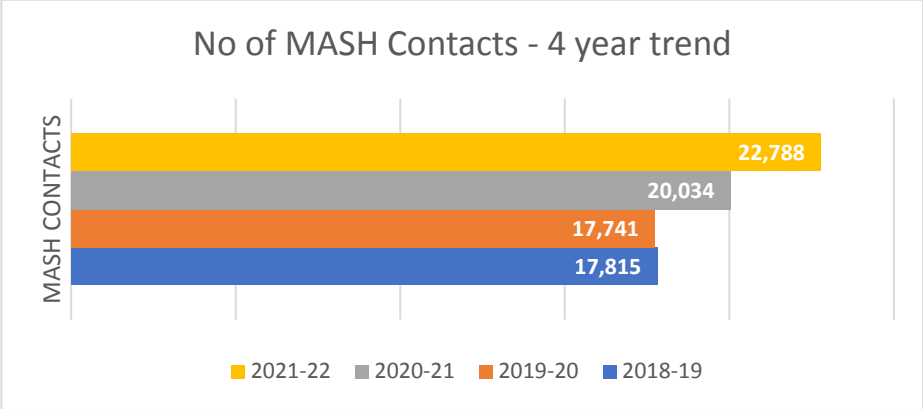
A suitable provider will be in place by October 2022 as part of a 1-year pilot.

## Childrens

### Children in Need of Protection

### *Children's MASH (Multi-Agency Safeguarding Hub)*

- There were 22,788 MASH contacts, an increase from 20,034 in the previous year. This was the highest number of contacts in the past 4 years. Police, schools and health services continue to be the main referrers.




- A review of the threshold guide led to an updated version being piloted by the MASH team at the end of the year, the new guide has resulted in an increase of referrals to Early Help and improved quality of referrals to the Assessment and Intervention Service.

- The domestic abuse hub has been relocated into MASH, where they provide immediate advice and support to those experiencing abuse. The move recognised the abuse hubs core role interfacing with the public

- There were 3,850 contacts made to children and family MASH relating to domestic abuse and 94 calls were made to the domestic abuse hub. Overall, there were 6,470 domestic abuse incidents recorded, a slight decrease from 6,598 in the previous year. In May 2022, SOLACE will be co located in the MASH. This will enhance MASH with the inclusion of accredited specialist SOLACE workers.

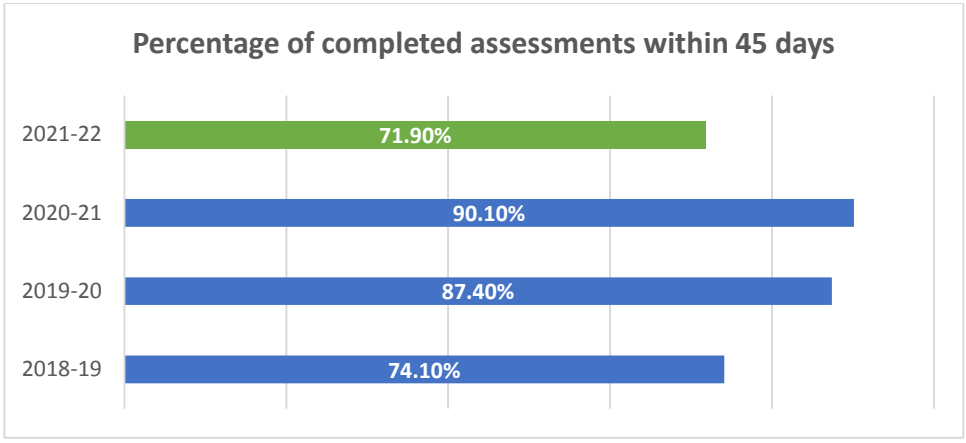
- Partnership working is strong in the MASH and the daily emergency duty team (EDT) handover meetings have been beneficial in ensuring multi-agency information is shared at the earliest opportunity. A professional consultation line is due to be launched in September 2022 for designated leads to seek advice and guidance.

- To increase understanding of MASH amongst partners and staff, MASH have provided shadowing opportunities. A range of staff and organisations have taken up this offer including schools, public health, and youth development service to date with further visits planned.

## *Assessment and Intervention*

- As of 31st March 2022, there were 2,540 young people subject to a multi-agency child protection strategy meeting. This is a 22% (2,078) increase on last year. 80.1% of child protection investigations led to an initial child protection conference a slight decrease on the previous year (82.9%).

- During 2021/22, there were 4,302 children and family assessments were completed, an increase on the previous year, with 71.9% of completed within 45 working days, a decrease on last year's 90%. Linked to vacant posts and Covid related absence.




- There was a rate of 9.40 (per 10,00 child population Cafcass care applications) an increase on last year from 7.30. In total there were 111 children subject of care applications. As of March 2022, there were 16 child protection cases in Public Law Outline (PLO).

- Five legal planning meetings, where advice was sought for a Forced Marriage Protection Order took place, this is the same number as last year. The safeguarding children partnership has led on forced marriage training, attended by children social care staff.

**IMPACT feedback**

Email from an organisation sharing information from a parent re: one of the social worker's.
*"… Mum shared that your approach with E allowed him to feel comfortable enough to share in more detail his abuse. She explained that you used videos to allow E to understand that he is not alone and that other children have gone through similar experiences to him. She also reflected that bringing the family together to sit around the table and discuss E's experiences, helped to unify them as a family. From your short intervention with the family, Mum feels that you have had a significant impact on E's current wellbeing and she is very grateful for all of your support with the entire family. It was incredibly warming to hear what a great impact your open and containing practice has made for this family. I hope that you will*

*share this feedback with your manager…"*

## *Child Protection and Child in Need*

- As of 31st March, there were 627 children allocated to social workers on a child in need plan (CIN), this was an increase of 33% on the same time last year (472).

- Audits continue to demonstrate that there is quality direct work with children and their voices heard and CIN plans are improving.

- As of 31st March, there was a 40% increase in the number of children subject of a Child Protection Plan from 237 at the end of last year to 333 at the end of March 2022 – a rate of 39.5 per 10,000 children. There was a slight reduction in the timeliness of plans being reviewed from 78% from 83.3% last year.

- The number of children subject to a CP plan for a second or subsequent time (having been subject to a CP plan at any time previously) is currently 5.9% this is a decrease from 7.8% last year. This continues a downward trend.

## *Child Specialist Services*

- The child specialist service consists of the domestic abuse team, adolescent safeguarding team, contextual safeguarding hub, and the emergency duty team (EDT).

- The domestic abuse team holds a small caseload of children to enable more intensive work. There is a dedicated perpetrator lead who has worked with approximately 12 perpetrators on a 1:1 basis, delivering sessions and supporting wider development across the team with respect to the challenge of working with individuals who perpetrate domestic abuse within intimate personal relationships.

- In June 2021, two adolescent safeguarding teams (AST) were set up to provide a more integrated response to exploitation, serious youth violence, missing episodes, and 'edge of care'.

- The adolescent safeguarding teams have worked with a total 281 young people over the last year. 245 of these young people were supported to remain at home, 16 came into local authority care and 20 were assisted to access supported accommodation.

- The contextual safeguarding hub collates, analyses, and maps intelligence to find trends and 'hot spots', which can further support effective safeguarding practice both on an individual and community level.

- Case file audit continue to show good practice, with 83% of 12 audited cases were graded either good or outstanding.

- There were 383 missing occasions during the year relating to 131 children of which 44 were looked after children. All missing children are offered an independent debriefing on their return, approximately 50% take this up. Information is shared with police and relevant social workers to inform their risk assessment / analysis and safety planning. Where the young person is known to the youth offending team, a discussion takes place to decide who would be best placed to conduct a return home interview

**IMPACT**

In October 2021, Enfield took part in the Independent Review in Children Social Care, the final report was published in May 2022, Enfield's Adolescent Safeguarding Teams, was chosen as a case study as an example of multi-disciplinary response to extra familial harm. The embedding of an education lead had resulted in increased attendance for young people and our trauma informed workshops for parents had resulted in parents have a greater understanding of extra-familial risks to their children.

**Wider response to contextual safeguarding**

- Partnership work with the Pupil Referral Unit has included seconding a social worker for 2 years with direct link into the contextual safeguarding hub.

- Workshops have been delivered with the support of a psychologist to address trauma. By end of March four workshops had been delivered. All parents requested one-to-one sessions. 6 one-to-one sessions have been held with one mother requesting a further session to include her 13-year-old son.

- In June 2021, the Safeguarding Adolescents from Extra-familial harm (SAFE) panel focussed on children, aged up to 18, (25 where appropriate) was set up. The panel considers the context of the harm, the level of known risk and considers what the partners can do to disrupt, protect, and prevent harm. The panel offers healthy challenge between agencies and has led to better understanding of what extra familial risks are and what has worked to increase safety.

- A total of 64 new referrals were discussed at SAFE. Of the 64, 53 had a primary concern of criminal exploitation and 11 of sexual exploitation. The most common type of harm referred to SAFE is criminal exploitation followed by serious youth violence. This year there has seen a noticeable decline in the number of CSE cases referred. In response a bespoke training has been developed to raise awareness.

## Maintaining Child Protection medicals:

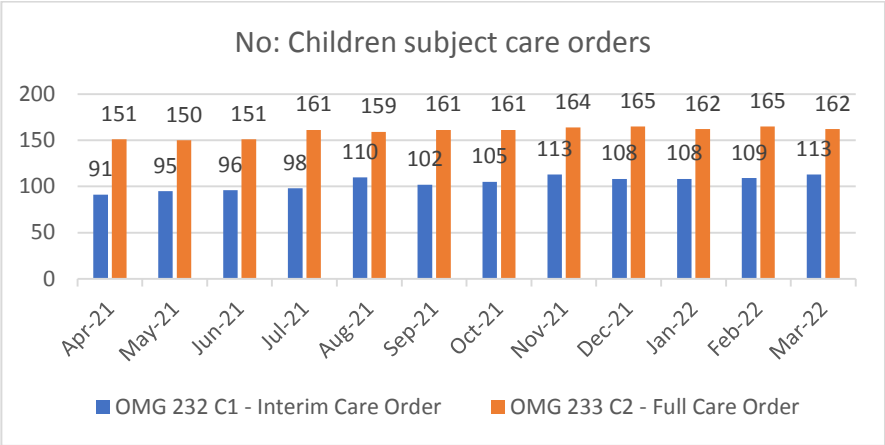
The Designated Doctor and Designated Nurse, are statutory roles and both take a professional and strategic lead for safeguarding in the Borough. There continues to be a gap in the Designated Doctors function for Enfield. An interim post-holder is in place and working to ensure children who require Child Protection Medical Examinations are seen in a timely manner.

## Children in Care and Care Leavers

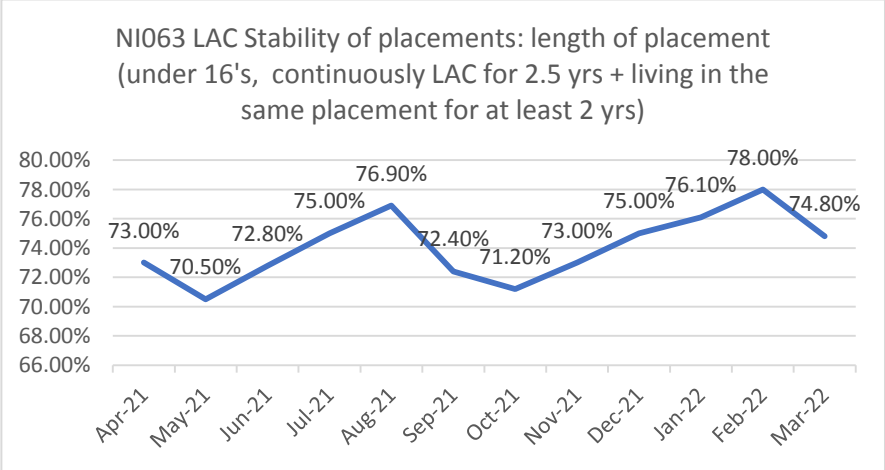
### Looked after Children Service

- At the end of March 2022, 396 children were looked after, compared with 391 the previous year and 395 at the end of March 2020. Although there has been a slight increase, the number of children has remained relatively stable over the past 3 years. Enfield's looked after children rate (45 per 10,000)

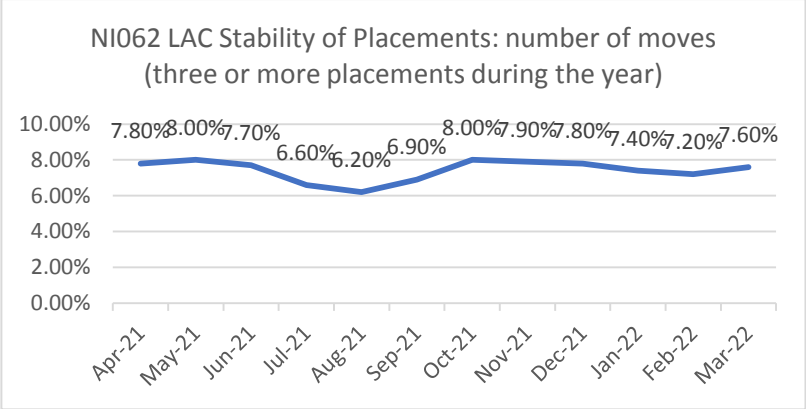
remains lower than the statistical neighbours (59.10 per 10,000) and the national average (67 per 10,000).




- As of March 2022, there were 113 interim care orders and 162 children on full care orders.
- The number of unaccompanied asylum-seeking children accommodated by the local authority decreased from 38 in March 2021 to 33 children at the end of March 2021.
- Placement stability for children in local authority care stays high at 74.8% and increase from 72.7% in the previous year.




- There was a decrease in the number of children placed with in-house foster carers down to 45.7% from 49.9%. The number of Looked After children who have had 3 placements or more remains low at 7.6%.




**Impact**
(Social worker), Looked After Children Service
The Judge said*: "Ms M.' evidence was clear, fair and honest. She is an efficient, child focused, hardworking and compassionate social worker. Her records are detailed and clear. She has a good relationship with the children (and the parents) and they are fortunate to have her as their allocated social worker. Ms M..is a highly competent social worker and a credit to the local authority. I have no hesitation in accepting her evidence".*

- The impact of the pandemic continues to be felt and is reflected in court proceedings not being concluded. This means for some children and family social workers have continued to be involved beyond the time that would have been expected.

- Audits are regularly undertaken to look at the quality of social work delivered to our children in care, generally the practice has been found to be good, with areas of improvement found around case files.

- This year saw the launch of New Beginnings a service that supports women who have experienced their children being permanently removed from their care and women who are at risk of further pregnancies that may result in additional care proceedings. The New Beginnings team are currently working with thirteen women.

## LAC Health Assessment:

The Designated Doctor for Looked After Children (LAC) post remained vacant in the reporting period, however the LAC Designated Nurse and the interim Designated Doctor work closely to ensure assessments are completed. However, this remains an unmitigated risk, the interim medical has escalated the gaps to Barnet, Enfield and Haringey Mental Health Trust, the Trust is actively trying to recruit to these posts.

## Fostering and Permanence

- Special guardianship cases have continued to grow this year there were 26 SGOs made to families.

- 6 Adoption Orders were granted and at the end of March 2022 there were 6 children in adoptive placements awaiting court dates for their final hearings.

- A robust approach continues to be used by the fostering recruitment and assessment team to recruit foster carers in a very demanding climate. This year 17 new foster carers were assessed and approved. In 22/23 we will be looking at 'invest to save' initiative to increase on this number.

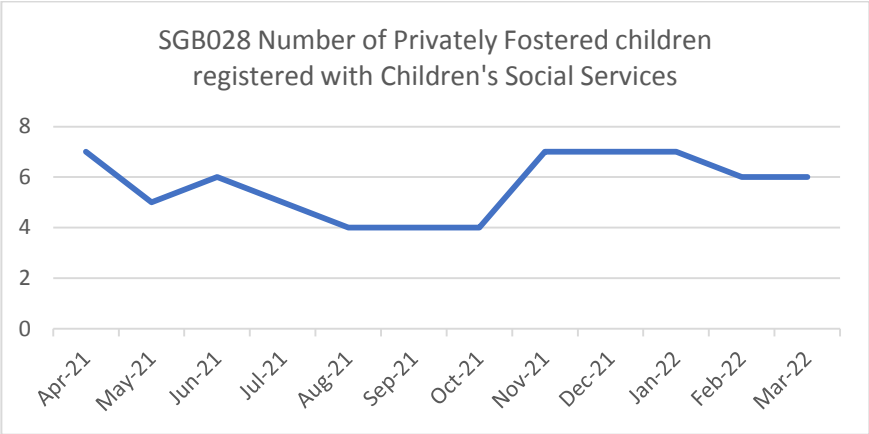
- Virtual training has continued to be offered to foster carers, with the mandatory Paediatric First Aid delivered in person. Foster carers had access to a range of training internal and external. Over the year they booked 894, places. Total number of courses offered 42.

- Private Fostering, Parenting Capacity Assessment (PCA) and the Contact Centre sit under the Fostering and Permanence service.

- The Contact Centre team delivers in the region of 100 supervised contact sessions per week to children and their birth families/siblings. The growing demand in this area has resulted in leaders investing in two additional contact supervisors. We have also built two pods in the garden of the centre to increase room capacity.

- The Parenting Capacity Assessment team have had to provide a number of updated court directed assessments due to the delays in court caused by the pandemic, which has affected cases being concluded within timescales.

- The number of private fostering arrangements has remained steady. As of March 2022, there were 6 privately fostering arrangements.




## Leaving care Service

- Care leavers are a strategic priority in Enfield, there is a comprehensive Local Offer which was updated in 2021. As of March 2022, there were 305 care leavers aged 18+, this was an increase from 284 in the previous year. 49.2% were in employment, education or training a decrease on 63.7% in the previous year.

- The STAAH Panel (Striving to Achieve and Aim Higher Panel) regularly reviewed care leavers who were not in employment, education and training. This panel is attended by a representative from the youth offending team. There has been investment to recruit an EET coordinator and an EET care leaver apprentice and the development of a CAMHS 18+ post to support care leavers with mental health issues.

- The pandemic impact reduced the number of health appointments available. This year, together with the LAC Heath Team the backlog and take up is now improving. The percentage of young people with up-to-date Immunisations has gone up from 53% last August (2021) to 85% in February 2022. Dental check-ups have gone from 30% in August 2021 to 80% in February 2022

- Unaccompanied Asylum-Seeking Children (UASC) experienced far longer periods of uncertainty, as the Home Office progressing their asylum claims was delayed due to the pandemic. At the end of February 2022 74 young people were waiting for an outcome on their immigration claim by the Home Office.

- Four care leavers were supported to access apprenticeship opportunities within the Council. One of the apprenticeships is being completed within the leaving care service and one is in the MASH.

- Two new specialist posts were created within the HEART teams to help care leavers access:
    - to therapeutic (trauma informed) support. This is aimed for care leavers over the age of 18 who do not meet the criteria for adult services but would benefit from this intervention and
    - to Education, Training and Employment opportunities.

- The care leavers hub was re-launched in July 2021 to promote participation and provide opportunities to access and engage with different services face to face. A representative from partner organisations has a weekly presence at the Hub to support young people in different areas including benefits, substance misuse, tenancy management, Education, Training and Employment and advocacy

- The Asylum and Immigration Leads Working Group (AIL) has been operational since March 2021 with the purpose of promoting professional development in this highly technical area. This group is supporting best practice and is allowing the Leaving Care Team to better understand and address the specific needs that young people who are seeking asylum, have otherwise insecure immigration status or are recognised as refugees. Amongst other achievements, through the AIL Group, we have supported our EU Looked After Children Nationals to access settled status as well as to apply for their UK Citizenship.

- An online survey was distributed amongst care leavers to aide gathering young people' views on the quality of the semi-independent placements they were living in as well as their overall opinion on the service they were getting from our team. The data collected in the survey provided positive and reassuring data. This included:
    - 82% of the young people confirmed they are either satisfied or very satisfied with their current placement.
    - 97% of the young people say that their key worker is supportive to their needs.
    - Nearly 90% confirming they felt safe in the placement they were living in
    - 88% confirming they felt fully supported by their Social Worker/Personal Advisor.
    - 85% of the young people that took the survey are either satisfied or very satisfied with the overall service that they are getting from the Leaving Care Team. The remaining 15% of young people have had their cases checked and their comments addressed where necessary.

- Monthly care leavers panel set up to oversee the needs of care leavers including progression of pathway plans. This ensures consistency in decision making, equality of provision and reviews proportionate use of resources that are needed to help young people achieve positive outcomes.

## Allegations against staff and volunteers:

- The service dealt with 75 referrals and 192 consultations during 2021/2022 compared to the 67 consultations provided during 2020/21. This was due to the partial closure of schools and other education provisions during the Covid pandemic where most referrals originate from.

- The Enfield LADO continues to provide bimonthly training to foster carers and designated leads from schools and early help.

- An annual LADO report is produced which is shared with the Cabinet Member and relevant Scrutiny Committees.

**Training data for 2021-22:**

| Course Name 1st April 2021 to 31st March 2022 | Course Type |
|---|---|
| Modern Slavery and Human Trafficking | eLearning |
| Safeguarding Adults - Awareness | eLearning |
| Safeguarding - Adult Abuse Awareness | Seminar |
| Mental Capacity Act Overview in house training | Seminar |
| Mental Capacity Act / Deprivation of Liberty Safeguarding Awareness | Seminar |
| Self Harm and Suicide training | Seminar |
| Liberty Protection Safeguards (LPS) Briefing Session for Adult Social Care and Children Services | Seminar |
| Mental Capacity Act - Advanced | Seminar |
| Personality Disorder | Seminar |
| BIA Refresher | Seminar |
| Making S42 Enquiries | Seminar |
| Learning Disability Team Suicide Bespoke training | Seminar |
| BIA Qualification | Seminar |
| Liberty Protection Safeguards For Responsible Bodies | Seminar |
| Safeguarding Adult Managers (SAM's) Training | Seminar |
| Suicide training | Seminar |
| DoLS Signatory Training | Seminar |
| Supporting older survivors of domestic abuse ( updated course name) * | Seminar |
| Understanding Domestic Abuse and Coercive Control | Seminar |
| Safeguarding Minute Taking and Recording Skills | Seminar |

*Previously know as Working with older survivors experiencing Domestic and Sexual Abuse changed of course

**Children's Multi-Agency Training data**

| Training Courses | Total attendees |
|---|---|
| Forced Marriage/Honour Based violence | 110 |
| Substance Misuse & Hidden Harm | 15 |
| Substance Misuse & Hidden Harm – Orchardside | 60 |
| Prevent | 37 |
| Missing Children | 24 |
| Managing Allegations against Staff and Volunteers | 17 |
| Influence of Conspiracy Theories | 5 |

# Learn from experience

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

Outcomes and findings from all our reviews are used to promote a culture of continuous learning and improvement across the partner agencies. The processes here are required by law, either the Care Act for adults safeguarding, or Working Together for children's safeguarding.

**ADULTS**

**[in box]**

**Care Act 2014 (Adults)**

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.

**What is a Safeguarding Adults Review?**

A Safeguarding Adults Review (SAR) 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 2021-22**

A thematic SAR review was agreed in November 2021, which included four referred cases. Of these, three cases were referred by the Rough Sleepers team following discussions at the Multi-agency Risk Assessment Meeting (MARAM) for Rough Sleepers. The review will be reported in 2022-23.

A referral was received in March 2022 about how partners provided care and support to a woman living at home with her son. The referrer was advised this referral would be progressing to a SAR. The review will be reported in 2023-24.

A referral was received in March 2022 about how partners provided care and support to a woman living at home with her son. The referrer was advised that the referral would not be progressing to a SAR.

**Safeguarding Adults Reviews in Progress:**

A review which was agreed in December 2017 in response to the systemic financial abuse of service users over a number of years is still in progress. The review will be reported in 2022-23.

A review was agreed in November 2019, about how partners provided care and treatment to a man. The review will be reported in 2022-23.

A referral was received regarding the care and support received by a man living alone in Enfield. In November 2020, the referrer was advised this referral would be progressing to a SAR.

## Published Safeguarding Adults Review

During 2021/22, one SAR was published. The review for Ms B was approved in June 2021. This can be found on our website. www.safeguardingenfield.org

### Summary of the case:

Ms. B was an 81-year-old clinically obese woman, living at home with the support of her neighbours and in receipt of a small domiciliary care package. There were no concerns regarding her mental capacity. Community nurses visited Ms. B regularly to dress her pre-existing leg ulcers and moisture lesion on her sacral area.

During a fall Ms. B fractured her left hip and was taken to hospital for treatment. She remained there for over two months following surgery to her fractured left hip. During this admission she also received treatment in relation to a pre-existing diagnosis of bladder cancer which included a surgical TURP (resection of tumour), associated chemotherapy and treatment to manage infection. Whilst in hospital, Ms. B developed a Category 4 pressure ulcer.

She was discharged home from hospital with an increased care package and was re-admitted 4 days later with suspected sepsis. Ms. B died in hospital three weeks later.

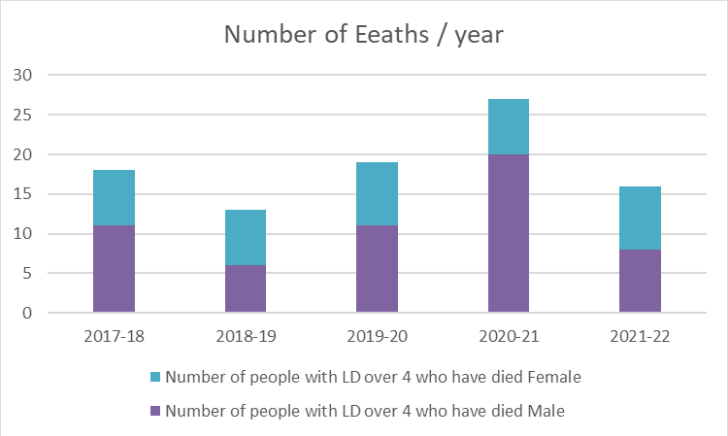
Key recommendations from the SAR revolved around the themes of:

- Communication and collaboration in longer term work – an important area of focus was around transition between acute hospital and community settings.
- Management systems - particularly around the different versions of equipment that are procured.
- Service User and Carer interaction with professionals – both in terms of working with someone who is refusing elements of care and support and providing information about health conditions to carers early enough to prevent unintended consequences.

The action plan for this Safeguarding Adults Review is being completed by the partnerships Practice Improvement Activity group

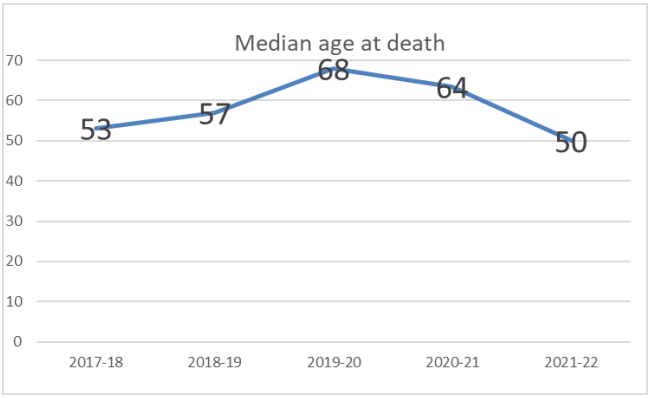
## Learning Disability Learning from Lives and Deaths Programme (LeDeR) – update received

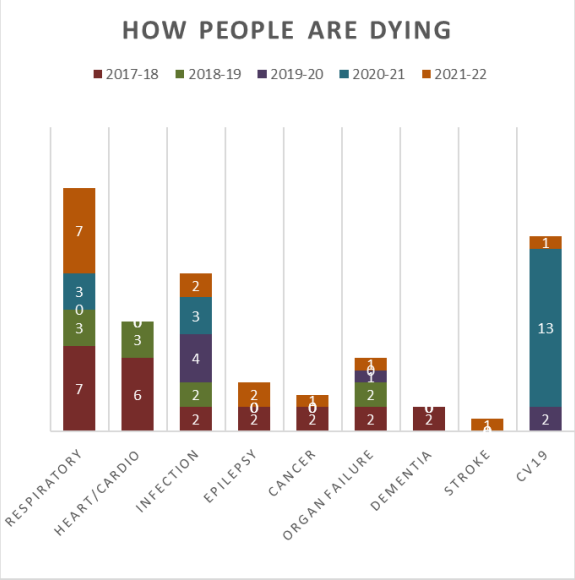
### Mortality




16 deaths of people with learning disabilities were notified to the programme in 2021/22. One of these deaths is currently being queried as potentially put of scope. After the very high mortality recorded during the pandemic, this appears more in line with previous years.

However, the median age at death was the lowest since the programme began. It's worth noting that there were 2 child deaths this year, which can have an impact on the over all figure when numbers are small




Respiratory infections are again the highest cause of death. Where we have data from Death Certificates, respiratory infections contributed to 54% of deaths. Of these only 1 was Covid-19. 4 were pneumonia, and 2 were aspiration pneumonia. This is also more consistent the situation before the pandemic.

### Performance

There were no dedicated funder reviewers during 2021 / 22, although one reviewer funded from the previous year continues to work on a back log case.

Limited capacity from the Integrated Learning Disability Service was used primarily to complete 2020 / 21 backlog reviews, submitting 6. Only one review from 2021/22 has been submitted.

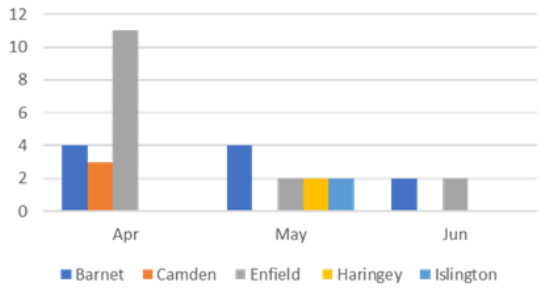
There remain 3 reviews from 2020/21 on hold. One awaiting the outcome of a safeguarding enquiry, one awaiting a GP review, and one awaiting a Structure Judgement Review.

Two reviewers were appointed by NCL in early July. Of the 15 outstanding reviews from 2021/22 all are now allocated. 11 are to NCL reviewers, 2 to the Child Death Overview Panel, and 2 to ILDS staff.

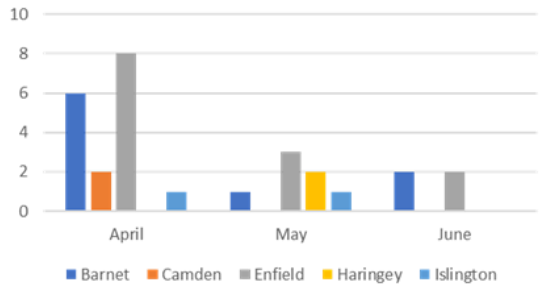
**Themes**

1. Appropriate escalation to acute care. ILDS are working with NCL to roll out the Whzan Blue Box. This is a telehealth package that included vital signs equipment wirelessly linked to a tablet computer. Staff are trained in using the 'New Early Warning Signs 2' to inform the escalation decisions, i.e., call GP, call 111, or call 999. This is being rolled out to residential, Supported Housing, and Domiciliary Care Services, as well as some family carers.
2. The GP Liaison Nurse offered training to GP' on how to deliver effective annual health checks, and incorporate Health Action Plans. This reached 5 PCN's representing 16 practices. This was followed by a series of webinars with care providers.
3. The epilepsy specialist nurse has worked with GPs to ensure all complex epilepsy care plans have been signed off, and SUDEP risk assessments completed. They have also trained 125 support staff and devised an accessible assessment tool.
4. Continued to promote End-of-Life Care and Advanced-Care planning. The End-of-Life Care Steering group has restarted its workshops for people with learning disabilities and is planning staff training for the autumn.
5. Last year's report identified a significantly high number of notifications in Enfield in April 2020 than in neighbouring boroughs. When looking at actual ate of death this was less pronounced.

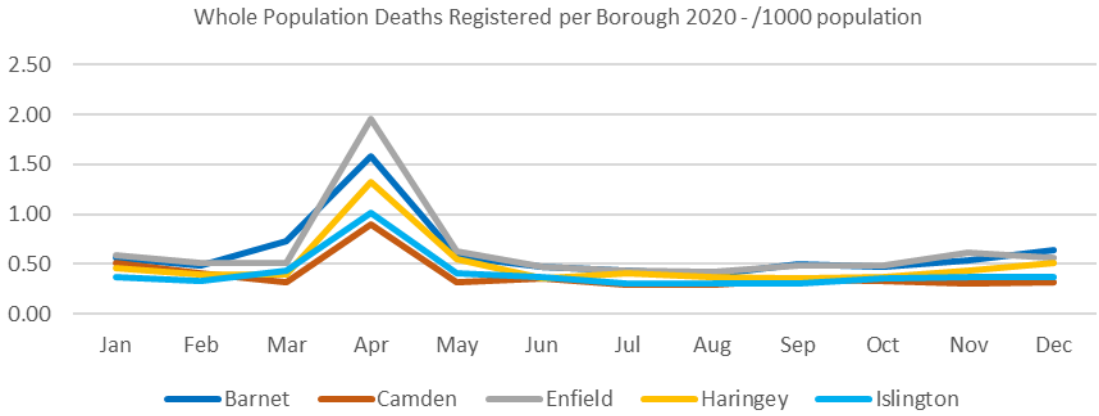
Notifications / month by borough




Deaths / month by borough



Data for whole populations shows Enfield was more impacted during this period, and the excess mortality of People with Learning Disabilities is consistent with this broader picture. Public Health continue to look into this.




6. Data Sharing. NCL are current taking the lead with the Annual Health Check Delivery Plan, with a target to have consistency this year.

**Best Practice**

Specialists from the Integrated Learning Disability Service were very proud to be represented at the Palliative Care for People with Learning Disabilities Network Bi-Annual Linda McEnhill Awards (2021).

Staff were part of the circle of support for Stuart Hasler and were presented with the award for Providing Outstanding End of Life Support at the ceremony in September 2021.

We are also very proud that the Linda McEnhill trophy was awarded to Stuart himself. This is the only time in the awards history it was awarded posthumously to a person with learning disabilities.

The award ceremony can be viewed on the (above sections starting at 40:20)

As a result, the University of Kingston's 3-year research project into End of Life Care Planning has been named the 'Stuart and Victoria' project. Chris O'Donnell (LeDeR Local Area Coordinator) and Sarah Pope (Service Manager Community Nursing) are members of the advisory group.

## CHILDREN

### Serious Incident Notifications & Children Safeguarding Practice Reviews:

When a serious incident takes place the Safeguarding Children Partnership makes a referral to the National Panel and undertakes a Rapid Review. The aim of the Rapid Review is to learn any lessons quickly, and also to help decide if a Local or National Child Safeguarding Practice Review is needed.

**Serious Incident Notifications:**

Two notifications were made to the National Panel during this reporting period:

The first involved a forced marriage case. The National Panel agreed that this case should proceed to a Local Child Safeguarding Practice Review. It is due to be published in 2022/23. In response to the findings of the Rapid Review, Forced Marriage and Honour Based Violence Training has been a focus of the Multi-agency training programme.

The second case involved the stabbing of a young person. The National Panel agreed that this case should proceed to a Local Child Safeguarding Practice Review. The name Andre was selected for the review. An Executive summary of the review has been published and can be found here:
https://new.enfield.gov.uk/safeguardingenfield/reviews-and-reports/

The full report will published later in 2022/23 and highlighted in the annual report for that year.

### Local Child Safeguarding Practice Review:

Following a Rapid Review in 2019, a Local Child Safeguarding Practice Review was conducted for Josef (Josef is a pseudonym). The review was published in August 2021. The report can be accessed here:
https://new.enfield.gov.uk/safeguardingenfield/reviews-and-reports/

Josef was a looked after young person from January 2019 and was 17 when he died in February 2020. Josef was known to various agencies at the time of his death, and the last few months of his life were particularly troubled, however those who worked with him remember him as being good fun, witty, funny with a great smile.

Josef was 17 when he died in the early hours of a mid-week morning in February 2020 after climbing on top of a train as it arrived at the destination station.
Josef was electrocuted by overhead cables after the train had stopped. There is only limited information about his final hours and his state of mind during those hours.

The review identified 7 learning points. The Practice Improvement group is overseeing the actions to make the improvements from this review. The full review can be found here…

The first three learning points are presented here:

Learning Point One

The Safeguarding Children's Partnership to review, and make amendments where necessary, to the guidance and procedures around the management of children and young people who are missing. Re-issue the guidance and procedures to all workers around how to respond to missing episodes and concerns around exploitation, and contextual safeguarding in order to achieve greater consistency in approach to managing risks in these areas.

Learning Point Two
The Safeguarding Children's Partnership to lead the opportunity for local agencies to consider ways to understand how to incorporate the concept of contextual safeguarding in the assessment of risk to children in the future and how to respond when the main safeguarding concerns are existent in the community. The development of the Adolescent Safeguarding Service to provide professional consultation, and the development of interventions to include working with peer groups.

Learning Point Three
It is important to ensure that practitioners are in a position to escalate their concerns when there are professional disagreements. The newly revised Safeguarding Children's Partnership Escalation Policy to be launched across the borough which demonstrates a clear escalation pathway.

**National Child Safeguarding Practice Reviews**

Child Safeguarding Practice Review Panel – click this link to go to National Panel pages

Summary of Arthur Labinjo-Hughes and Star Hobson review

NSPCC have helpfully summarised key points within the review which can be found on their website here NSPCC: Summary of the national review into the murders of Arthur Labinjo-Hughes and Star Hobson .

In the foreword it is noted that when completing the review, it was felt that the experiences of Arthur, 6 and Star, 16 months were not unusual. Arthur and Star were both murdered in 2020 because of sustained abuse and neglect from their caregivers. Wider family members voiced multiple concerns and shared evidence of physical abuse with professionals prior to their deaths. There was also a history of domestic abuse in both cases.

The findings are important to read along with the recommendations. Findings were that information sharing between agencies was not good enough, alerting significant weaknesses and that there was a lack of critical thinking and challenge between agencies, to name a few.

The National Review have published a recording of their presentation for frontline practitioners which is available on their YouTube channel. The video outlines findings and recommendations that were found within the review.

In addition they have also created a short briefing on the review for practitioners, which you can download here. Please watch and review the information provided for additional learning.

Enfield's Safeguarding Children Partnership initiated a multi-agency audit into physical abuse cases to ensure we had a strong response, and where necessary, we could improve practices. This will be completed in 2022/23.

## Local Child Safeguarding Practice Review of note - Child Q

Enfield Safeguarding Partnership acknowledge that the treatment to Child Q was unacceptable and demoralising. It is important that we read the review and pay particular attention to the recommendations outlined in order to ensure that practice across the partnership can be scrutinised to prevent another child being treated in this way.

### Child Q- City & Hackney Practice Review

Following the publication of this review, the Enfield Safeguarding Children's Partnership set-up a group to look at the recommendations from this review and make improvements in Enfield. Following the publication of the report, the Education Department contacted all schools in Enfield and no strip searches had been conducted.

The Safeguarding Ambassadors will be working with the group to make sure the views of young people inform how we improvement practice.

### Done - North Central London Child Death Overview Panel (CDOP)

The North Central London (NCL) Child Death Review partners held four (4) panel meetings in 2021/22, reviewing and closing over 60 cases. Each child death is presented by the clinical leads and scrutinised by the panel for learning purposes. Learning from cases can take the form of individual case actions or wider NCL learning that is currently disseminated via the panel members. From April 2022, the NCL Clinical Lead Nurse will be a panel member for the various learning subgroups of each of the 5 Partnerships, creating a direct link with the panel work.

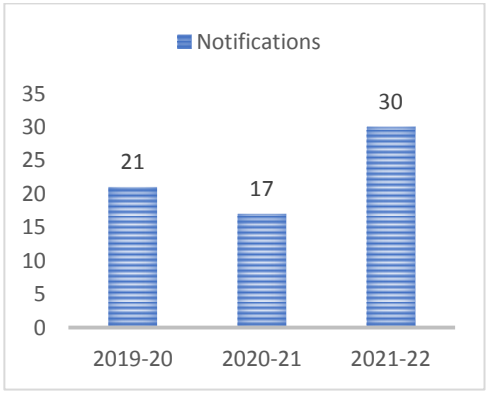
Following the successful business case for funding in February 2021, NCL Clinical Commissioning Group (CCG) now the Integrated Care Board (ICB) employed 1.5 WTE administrators along with a clinical lead nurse who joined full time in February 2022. NCL CCG have also recruited an Independent Chair, who started in April 2022. This will ensure independent scrutiny and challenge of the anonymised cases and service provision to identify learning. Detailed analysis of the cases and findings will be included in the annual report.

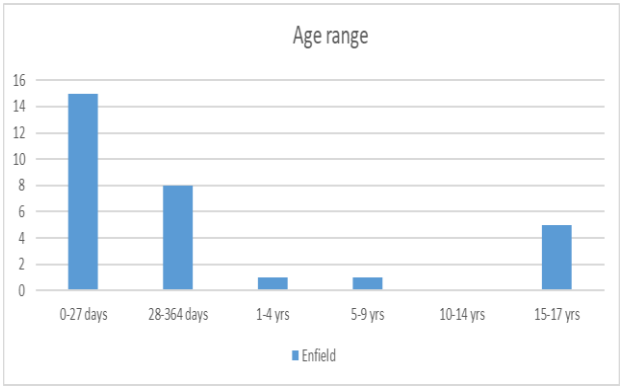
In 2021/22, the central team received 103 notifications (via the electronic system – eCDOP), with 30 of these notifications for Enfield children. The electronic system (eCDOP) allows for the prompt notification of a child and is used by all agencies across NCL. The central team reviews each notification and determines with the practitioners (if not already identified) the need for a Joint Agency Response (JAR) meetings. The team have co-ordinated 21 JAR meetings in the reporting period, 5 for Enfield. Each provider Trust continues to develop and embed their internal child death process with the assistance of the central lead. The NCL Lead Nurse attends various Trust meetings such as Peri-Natal Mortality meetings, along with the Child Death Review Meetings to review all information relating to the child death.

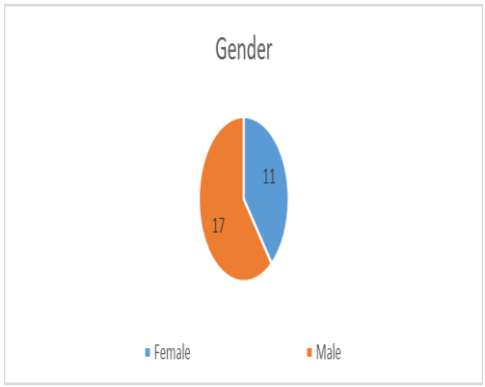
In addition, to the funding for a central team, the business case included resource to develop the key worker role. A mapping of the current bereavement offer, including a visit to Noah's Ark Hospice was undertaken. The exercise demonstrated the need for further work to ensure a seamless package of support is offered to all families, regardless of the cause of death. To this end, the team co-ordinated a pilot training session on "when a child dies: supporting parents and families" to support front line workers who are identified as key workers. The training session in March 2022 was positively evaluated with a plan to develop a rolling programme of training for all agencies.

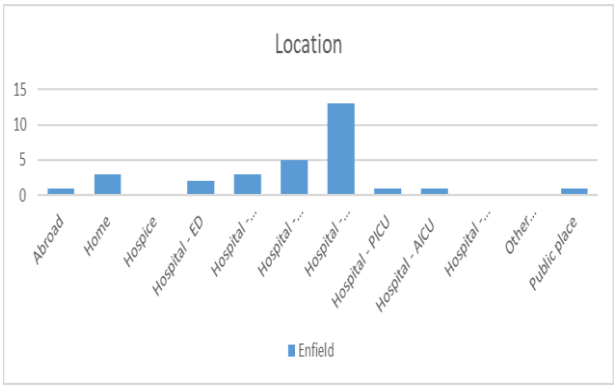
The annual report is being co-ordinated and is due for sign off by the panel in September. The annual report will then be presented at each of the 5 Safeguarding Children Partnerships and the ICB Quality committee along with the 5 Directors of Public Health.

**Enfield data summary**




Full analysis will be included in the NCL CDOP Annual Report

## Improve Services

We have a number of processes to help us improve the quality of our services. This is an important part of managing safeguarding risks.
Some of these processes are national, for example, OFSTED inspections, and others are local, for example, the Quality Checkers.
They all have a role to play in making sure our services and safeguarding responses meet local people's needs.

## Adults

### Supporting Enfield's Adults Social Care Providers

Enfield has one of the largest number of care providers in London, including 82 care homes.
The map here shows the spread of care homes (nursing and residential) we have in the borough, one of the highest in London. All registered providers are monitored by the Care Quality Commission.

[in box]
**Who are the CQC?**
The Care Quality Commission (CQC) is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England.

### Provider Concerns

**Provider Concerns Process**
Our Provider Concerns process was initiated 14 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 deregistration, an exit strategy.

Analysis of the data from the Provider Concerns process demonstrates that where the process is initiated in response to a poor CQC inspection and rating, it has consistently driven service improvements and improved CQC rating following re-inspection. Recently, two providers with an 'inadequate' rating in one or more of the CQC domains were re-inspected and achieved a 'good' rating.

The Provider Concerns process was developed in Enfield, but now forms part of the Pan- London Safeguarding policy and procedures. The policy can be found on the MyLife Enfield website. Go to: www.enfield.gov.uk/mylife

**Care Quality Commission Rating Data**
**The most recent ratings (2021-22) are presented first, followed by 2020-21 and finally 2019-20.**

**2021-22 (ratings at the end of March 2022)**

| Row Labels | Outstanding | Good | Requires improvement | Inadequate | Registered but not yet inspected | Total |
|---|---|---|---|---|---|---|
| Community based adult social care services | 2% | 59% | 7% | 0% | 32% | 113 |
| Nursing home | 0% | 57% | 29% | 0% | 14% | 14 |
| Residential care home | 3% | 81% | 13% | 0% | 3% | 68 |

*All Inadequate provision have been subject to Enfield's Provider Concerns Process.

**2020-21 (ratings at the end of March 2021)**

| Row Labels | Outstanding | Good | Requires improvement | Inadequate | Registered but not yet inspected | Total |
|---|---|---|---|---|---|---|
| Community based adult social care services | 1% | 67% | 5% | 0% | 27% | 107 |
| Nursing home | 0% | 62% | 31% | 0% | 8% | 13 |
| Residential care home | 3% | 78% | 13% | 1% | 4% | 68 |

*All Inadequate provision have been subject to Enfield's Provider Concerns Process.

**2019-20 (ratings at the end of March 2020)**

| Row Labels | Outstanding | Good | Requires improvement | Inadequate | Registered but not yet inspected | Total |
|---|---|---|---|---|---|---|
| Community based adult social care services | 1% | 64% | 11% | 0% | 23% | 90 |
| Nursing home | 0% | 67% | 33% | 0% | 0% | 12 |
| Residential care home | 2% | 79% | 8% | 4%* | 7% | 85 |

*All Inadequate provision have been subject to Enfield's Provider Concerns Process.

## Quality Checker projects

The Quality Checker programme has continued to go from strength to strength with new volunteers recruited and new projects being developed. During the reporting period the Quality Checkers have completed the following activities:

| QC Activity conducted in 2021/2022 | Number of visits calls (QC volunteers visit in pairs) , reports , publications and toolkits developed and circulated |
|---|---|
| Welfare calls to residential care providers and friends and relatives of people living in residential care. | Quality Checkers supported the Safeguarding Information Panel and Provider Concerns process by making 231 calls to friends and families of people in receipt of care services to obtain feedback and service improvement. |
| Customer Feedback calls to users of the SPA (Single Point of Access) and Enablement services. | Quality Checkers made 80 calls to users of the SPA (Single Point of Access) and Enablement service to gather feedback on the experiences of people having an initial contact with Adult Social Care. Feedback to be used to identify areas for improvement and share identified good practices |
| New Ways of Working – Strength Based Approach | Quality Checkers contacted LBE staff who have received training on the Strength based approach practice. Quality Checkers collected feedback from staff on how the new ways of working had been received and suggestions for future improvements. This was shared with relevant Council teams. |
| Welfare Calls to residential homes regarding home security and CCTV. | Following a break-in at a residential home, Quality Checkers were asked to contact a sample of care providers to find out whether homes have sufficient security installed to protect residents. Quality Checkers sampled 12 homes, a mixture of nursing, residential and supported living and feedback was shared with the Safeguarding Information Panel. |

## Checking our Safeguarding Adults practice

**By using Data:**

The Insights activity group provided data around Domestic abuse police callouts which allowed us to identify two cases where the survivor may have had vulnerabilities not apparent to the responding officers. Safeguarding Concerns have been raised and the Adults MASH officers allocated to offer these adults support.

This is a great example of multi-disciplinary practice and the highlights how the data analysis at the Insights group is helping to improve practice.

**By checking cases:**

Adult Social Care recently commissioned an external audit of our Safeguarding Enquiries and the feedback as been very positive – saying that practice in Enfield is good with elements of outstanding. Areas for improvement identified on were around partnership working and focusing on achieving outcomes promptly (rather than focusing on an investigation process and then outcomes).

We have improved our internal safeguarding audits, we are focussing on how long the safeguarding process takes. This has enabled us to identify those cases where there has been delays and offer workers support in bringing these to a conclusion.

**Childrens**

**Safeguarding Ambassadors**

The Safeguarding Ambassadors are a group of Enfield young people who are working with the Safeguarding Childrens Partnership to improve practice. They are part of Enfield Youth Service's Young Leaders programme and have been trained specifically on safeguarding issues and how to work with the partners.

We are now working with our second cohort of Safeguarding Ambassadors, with members of the first cohort assisting in the training.

During 2021/22, as we came through lockdown, training the second cohort was the main priority for the programme. They have also worked with our Independent Review to help the Safeguarding Children's Partnership explore issues around cultural competence. This has been the springboard for the work in 2022/23, where they will have an important role in helping the Enfield Safeguarding Children's Partnership make improvements, particularly in light of the recommendations from the Child Q review.

## Everyone's Invited response

Following the thousands of disclosures of sexual harassment, assault and rape on the Everyone's Invited website, alongside the dedicated helpline set-up by the NSPCC to provide support and advice to victims of sexual abuse in schools, OFSTED undertook a review of sexual abuse in schools and colleges. The review can be found here, and was considered by the Executive group on the 22nd June 2021.

Two important areas of improvement following the review were:

1) Improved links between the Safeguarding Children's Partnership and Education – through attendance at Activity groups, the Designated Safeguarding Leads meetings and from April 2022 the Director of Education being part of the Executive Group
2) The Insights Activity group undertook some analysis of police reports related sexual assaults and abuse at schools and this was presented and discussed at the Executive Group, and the Designated Safeguarding Leads Network.

### Changes in Charing arrangements at the Executive Group

During 2021/22 it was agreed that the Safeguarding Children's Partnership will annually rotate the chairing of the Executive Group meeting. From the 1st April 2022, the Executive Group will be Chaired by Detective Superintendent Sebastian Adjei-Addoh from the Metropolitan Police Service North Area.

Geraldine Gavin was the chair of former Enfield Safeguarding Children's Board and stayed in as chair of Executive Group as the new arrangements were embedding. The transition to these new chairing arrangements were delayed due to COVID. Geraldine will continue to chair our Safeguarding Adults Board.

## Scrutiny of the partnership

In the 2021/22, it was agreed that the scrutiny arrangements for the Safeguarding Children's Partnership will include an evaluation by an external organisation. In 2022/23 the organisation we will be working with are called RedQuadrant. Their team, which consists of experts from Health, the Police and Children's Social Care, will evaluate our partnership working in September 2022.

### Resolving multi-agency practice issues:

The Designated Nurse has established a regular multi-agency partnership meeting, to resolve operational issues and to enhance communication across the partnership. All statutory agencies are represented including the police, local authority and health services. This has helped with development of "Back to Basic" sessions facilitated by the Designated Doctor, raising the awareness of process and criteria for arranging Child Protection Medicals.

**Checking Enfield's Safeguarding Children arrangements**

During 2021/22, the partnership completed its multi-agency audit into professional curiosity and information sharing.

The recommendations from the audit included:

- Development of an Enfield Safeguarding Partnership learning briefing regarding professional curiosity as well as a practitioner survey
- Each agency to assure itself and the ESP through audits that practitioners have opportunities to reflect upon cases regularly
- Partners undertake a review of agreed operational information sharing practices to ensure that all opportunities to share information within CP processes are taken.

Professional curiosity has been addressed by a survey to all practitioners asking about their experiences. We have also developed a practitioner tool that is on the website, and a focussed partnership event took place on the 1st December 2021.

Information sharing has also been identified from Child Protection concerns that were raised around GP's. Work has been completed with GP's in this area. However, this is still a feature in the reviews as a concern from all partners, and as such remains an area of focus for the partnership.

*Independent Scrutineer statement – GG updated draft*

2021-22 was a year of consolidation and progress across many areas of the Safeguarding Children's Partnership in Enfield.

The Safeguarding Partners have continued to show strong leadership, this is exemplified by the chairing and joint commitment of the Executive Group from April 2022. The role of independent scrutiny in Enfield is enhanced by the on-going work of an external Independent Reviewer and our Safeguarding Ambassadors. The independent scrutiny organisation contracted for 2022-23 will be utilising experts from across the three sectors.

The programme of audit work is driven by the Practice Improvement Activity group. The audit focussing on Professional Curiosity and Information Sharing, generated important learning for the partnership that was well received at the learning event on the 1st December 2021.

In response to the national reviews of cases of Arthur Labinjo-Hughes and Star Hobson, the Executive Group requested an immediate focus on Physical Abuse. The audit and learning from this work will be presented in 2022/23.

I've been particularly pleased with two important new appointments which should have a significant impact on Enfield's Children's Safeguarding. These are the new Safeguarding Children's Partnership Manager post, which Chloe Pettigrew is now in, and the Senior School Improvement Advisor for Safeguarding & Inclusion post which Daniella Lang has taken on.

These appointments will be especially important in helping the partnership tackle the issues that have emerged from the national reviews, and to enhance the joint working with education. The ways in which we evolve our work with schools and share information and intelligence about areas of risk is an essential part of how we will keep Enfield children and young people safe.

Overall, the children's partnership is a strong one and I am confident this focus on impact will continue and strengthen.

**Geraldine Gavin**

Independent Safeguarding Chair/Scrutineer.

**Priorities for 2021-22:**

The following pages outline the key actions for 2020-21 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.

| What is our objective? | How are we going to do this? | 2021-22 Actions | How will we know | 2021-22 update | 2022-23 Actions |
|---|---|---|---|---|---|
| Engage with our community, to promote a culture where abuse and neglect are not tolerated<br><br>(Children and Adults) | Create a culture in Enfield where our community has a zero tolerance of abuse and neglect and understands how to report any concerns they may have. | Develop network of Safeguarding Champions through Community Awareness raising group. | Attendance and feedback from community engagement activity. | Safeguarding Community Engagement group being re-established by Mar 2022 | Continue work on website. Engage 20 community champions to join our multi-agency training (Forced Marriage). |
| Use technology and social media to engage with our community, professionals, providers and voluntary organisations<br><br>(Adults and Children) | Improve website a social media presence, so people can stay informed and report concerns; promote developments in assistive technologies and social media options (including video calls). | Continue to develop the website. More social media activity and work with Safeguarding Ambassadors to develop this approach. | 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. | The content on the website has been reviewed. Work started to move the website into the main Enfield Council website. | Safeguarding Enfield website moved. Online information for residents to be improved. |
| Work to reduce isolation (which can increase safeguarding risks)<br><br>(Adults) | Online training; community engagement to encourage groups to stay in touch with people who might be isolated. | 250 devices secured. Pilot project to be expanded to care home; ICES and Libraries to be used as channels to deploy; Work with research organisation to evaluate approach. | Monitor responses to the isolation question in our social care survey. | Completed and SMART Enfield project developed with libraries and ICES. Middlesex University engaged to evaluate | Training for ASC staff on SMART tech in place. Rollout of PainChek app to Enfield care homes following pilot. |

## Safeguarding Priority 1 – Prevent Abuse

# Safeguarding Priority 1 – Prevent Abuse

| What is our objective? | How are we going to do this? | 2021-22 Actions | How will we know | 2021-22 update | 2022-23 Actions |
|---|---|---|---|---|---|
| Work with people alleged to have caused harm to prevent further abuse<br><br>(Adults) | Identifying and working with people who will benefit from support and intervention. | Enfield has been selected to be part of National project working with adult service users who are have alcohol dependency. | Evaluation of the programme by professional, and through customer feedback. | A pilot scheme for Rise Mutual, a behavioural change programme for those who perpetrator domestic abuse was run between November 2020 and March 2021. This was funded by the National Probation Service, Children's' Services, Adult Social Care and the Community Safety Unit.<br><br>Enfield continues to work with Alcohol Change UK on developing guidance around this important topic. Workshops were held in late 2020 and further training sessions are being developed for 2021. | Evaluation of the outcomes of this service are taking place at the moment and will determine future plans.<br><br>Due to COVID-19 delaying some work on the Alcohol Change Project, this will be continuing into 2021/22. The final version of the guidance will be available shortly and the Safeguarding Adults Board will look at recommendations made.<br><br>Multi-disciplinary training sessions on alcohol and addiction will also take place in the first half of 21/22. |
| Raise awareness of exploitation of adolescents to wider partnership<br><br>(Children) | Ensure Safeguarding Adolescents from Exploitation strategy action is overseen by Vulnerable Young People Activity Group. Ensure on-going awareness on website, in newsletter and through events | Further information sharing through social media, website and newsletter working in partnership with Safeguarding Ambassadors. | Feedback from Safeguarding Ambassadors, Independent Scrutineer, and attendees of events. | Newsletters; Partnership event in Dec 2021 for Josef and work on Professional curiosity helped partners consider how we engage effectively with adolescents. | Partnership event in May will highlight the Andre case review; serious youth violence is on the multi-agency audit plan for 2022/23; the Safeguarding Adolescents From Exploitation strategy is being refreshed by the Vulnerable Young People's group. |
| | | | | | |

# Safeguarding Priority 2 – Protecting Adults at Risk, Children and Young People

| What is our objective? | How are we going to do this? | 2021-22 Actions | How will we know | 2021-22 update | 2022-23 Actions |
|---|---|---|---|---|---|
| Make sure our community knows how to recognise and report abuse<br><br>(Adults and Children) | Raise awareness about our Adult abuse line, online resources, and different types of abuse through our marketing and community engagement activity. | Safeguarding Champions network to be established to take messages into community. | Attendance and feedback from community activity and visits to website. | SCE group will be leading on this and a method developed. This area has been impacted by COVID. | 20 community members will be invited to multi-agency training. The website will be updated. |
| Make sure professionals are appropriately trained, with a focus on Making Safeguarding Personal<br><br>(Adults and Childrens) | 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. | Multi-agency training plan is overseen by practice improvement group – includes: LADO, Missing children, Parental Mental Health. Pool of trainers to be developed. | Attendance and feedback from training sessions. | See training information for 2021/22 above. In addition, the Safeguarding Children's Partnership event engaged over 100 people. | Pool of trainers to be developed.<br><br>At least two partnership events to be held in 2022/23 |
| Develop ways to help people protect themselves from abuse and harm (Adults) | Paper and online factsheets; information videos; and links to organisations that can help (e.g. for fraud, home security). | To be developed further with Safeguarding Champions and Ambassadors once the network is established. | Downloads of factsheets; visits to page. | This area has been impacted by changed to the website and COVID. Plans for the new website developed. SCE group was re-established. | Information for community will be co-produced with the Safeguarding champions. |
| Develop online tool to make sure everyone knows how to access or make referrals to different services (Adults) | 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. | | Hits on website, improved referrals, feedback in audits. | This is in the escalation policy - business unit acting as place to identify new people | Escalation for Adults to be developed, which can hold information about teams and panels. Information on Childrens Panels to be included in Escalation policy update. |
| Ensure there is effective multiagency analysis of data/ information to understand current and emerging risks (Children and adults ) | Develop work of Insights Activity group to explore current data and methods to create an effective local picture. | More analysis of Safeguarding Adults data – conversation rates. More work to understand who is and isn't in contact with us. Ethnicity analysis. | Analysis product completed, and response options identified. | Insights local and national work helping | Insights activity group to develop tools to monitor key areas of risk and measure progress/ improvements. |

# Safeguarding Priority 3 – Learning from experience

| What is our objective? | How are we going to do this? | 2021-22 Actions | How will we know | 2021-22 update | 2022-23 Actions |
|---|---|---|---|---|---|
| Check that the way we are managing safeguarding is working properly<br><br>(Children and adults) | We have regular checks and an annual adults independent audit and we will work with our neighbours. Checks will include: the user experience and applying the Making Safeguarding Personal approach. We will also work with neighbours to develop consistent London-wide assurance framework, and thresholds. We also conduct the Statutory Section 11 audits for children safeguarding. | Section 11 learning to be reviewed.<br><br>SAPAT being organised with Haringey in a peer-challenge format. | Audit reports (including Section 11) and confirmation from partners of the actions they have taken. | Section 11 learning review on-going.<br>Independent scrutiny plans developed for 2022/23<br><br>SAPAT organised with Haringey for 2022/23 | Section 11 to be undertaken. New scrutiny arrangements in place.<br><br>SAPAT with Haringey in a peer-challenge format. |
| Learn from the advice of our Service Users, Carers and Patients<br>(Adults) | Implement learning from Quality Checkers; ask people who have been through a safeguarding process about their experience and make improvements where necessary. | Quality checker calls to friends and relatives to continue | Partners' confirmation of the action they have taken to address issues in feedback. | See Quality Checker update in Improve Services section | Quality Checkers programme to recruit additional volunteers. |
| If things go wrong, review what happened and learn lessons<br>(Children and Adults) | Identified in Care Act, and Working Together 2018, we have to undertake Reviews, learn lessons, and make system improvements | Continue to work on publishing SARs , and local learning reviews and analysing learning opportunities based on recommendations. | Audits feedback, data. | See Learn from Experience section above | Publish at 4 Safeguarding Adults Reviews, and two Childrens Practice Reviews. |
| Learn from the experiences of other local authority areas<br>(Adults) | 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. Commitment to share spaces at SAR learning events. | Annual review and audits to identify improvements based on learning from other boroughs. | NCL SAB Chairs and managers meetings have re-started. Financial abuse workshop and engaging Health senior managers has been focus. | Work with Barnet on Financial Abuse for North Central London; take on Chairing of the NCL SAB Chairs and Managers meeting. |
| Improve sharing of learning between adults and children's safeguarding<br>(Adults and Children) | Establish Practice Improvement Activity group by September 2019. Ensure discussions relating to children's and adult's issues are influencing improvements. | Practice Improvement group has received feedback on 1 Children LLR, and at April meeting will input on recommendation of Safeguarding Adults review. | Group established and has met. Terms of reference agreed. Minutes from meetings. | Practice Improvement meeting considers adults and childrens reviews and provides the opportunity to learn across both areas | Joint meetings to continue. |

# Safeguarding Priority 4 – Supporting Services Improvements

| What is our objective? | How are we going to do this? | 2021-22 Actions | How will we know | 2021-22 update | 2022-23 Actions |
|---|---|---|---|---|---|
| Ensure we have effective arrangements in place to intervene when provider quality drops below expected standard (Adults and Children) | Support Enfield services to improve, due to quality standards, whenever possible. | Provider Concerns policy will be reviewed. Infection Control action plans will be developed to support all providers, learning lessons from last year. | Number of Provider concerns/ | Provider concerns policy update being undertaken. See Prevent abuse section for infection control activity. | Provider Concerns and Infection Control activity to continue. |
| Ensure partners share information and intelligence about poor quality services (Adults) | Ensure there are arrangements in place to share information properly about services so that partners can act quickly to respond to unsafe services. | More detailed data analytics to be introduced into meetings. | Regular meetings with partner agencies and evidence of actions. | Safeguarding Information Panel meetings continued through the year. | Safeguarding Information Panel meetings to continue |
| Online space for providers<br><br>(Adults) | Develop online presence to share information, policies and best practice with providers to ensure organisations have tools they need to improve. | The provider section on Mylife will continue to be updated. | Traffic on website; download of resources. | Work ongoing | In addition to the provider web page on Mylife, a newsletter for providers is being developed. |
| Consistent policies with neighbouring boroughs<br><br>(Adults) | Make sure Enfield has clear and consistent policies with neighbouring boroughs which represent best practice in all areas. | Continue to work across London around the COVID analysis. Undertake SAPAT. | Audits, and data analysis will confirm consistence of practice | We engaged with National Insights work into COVID related safeguarding trends | We are chairing the quarterly NCL SAB chairs and managers meetings from September 2022. |
| Ensure the voices of children and young people, as partners and scrutineers, are built into our Safeguarding Partnership work (Children) | Recruit 8 children and young people to scrutinise and develop our arrangements. | Next cohort of Ambassadors to be recruited. Work on Voice of the Child short film as identified by in Section 11 work. | At least 8 young people recruited and working with us on projects (website, Section 11 audits). | Next cohort of ambassadors recruited. Draft videos have been produced. | Working with the Child Q task and finish group; joint work with the Executive group on young people's relationship with the Police and partners. |

# Safeguarding Priority 4 – Supporting Services Improvements

| What is our objective? | How are we going to do this? | 2021-22 Actions | How will we know | 2021-22 update | 2022-23 Actions |
|---|---|---|---|---|---|
| Ensure we have consistent effective practices across the partnership to safeguard children and young people (Children) | A multi-agency audit programme that is agreed with partners | Methodology and programme of audits agreed. Focussing on Professional Curiosity and Information sharing; children affected by domestic abuse; serious youth violence. | Completed audit reports; improvements in practice | Professional Curiosity audit completed. Plan changed in light of national reviews to audit physical abuse cases. | Physical abuse multi-agency audit completed and presented; Children's MASH cases (with focus on Domestic Abuse) to be reviewed. |
| To improve communication between workstreams and Exec and activity groups (Children and Adults) | Progress report using a project management approach | System in place and working across groups. | Better awareness of members of our partnership groups about what is happening across the whole | This work is on-going | Simplified report based on briefing document to be trialled. |
| | | | | | |
| | | | | | |
| | | | | | |

**Appendix A -Detailed information from Childrens Safeguarding Partners (2834)**

## Metropolitan Police Service (MPS) -North Area

### *Overview of work over 2021/22:*

Police continue to be an active partner in Enfield's multi-agency response to safeguarding children. Police take a pro-active stance in sharing relevant information with partners.

The police have continued to make Violence against Women and Girls (VAWG) offences a priority and are bringing more offenders to justice, but still haven't reached the target as outlined in the Met business plan 2021-22.
https://www.met.police.uk/SysSiteAssets/media/downloads/force-content/met/about-us/met-business-plan-2021-22---quarter-1-progress-report.pdf

In May 2021, officers across the Met carried out a "day of action" to highlight how we are working to prevent violence against women and girls. Each Basic Command Unit (BCU) put a local operation plan in place – executing warrants and going after wanted offenders, focusing on arrest enquiries, leveraging additional resources to do so. Known offenders were visited for compliance checks. Reassurance patrols were increased in public spaces with officers and staff engaging with communities and with local businesses (such as cab companies, bars, hotels), focusing on the role they can play and how we can provide support to their staff. About a hundred people were arrested in a series of reactive and proactive arrests for offences including domestic assault, sexual offences, and violence against women and girls.

We have developed and delivered a number of training events specifically in relation to protection orders. These one hour webinars are co-delivered by Met Harmful Practice Tactical and Policy Advisors and solicitors from the Directorate of Legal Services. These sessions are specifically aimed at Public Protection officers on BCUs and cover the benefits of the orders, how to obtain them and how they are managed subsequently. Since January 2021 seven sessions have been delivered to over 300 officers. In addition, we have developed and delivered training to BCU 'Harmful Practice Advisors' (HPAs) which covers various topics including protection orders.

A new national artificial intelligence system went live in April 2021, which automatically sends Protection Orders obtained in Family Courts relevant to the Met. This will allow for more accurate recording and also better safeguarding of victims.

Public Protection - Exploitation:

The Pan-London Protocol was published in March 2021. In addition to key partner briefings, over 3,000 colleagues (including response teams, parks and roads

police and all youth strands) have now been provided with training and information regarding the requirements of the protocol. The remaining weeks will cover neighbourhood teams.

Public Protection – OCSAE (Online Child Sexual Abuse & Exploitation): we created and implemented training and work with our MASH teams and Children's Social Care to enable investigators to understand the processes (MASH/ CAIT (Child Abuse Investigation Team) referrals / strategy discussions/ Local Authority Designated Officer involvement) to safeguard children at the earliest opportunity.

Specific investigation training has been provided to all officers and supervisors on OCSAE teams in how to take part in strategy discussions and the requirements under S47 of the Children's Act 1989. This milestone has been delivered and the response has been to ensure strategy discussions are completed prior to police action, with all parties possessing a greater understanding of each other's role.

## Safeguarding Children Priorities 2022/23

The safeguarding of children remains a key priority. Despite challenges, the CAIT teams have been restructured and an uplift of staff provided. The CAIT shift pattern has been remodelled to provide coverage at key times. The official corporate implementation is still in progress with it expected before the end of the year. This will not only provide greater resilience around child abuse investigations, but will allow for enhanced partner co-operation.

The MPS continues to invest heavily in safeguarding of children online. The OCSAE teams based on each BCU carry out high-level investigations and have had notable successes in the last year. This includes a case involving the seizure of the largest amount of IIOC material in MPS history. This work continues, remains a priority and will continue to receive the investment it requires.

A draft North Area BCU child exploitation plan has been formulated. This plan is subject to final amendments before a consultation phased and implementation. Discussions have been held with our Enfield partners on this matter including the potential for a Police officer to be based in the contextual safeguarding hub. This is still under discussion and not yet approved. In addition, proposals will be made as part of the exploitation plan to provide a level of support for transitional safeguarding. The MACE (Multi-Agency Criminal Exploitation) panel which is co-chaired, continues to undergo self-assessment and discussion over improvement. A MACE action plan is under review and will be further discussed in September.

To facilitate the above goals, and enhance understanding of matters relating to safeguarding of children, training remains a priority. Bespoke training packages for both frontline officers and investigators continues to be disseminated. Although the voice of the child has for some time been an

integral part to our approach, further work will be done to enhance understanding around trauma informed practice and adultification.

Inter-agency co-operation will continue to be a key priority. Information sharing and clear lines of communication are key.

## NHS North Central London (Enfield) Integrated Care Board

### Overview of work in 2021/22

The CCG Designated Nurse represented the CCG along with NCL CCG Director of Quality and Chief Nurse at the ESCP Executive meeting. The CCG has maintained its 2021/22 funding commitment to the Safeguarding Children's Partnership. During this period two of the key areas of focus for the Partnership, has been professional curiosity and physical abuse, themes that also been have highlighted through local and national learning reviews. The Designated Nurse and the Named GP have been fully engaged with the multi-agency audit process and worked closely with front line health practitioners to embed learning. The CCG leads have prioritised working in the partnership with other statutory and non-statutory organisations to ensure shared learning across the health economy, particularly in the recovery period post COVID to help refocus practitioners.

The Designated Nurse for Safeguarding is a core member of the Practice Improvement group, which continued to meet on a regular basis in 2021/22. The Designated supported the presentation of cases for consideration as well as disseminating learning from completed reviews.

The Designated Doctor and Designated Nurse, are statutory roles and both take a professional and strategic lead for safeguarding in the Borough. There continues to be a gap in the Designated Doctors function for Enfield. An interim post-holder is in place and working to ensure children who require Child Protection Medical Examinations are seen in a timely manner.

The Designated Doctor for Looked After Children (LAC) post remained vacant in the reporting period, however the LAC Designated Nurse and the interim Designated Doctor work closely to ensure assessments are completed. However this remains an unmitigated risk, the interim medical has escalated the gaps to Barnet, Enfield and Haringey Mental Health Trust, the Trust is actively trying to recruit to these posts.

The Designated Nurse has established a regular multi-agency partnership meeting, to resolve operational issues and to enhance communication across the partnership. All statutory agencies are represented including the police, local authority and health services. This has helped with development of "Back to Basic" sessions facilitated by the Designated Doctor, raising the awareness of process and criteria for arranging Child Protection Medicals.

The Designated Professionals take proactive measures to learn from best practice and encourage relevant staff to attend specific training seminars and courses and participate in national safeguarding groups to disseminate best practice and learning. Additionally the Safeguarding General Practitioner Forum

has continued to meet virtually, providing regular training updates and awareness raising. In this reporting period the independent author who completed the practice review on Josef was invited to the lead GP forum present the learning from the review. Learning from the professional curiosity audit was also presented by the Partnership lead. The Designated Nurse and Named GP have continued to maintain close communication with GP's with a number of practice visits throughout the year.

### Evidence of Impact:

The CCG ascertains patient experience through provider meetings, contract monitoring and patient complaints. The NCL Designated Professionals have continued to monitor, and quality assure the NCL Safeguarding Health Providers. Designated and Named Professionals attend providers safeguarding committees and local partnership meetings. Where gaps are identified, further assurance has been sought and is monitored at a local level by the relevant borough Safeguarding Leads. There are no plans that required escalation.

### Priorities for 2022/23

Physical Abuse and Neglect

Transitional Care Arrangement

Forced Marriage/Honour Based Violence

Criminal and Sexual Exploitation

Recruitment to Designated medical posts – LAC and CDOP

## Local authority

**In this section we highlight information not contained in the main body of the report.**

- During 2021/22 children's services in Enfield had to respond to the challenges faced by children and families due to the Covid-19 pandemic by focusing on recovery and ensuring our services continued to deliver to the highest possible standards.

- As national restrictions eased there was a significant increase in face-to-face contact with children and families. Technology continued to play a key role in minimising infection risk. Blended ways of working with children, families and partners are now the norm and used across all services.

- National children's social worker shortages were also felt in Enfield, resulting in the increased use of agency staff and periodic increases in social work caseloads.

- In the height of the lockdowns, we know children were less visible to partner agencies, with schools having fewer children attend, other services were not seeing children regularly with many children at home. This meant the infrastructure that would normally pick up early indicators of concern was not there, this showed in concerns being in an acute state when referred to children's social care services.

- Throughout the year we continued to deliver services working hard to improve the quality of social work practice and the lived experiences of children, striving to include and hear voices of all children and young people where possible.

- This document provides an overview of what has gone well, what has been a challenge and what needs to happen, using audit findings, data and performance. The data within this report is for the period April 2021 to March 2022 unless otherwise stated.

## Highlights of progress against 20/21 priorities

We have:

- Made progress in catching up with health and dental checks for children in care that had been delayed due to the pandemic.

- Set up two adolescent safeguarding teams and a contextual safeguarding hub. Widened our contextual safeguarding approach to include bespoke work with parents. Created a youth panel to reduce re-offending and launched a social care and youth justice joint protocol.

- Increased participation of our young people with the relaunch of the care leavers hub and increased the number of care leavers on apprenticeship schemes.

- Redesigned key services such as Early Help which now sits with other preventions services such as youth and community, strengthening the delivery of our early intervention.

- Undertaken more quality assurance exercises, including an internal review of the Leaving Care service, an audit peer review and a culture survey with staff to understand what it is like to work in the children and family's service.

## Key data as at 31/3/2022 – Children and Family Service

| | |
|---|---|
| | 333,587 residents<br>5th largest London borough by population<br>27% (91,444) of population aged 0-19 |
| ↓ | **187** stepped down to early help services, a decrease from 198 in the previous year. |
| ↑ | **91** families stepped up to statutory services an increase from 39 in the previous year. |
| ↑ | **22,788** MASH contacts an increase from 20,034 in the previous year. |
| ↓ | **71.9 %** C&F assessments completed within 45 days a decrease from 90.1% in the previous year. |
| ↑ | **2289** child protection investigations an increase from 2,078 in the previous year. |
| ↑ | **333** children subject to child protection plan an increase from 254 in the previous year. |
| ↑ | **627** Children with a CIN plan (allocated to a SW) an increase from 472 in the previous year. |
| ↑ | **396** Children in care an increase from 391 in the previous year. |
| ↑ | **305** care leavers aged 18+ an increase from 284 in the previous year. |
| ↑ | **53** new allegations meeting LADO threshold an increase from 40 in the previous year. |

## Leadership and Governance

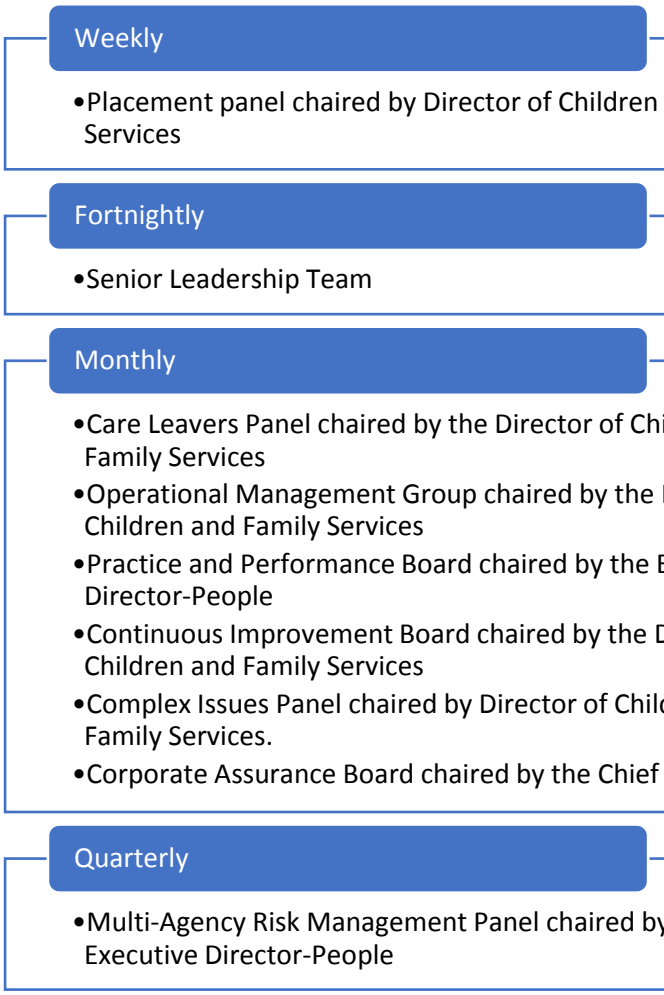
- Enfield has an experienced and committed departmental, corporate, and political leadership team that puts children first. The leadership structure

includes Full Council, Cabinet, Overview and Scrutiny committee and several standing panels including, the Children, Young People and Education scrutiny committee.

- Councillors are included in the membership of, the Corporate Parenting Board, the Fostering Panel, Schools Forum, Enfield youth justice management board the Learning for Excellence Partnership and the Member/Governor forum. The Cabinet Member for Children Services also a participant observer of the multi-agency Risk Management Panel.

- The senior management team has been stable providing calm and consistent support to frontline staff. New Heads of service have successfully settled into their roles following the retirement of long-standing heads of service.

- Senior leaders continued to have clear oversight of performance and practice; with weekly activity report collated throughout the pandemic. The performance and quality assurance cycle remained in place, meetings took place virtually, which included:




- Senior leaders share regular updates with the Cabinet Member, the Leader of the Council and the Assurance Board chaired by the Chief Executive.

- Challenges around staffing numbers in the year resulted in increased caseloads in some teams, senior leaders took effective action by investing in a range of workforce initiatives to stabilise staffing, reduce caseloads and build more capacity across services for example recruitment overseas, sabbaticals and retention payments.

- Leaders have worked constructively with partners to strengthen the response to exploitation, therapeutic

support to unaccompanied minors and domestic abuse.

- The Enfield Safeguarding Children Partnership (ESCP) continued to have strong scrutiny arrangements in place. The original independent scrutineer arrangements ended in March 2022 new plans are in place for the forthcoming year which includes rotating partnership chairing.

- This year we were one of 10 local authorities that took part in the Independent Review of Social Care helping to influence national reform.

- We rebooted our practice model Signs of Safety, developed a trauma informed parenting programme and transformed the Family Hub model in Enfield.

- Hearing the voice of those we work with, is a priority, leaders have ensured the voice of young people and staff has influenced the design of the future Children's Hub where all Children and Family's will be based late 2022.

## CAMHS HEART, Virtual school & KRATOS

- The virtual school is incorporated into the wider Health, Education & Access to Resources Team (HEART) and is co located with the social work services for looked after children.

- Overall attendance of looked after children in 2020/21 was 93%, which is above national and statistical neighbours. Persistent absence in 2020/21 was 22% against a national average of 30.4%.

- Looked after children in Enfield also achieved better outcomes than peers.

> *"Enfield Virtual School was robust and rigorous with attendance monitoring and strategies."* DfE, January 2022

- There were no looked after children permanently excluded from school in 6 years and school suspensions are in line with the national average.

- Almost all eligible looked after children have an up to date personal education plans (PEP).

- KRATOS (the children in care council) have contributed to the development of policy, strategies and guidance. They have also enjoyed trips to museums, swimming and other leisure activities culminating in an achievement day attended by 68 children and their carers.

### Family Group Conference Service:

- The family group conference team was launched in October 2020 with the aim of helping families to find solutions to reduce the likelihood of children coming into care. 159 family group conferences took place and 90 reviews.

- There is strong evidence that the family group conferences have contributed to better outcomes by reducing the time children are subject of child protection plans or subject to legal proceedings.

- Families and professionals are provided with feedbacks following every family group conference. Families view the conference process as an opportunity to build family connections, and empowering themselves to contribute positively to the child's care plan

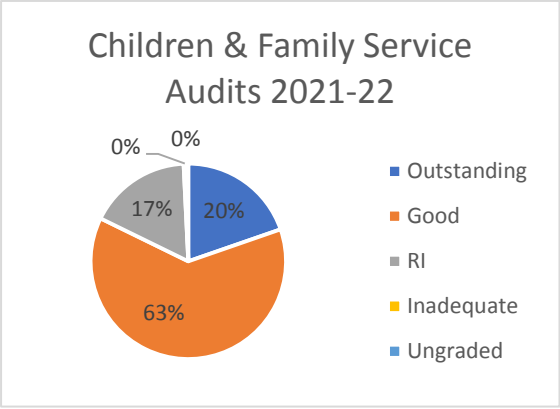
## Quality Assurance

- Quality assurance (QA) activity has driven up standards across all services. Senior managers respond quickly to meet changing needs and demands for services. Action plans are devised and monitored via the Practice and Performance Board and the Continuous Improvement Board.

- The Independent Reviewing Service managed within the Safeguarding and Quality Service maintains autonomy from case holding services. There are quarterly meetings with the Executive Director-People, Director of Children and Family Services and Head of Safeguarding to hear the observations of IRO's on operational practice.

- Performance information is provided regularly and enables managers to have an overview of effectiveness and understand what actions and areas of further development are needed. This is supplemented by data analysis to inform improvement actions. We continue to review our data to ensure it tell us what we need to know.

- Activity and performance information at individual, team and service level is obtained.This information is used routinely at team meetings, service management meetings and the monthly Practice and Performance Board.




- In addition to the usual audit moderation program Practice Leads have:
    - Reviewed the quality of the service to care leavers
    - observed team and service managers supervision and provided feedback to improve practice standards.
    - participated in sector led improvement programme focused on consistency of auditing across the NCL.

- There were 259 cases audited as part of the regular moderation programme. Of the 259 cases, 20% were considered outstanding, 63% good, 17% required improvement, with no cases deemed inadequate.

- Auditing is well embedded within all services; leadership have a clear line of sight on the quality of practice. Each audit section is now graded, this provides a fuller understanding on the quality of practice. Moderated audit reports completed by Heads of Service are reviewed by the Executive Director-People and Director of Children and Family Services.

- Following on from last year's audit consistency workshops, consistency guides have been developed and adapted for different services.

## Workforce development

- Ensuring sufficient numbers of high calibre staff is a key priority for Enfield Children Services. To that end, short term, medium- and longer-term plans are in place to ensure succession of suitably qualified staff.

- To improve recruitment rates, we adopted different strategies that included overseas recruitment, care coordinators who progressed to social work posts, recruitment and retention payments.

- There was further investment in the longer-term strategy of growing our own social workers, with another cohort of 3 social work apprenticeships starting in September 2021, with a commitment of a further 6 places to be offered in 2022.

- We have continued to attract a high number of students and newly qualified social workers (NQSW), with 25 students in placement and 24 NQSWs. Our Assessed and Supported Year in Employment (ASYE) programme has been internally reviewed and a cohort system and a readiness to practice programme has been put in place aimed to better prepare NQSWs.

- In December 2021 Skills for Care carried out a Quality Assurance visit of the ASYE programme, and the support given to NQSW's.

The reviewers noted: *"There was general acknowledgement by people the reviewers spoke to that there are good things happening and the ASYE programme is striving to further continuous improvement. The program has been on a significant improvement journey over the past 12 months……"The NQSW's spoke positively about how they felt their individual needs were considered, feeling the authority and the program were very responsive to any requirements, several the NQSW's giving examples of how their needs had been met".* [1]

- This year staff had access to a range of training courses delivered both virtually and face to face. They had access to bespoke courses put on by their individual teams as well as 33 courses offered via the Centre of Excellence and externally. Of the 33 courses, 1283 places were booked this is an increase on 1174 in the previous year. We have ensured that all social work training is aligned to Post Qualified Standards and the Professional Capabilities Framework

- Training this year included a continuation of Trauma Informed Practice training continued to be rolled out across Children and families, including police and education colleagues.

[1] Taken from Skills for Care letter, December 2021

- Enfield continues to be part of the North London Social Work Teaching Partnership which complements the local comprehensive learning and development programme for social workers. Individual teams also commission team specific training.

- In November we held our whole children services conference themed resilience, recovery. 205 staff members attended, overall, the feedback was good, with many staff taking away practical ideas on how to look after themselves.

- Our focus on attracting and shaping leaders for the future continued, with the delivery of a bespoke social care Service Managers training programme, which is now being developed for middle managers across social care.

- We continued to support managers to attend a range of specific programmes including Firstline social work management programme, Practice Supervisor Development Programme (PSDP), Leaders for London, Black and Asian Leadership Initiative (BALI) and Upon Aspiring directors were promoted and managers were supported to join.

- Expenditure on the professional development of the children's workforce has been maintained despite the challenging financial context.

- Prior to the National Accredited Assessment System (NAAS) ending we had been part of the pilot and had been on the way to meet our target of practitioners being assessed.

- We undertook a cultural conversation speaking to staff across children services. This provided insight into issues that make staff stay in Enfield and things they would like to change. 320 across the whole of the Children and Family Service participated, 81% of the workforce. Of the 320, 193 were registered social workers, both case holders and non-case holders.

- The survey found the experience of Enfield Children and Family Services is an inclusive culture that is professional, helpful, and supportive. Caseloads and limited business support were identified as areas that could improve the overall experience of practitioners working in Enfield Our social care workforce report being well supported by managers with staff safety and emotional wellbeing being given priority.

- Listening events regularly take place and are an opportunity for the Executive Director-People and the Director of Children and Family Services to obtain feedback from social workers and other frontline staff.

## 2022/23 Priorities

- Launch bespoke middle management program.
- Ensure that service user feedback is recorded on case files.

- Develop Family Hub model
- Relocate services to the Children Hub
- Launch "Enfield Talks" giving parents and carers the opportunity to share their experiences of the children and family services
- Review impact of New Beginnings
- Continue to work on consistency of case work including updating plans after significant events
- Workforce recruitment and retention
- Improve timeliness of assessments

## Appendix B - Partner Updates

DONE_ Barnet, Enfield and Haringey Mental Health NHS Trust

### Safeguarding Enfield Annual Report information for 2021/22

### Safeguarding Adults:

**What have been the three key achievements for safeguarding adults partnerships work:**

- Preventing sexual violence
- Domestic Abuse – see below
- Training for staff – see below

**How effectively did partners collaborate during the pandemic?**

The MH trust worked closely with all three local authorities during the pandemic and relationships improved through increasing contacts and meetings to monitor the effects of the pandemic. The trust worked collaboratively to ensure that information was shared in relation to additional resources and systems to support those areas in which safeguarding concerns increased - i.e. self-neglect, domestic abuse, neglect.

**Emerging trends that have been identified with regards to adults safeguarding during the COVID-19 pandemic?**

The safeguarding team saw a significant increase in 4 areas of concern: Financial abuse, Self-neglect, domestic abuse (in the form of physical and psychological) and neglect. During lockdowns we also saw increases in sexual abuse on inpatients wards.

## Actions taken to mitigate risks:

We have created additional training and resources for the areas of concern. These includes training and resources for self-neglect, domestic abuse, sexual safety and financial abuse. We have also created an additional role: Domestic abuse and sexual safety coordinator.

### Safeguarding Childrens:

## Overview of work in 2021/22

### Audit and Statuary Review

- ✓ Continued contribution to Rapid reviews, local learning reviews and child safeguarding practice reviews
- ✓ Continued contribution and dissemination of learning for Domestic Homicide Reviews; The safeguarding team have received and delivered three Internal Management Reviews for DHRs in 2021/22.
- ✓ We continue to improve and refine our safeguarding audit strategy to ensure audits are relevant, meaningful and learning is disseminated Trust wide.
- ✓ Escalation of cases to HSCP
- ✓ Continue to contribute to AAR from a safeguarding children perspective
- ✓ Reviewed safeguarding children audits
- ✓ Increased the reach of the 'Think Family audit' to include more adult teams
- ✓ Delivery of 'Think Family' training to Barnet recovery house

### Training

- ✓ We have achieved over 90 percent compliance in our Safeguarding Level one to three training owing to the online integrated training programme developed in 2021 and a drive for increased compliance.
- ✓ We have provided specific safeguarding training in the areas of Modern slavery, Gang and county lines, Grooming, PREVENT and Domestic abuse.
- ✓ We have created new training in the areas of safeguarding supervision, safeguarding process's, and Think Family.
- ✓ We continue to contribute to corporate induction training of Trust staff
- ✓ We created a webinar for self-neglect with Camden and Islington which was attended by 80 plus staff across North Central London and beyond.
- ✓ Completed bespoke safeguarding training for a number of teams (i.e. Locality teams. Ward staff and drug and alcohol services)
- ✓ Commenced safeguarding supervision for staff in BEH Crisis pathway.
- ✓ Delivery of local safeguarding induction at the Beacon centre

- ✓ Disseminated learning from BLPI in champions meetings, bespoke training and to HSCP learning subgroup
- ✓ We have created a safeguarding clinic, held monthly, for those trained at L3 safeguarding can attend for further information and group supervision.

### Partnership Working

- ✓ Continued participation in Local Safeguarding Children Partnership multiagency audits
- ✓ We continue to work proactively and collaboratively with partner agencies and ensure regular attendance to partnership meetings

### Policy

- ✓ Update of Safeguarding Children policy
- ✓ Update of Safeguarding Children Supervision
- ✓ Update of Children's Did Not Attend & Was Not Brought In Policy
- ✓ Update of Allegations against staff policy
- ✓ Revision of Parental Mental Health protocol
- ✓ Update of Chaperone Policy

### Safeguarding Champions

- ✓ Continued to provide safeguarding supervision to the Perinatal Team
- ✓ We have strengthened the role of safeguarding champions ensuring that safeguarding really is everyone's business and expanded the champions network to include forensic services.
- ✓ We held a champion away day in August 2021 which focussed on the new Domestic Abuse Act, Managing allegations against staff including PIPOT and LADO as well as training on radicalisation. The event was attended by over 80 staff from across the trust.
- ✓ We have created a safeguarding process training, disseminated it across the trust, to improve knowledge around safeguarding responsibilities and pathways.
- ✓ Development and delivery of Think Family training.

### Resources

- ✓ We have advertised new development and resources on a monthly bulletin using our COMMS.
- ✓ Designed a flow chart to support safe discharge from a safeguarding and 'Think Family perspective.
- ✓ We have started the creation of toolkits and quick grab guides as a resource for staff carrying out S42 enquiries.
- ✓ We have contributed to the spotlight newsletter with safeguarding updates and resources.
- ✓ We have created 7-minute briefings for quick and effective learning.

- ✓ Updated safeguarding posters
- ✓ We have created a Sexual Safety directory detailing resources and stakeholders across North Central London. The objective of this directory was to specifically list stakeholders that can provide culturally sensitive support to those impacted by Sexual Abuse.
- ✓ We have created a Preventing sexual violence flow chart to support staff respond to disclosures of sexual violence.
- ✓ Our safeguarding handbooks continue to be distributed to all established and new staff
- ✓ We have developed 7 minute briefings to ensure that all finding and recommendations from Safeguarding Reviews and Domestic Homicide Reviews are disseminated to all staff to further develop our continuous culture of learning
- ✓ Our safeguarding handbooks continue to be distributed to all established and new staff

**Service Development**

- ✓ Reviewed and updated the Named Safeguarding Doctors Job description along with agreeing that each borough would require a Named Safeguarding Children's Dr. we have recruited to each position
- ✓ We have made a successful Business Case for a band 7 Safeguarding advisor whose responsibilities will be Domestic Abuse Coordination for the trust and sexual safety Lead.
- ✓ We have worked directly with wards to improve preventative measures around safeguarding.
- ✓ We have increased the number of safeguarding champions in the trust .
- ✓ We have improved the relationships between local authorities and the trust.
- ✓ Commenced safeguarding supervision for staff in BEH Crisis pathway.

**Domestic Abuse**

- ✓ We now have three fully established Independent Domestic Violence Advocates co-located in our hospital sites in Barnet and Haringey.
- ✓ We have been successful in our bid for funding for a domestic abuse coordinator for the trust
- ✓ We have created a domestic Abuse working group for the purpose of making improvements in six main areas:

1. Data Collection
2. Legislation, Policy, and procedure
3. Training
4. Coordination in community response and Partnership

working

5. Support for victim survivors
6. Prevention and Perpetrator Accountability

- ✓ We have created a MARAC quick grab guide to promote the use of MARAC and IDVAs for domestic abuse safeguarding.
- ✓ Continued to provide safeguarding supervision to the Perinatal Team

## Priorities for 2022/23

Childrens:

- **Sexual Safety**
- **Further deep dive audit**
- **Domestic abuse**
- **Transitions** and life-long safeguarding (Partnership working between Children and Adult services)
- **Prevention**: Promoting awareness Campaigns (e.g. Early Help)
- **Psychiatric liaison teams** – Increase safeguarding skills and knowledge to help identify safeguarding

Adults:

Increase awareness of the importance of effective information sharing at all levels.

Priority areas include domestic abuse, neglect, sexual abuse, financial abuse, self-neglect and substance misuse. rough sleeping and focus on cares and mental capacity.

Refresh strategy and enhance training via light bites, lunchtime learning etc. Trust wide policies relating to safeguarding to be continually updated.

Promote awareness and understanding of contextual safeguarding across the organisation.

Promote early help to prevent abuse occurring in the first place. The trust will maintain a culture of robust and continuous learning related to all aspects of the safeguarding agenda.

Effective data collection systems will be established that allow collection and monitoring of data from all available systems and sources e.g. Ulysses, RiO, complaints, patient safety. The trust will be assured that safeguarding really is everyone's business and there are enough systems and processes in place to support this

DONE_Community Safety Unit

**Safeguarding Enfield Annual Report information for 2021/22**

## *Overview of work over 2021/22:*

- *Prevent programme has worked to safeguard people from the dangers of extremism & terrorism*
- *Help facilitate the continuation of the local Chanel Panels – A multi-agency panel that works to safeguard people.*
- *Provided training and relevant Prevent-related briefings to local partners to ensure they understand the full range of support services that are available through the Prevent programme.*
- *Deliver training & workshops to young people and school children.*
- *Regular engagement with local educational establishments to ensure clear referral pathways and appropriate communication channels are open.*

## *Evidence that demonstrates impact:*

- In the last 12 months delivered training to over 1900 staff with most of them being schoolteachers or school-based staff
- We have also carried out workshops with over 2160 school children on Prevent & Hate Crime related materials.
- Monthly Channel panels that have cases of vulnerable adults and young people at risk of radicalisation.
- In the last 2-year period, we have trained & engaged with nearly 80% of secondary schools and 72% of primary schools in Enfield.

## *Priorities for 2022/23*

- Further improve its work with partners, front line workers and the local community to ensure adequate and targeted support is available to those at risk of radicalisation.
- Going forward we will enhance support to ensure that these key areas are also equipped with further tools to support and build resilience within partners.
- We will further develop resources available for primary and secondary schools. We will make this available in an online catalogue format so the resources can be readily accessed by teachers and safeguarding leads.
- Further to this, early next year we plan to update the Prevent Education Toolkit that has been received well by local educational establishments.
- Improved support to out of school settings that provide services to our young people.
- We will build on our work with a panel of community members to enable the community to better understand the way Channel panels function.

- Training will continue to play a significant part in delivery over the next year as we have seen a significant and continuous staff change over in a number of areas such as social care and education.

DONE_ Enfield Carers Centre

## Safeguarding Enfield Annual Report information for 2021/22

Enfield Carers Centre conducted an audit of our Safeguarding policies and comparing the regulated homecare safeguarding policies (inherited as part of the merger with Crossroads Lea Valley Carers Trust) and the ECC Safeguarding policies.

The ECC Staff Team received Modern Slavery Training in March 2021 organised and delivered by Sherry Salih and Emine Arif from Enfield Council's Strategic Safeguarding Team.

- We have appointed two nominated Trustees as Safeguarding Leads
- Newly recruited members of our admin staff team have received Safeguarding training

DONE_Enfield Children's and Young People Services – awaiting return

## Safeguarding Enfield Annual Report information for 2021/22

There has been a slow recovery since the pandemic, building resilience and reducing isolation were pivotal to ECYPS' work. We have seen a significant increase in areas such as domestic violence for both men and women, food poverty, mental health issues and financial difficulties. 'Safeguarding is everyone's responsibility'- our key achievement has been the support to organisations working with children and young people and their families to have robust policies and procedures in place, to embed these in their settings and for all staff and volunteers to collectively provide safe environments for children and young people.

2021-2022 Key achievements

- Bespoke training developed in response to the impact of the pandemic including county lines-post Covid-19, mindful moments, take a breath, community child protection for people working in food banks and street patrols. We have embedded professional curiosity into our child protection training programmes. **477** individuals attended training. The following multi agency training courses were delivered:

Child protection, child protection refresher, child protection and diversity, FGM, impact of parental mental health, community child protection covering grooming and county lines, domestic abuse, knife crime, prevent.

- Providing safe environments to rebuild the community. Bringing the community together, connecting with people to reduce isolation. We have continued our outreach and attended various events across Enfield to raise awareness to better equip organisations to deal with safeguarding concerns including schools and the community -Eldon Primary, Houndsfield Primary, Wilbury primary, Forty Hall, Shpresa, Phoenix Family Support, Edmonton Mosque, Palmers Green Mosque, Rumi Mosque, Metropolitan police event at Montagu recreation and Broomfield park.

- Reducing food poverty through our regular food-bank and working jointly in partnership with grassroots groups reducing food poverty and tackling issues that left long term impact on families due to the pandemic.

- Improving community engagement and raising awareness and understanding- supporting the Bulgarian/Turkish community and groups underrepresented in safeguarding referrals. We identified and put in place early interventions, jointly working with our partners for families effected by Covid-19. Due to the deadline of EU Settlement we worked with Edmonton Community Partnership and Settled to ensure families submitted their application forms.

- Our forum in March highlighted concerns around funding issues which hugely impacted smaller organisations resulting in many closing and leaving gaps in services.

- Improving mental well-being through fitness programmes, extended youth provision, mental health forum and specialist training. Due to the increase in suicide amongst young people under 35 in UK, we organised suicide prevention training delivered by Papyrus. 27 people attended from multi agency organisations including schools, social care, foster carers, faith groups, sports, youth provision, local mental well- being organisations. Papyrus highlighted the diversity of the groups in Enfield and said it was the first time the trainer came across a room full of participants from a wide range of agencies. Feedback included: this training helped with the next steps once you have received a disclosure from a young person, brilliant and much needed course, more confident if I was to be approached by a student with suicidal thoughts.

- Through our parenting programmes we had insights into the day to day struggles and challenges that families faced but also the resilience and strength they used to cope with daily life. Families on low income struggled, many trying to juggle the cost of rise in food and increased costs due to being at home over the pandemic placing an additional burden on household finances.
  Isolation from friends and peers, many families expressed that their children were struggling from mental health issues but also the disruption of schoolwork resulted in many young

people having anxiety specifically over the uncertainty of GCSE exams taking place. ECYPS continued to provide training around mindfulness. Our specialist training included 'Mindful moments' and 'Take a Breath' providing a rapid response to support schools and many out of school providers to tackle the increased mental health problems since the pandemic.

- Circulation of safeguarding news and key safeguarding messages via social media platforms- safe sleeping, domestic abuse helpline, professional curiosity, modern slavery, Thrive mental health leaflet, Covid -19 vaccinations and childhood immunisations.

- Partnership work-we worked with our partners, sharing resources, networking to keep children and young people safe in Enfield. Information sharing has been key and relaying messages from the safeguarding board has been an integral part in safeguarding children.

- One to one support-12 organisations were provided with support on training, DBS checks, policies and procedures

- 240 Disclosure and barring checks completed for staff and volunteers working in the third sector

DONE_Enfield Council Safeguarding Adults

## Safeguarding Enfield Annual Report information for 2021/22

### What have been the three key achievements for safeguarding adults partnerships work:

- Continued co-working around COVID-19 challenges - especially around infection control work with care providers, changes to new ways of working and maintaining and enhancing our response to Modern Slavery and Domestic Abuse.
- Establishment of the MARAM to discuss rough sleepers - this was led by Housing Partners but a number of Board partners have contributed.
- Given an increase in the complexity of cases coming into Adult Social Care, we have established a High-Risk Advisory Panel, service-specific Complex Cases panels and continued to work closely with the Community MARAC on cases with an element of Anti-social behaviour.

### How effectively did partners collaborate during the pandemic?

- The frequency of SAB was increased.
- Partner updates regularly provided to all which has been an effective tool and useful to highlight common issues (such as domestic abuse).
- Specific agenda items on COVID allowed discussion and communication during this time.

- An Extraordinary SAB was pulled together to look at hospital admissions and care homes using DNAR and how these were quality assured. This flexibility around urgent issues is very useful.
- Regular updates on meetings like the MARAM (for Rough Sleepers), Modern Slavery and Public Health at each SAB helped to ensure all partners aware and collaborating around these issues.

**Emerging trends that have been identified with regards to adults safeguarding during the COVID-19 pandemic?**

- Increase in total number of concerns coming in.
- Increase in Self-neglect cases (with a factor of non-engagement).
- Increase in Domestic Abuse cases.
- Increase in complexity of enquiries with a potential need for more longer term work.
- Increase in cases which involve multiple factors of disadvantage and require working across professional groups.
- Increase in cases involving poor discharge from different care settings.

**Actions taken to mitigate risks:**
Additional staffing being put into the Multi-Agency Safeguarding Hub with a further review of this service being on-going.

A hoarding database has been created and is in active use between Local Authority staff and Fire Brigade. This needs to be extended to work in a wider way with other partnership colleagues. Funding is being sought for a co-ordinator to scope out what resources (eg theraputic) might be required.

Each service area within Adult Social Care has it's own Complex Cases panel (though names vary) which allows for discussion of cases - with those that are particularly challenging being escalated to a monthly High Risk Advisory Panel which includes Board partners. "

**Priorities for 2022/23**

Adults:

- The Dependent Drinkers Task and Finish group has begun meeting and will be key in developing our work around this key area of risk.
- Community engagement - in particular ensuring that we have the views of those with recent lived experience of the safeguarding process and developing our relationships/ cultural competency with hard-to-reach communities.
- Within ASC, continuing to develop our audit process to specifically address/ pick up on learning from SARs.

- Independent audits with Red Quadrant - this should provide us with assurance and suggestions to make real improvements (as well as assisting in preparing us for CQC inspections coming '23/24).
- CQC inspection readiness will be a real focus for the coming year - ensuring that we can evidence good practice.
- Development and Consultation on the 2023-28 Safeguarding Adults Strategy.

DONE_ Enfield Council Housing

## Safeguarding Enfield Annual Report information for 2021/22

Housing Advisory Service (HAS)

- The Housing Advisory Service updated its safeguarding procedure for staff.
- Our Resilience Team have been delivering refresher training across the HAS covering domestic abuse, safeguarding and suicide prevention.
- We were invited to join a meeting with the safeguarding team to review the Missing Persons Policy as the Street Homeless Team are developing their own and we wanted to see if we could be covered within one policy.
- We have made contact with the Modern Slavery team to deliver training across the HAS so teams have increased awareness, can identify and understand how to make a referral when concerned
- Ongoing work towards a DAHA accreditation
- MARAC meets fortnightly by Resilience Team Manager, Housing Advisory Service.
- MAPPA meetings are attended by the Resettlement Pathway Manager.
- The Resilience Team have had positive multi-agency work with two adults at risk in the last month. Both were single females fleeing domestic abuse, No Recourse to Public Funds and with complex needs and had been heard at MARAC. Through strong partnership working, both were initially placed in an emergency room the moved into a refuge where they were removed from further harm.
- We have recently developed a sex workers pathway to provide emergency placments for a vulnerbale woman with wrap around support ensuring a place of safety and housing.
- We are developing an implemntation programme for the new Housing service, which includes safeguarding training.

Housing Management

- Ongoing work towards a DAHA accreditation - new Housing and Regeneration Domestic Abuse policy has been circuated to stakeholders and is under consultation due to end on 13th December.
- We have lauched our resident relationship service within housing management, who are offering a bespoke person centred complex case management service. This service has already found a significant number of safeguarding case work we have seen an over 80% increase in safeguarding referrals as a result. As such we are looking at funding a specliased post for a qualified social worker within housing management to support the significant demand for additional expertise in this area.

- Safeguarding Adolescents From Exploitation (SAFE) panel, meets fortnightly – Head of place operations within Housing management is a core member
- We are continuing to develop a vulnerable resident procedure, setting out our processes for supporting and engaging residents, who are at risk of neglect and abuse
- Due to volume of new staff we have rolled out mandatory training for staff on safegurarding and working with external trainers to develop a suitable safeguarding training course for all staff;
- Some positive outcomes on hoardng case work
- Contractor Glo Clean have a hoarding specialist within their team who has been an exceptional support on our hoarding case work – looking at ways to better use this service
- Looking at a protocol for our out of borough stock, it is incredible challenging to achieve engagement on safeguarding cases where resident live in council stock out of borough; we need to much stronger partnerships between borpughs on safeguarding issues.

DONE_Healthwatch Enfield

Link to HealthWatch Annual Report can be found here:
https://www.healthwatchenfield.co.uk/sites/healthwatchenfield.co.uk/files/editors/Healthwatch%20Enfield%20Annual%20Report%202021-2022_0.pdf

DONE_Integrated Learning Disabilities Service (ILDS)

**Safeguarding Enfield Annual Report information for 2021/22**

- Safeguarding concerns have continued to be received by the service and safeguarding plans are completed within usual time frame, usually on the same day and at the latest the following working day.

- Face to face visits have continued and are starting to increase now that restrictions have eased.
- AAR's remain central and fully involved in our safeguarding work and this was highlighted during both recent and external safeguarding audits. We continue to implement MSP principles to the forefront of our safeguarding adults work.
- SAM oversight remains consistent and constant.
- SAM's and Team Manager are delivering Safeguarding Training to our internal colleagues to ensure safeguarding work maintains high standards.
- We continue to fully engage and make use of relevant resources and as such have presented cases to CMARAC, MARAM and The High-Risk Advisory Panel.
- We have re shuffled our resources to enable us to meet the increasing number of referrals and to manage the complexity of the referrals to ensure we continue to keep people safe.
- Continued to escalate cases to Strategic Safeguarding Team for support with complex and very high-risk cases.

Excellent integrated multi-agency working remains crucial as the complexity and risk we currently manage is increasing as the pandemic enters endemic, which includes death threats and stalking. We have involved police, providers, families, Cheviots, Health MDT etc to agree management strategies This is ongoing and involves many agencies.

Examples of excellent practice by an officer or team that you'd like to highlight:

Example of good partnership working was in the case of a young woman with dual diagnosis of LD and MH. Was admitted to North Middlesex Hospital and refused to go home as she said her parents had been abusing her. After this allegation the service stopped talking and communicating with people, so it was difficult to understand what the allegations and risk were. The service user was supported by the SW from ILDS and the hospital liaison nurse along with Psychology to support her start talking again and they worked together with the hospital MDT and her family to ensure she could be discharged safely home.

DONE_London Ambulance Service

**To read updates from the London Ambulance Service 2021/22, please go to**

**https://www.londonambulance.nhs.uk/about-us/our-publications/**

DONE_London Fire Brigade

## Safeguarding Enfield Annual Report information for 2021/22

We have continued to meet with partners within the Fire Safety Partnership to ensure recommendations made following previous fatal fires have been adopted. Further meetings are diarised on a monthly basis.

LFB have been consulted on the implementation of the LBE Hoarding Database and we hope to be able to access this at Station Commander level in LFB. It is anticipated that this will make information sharing more streamlined throughout services.

LFB crews within Enfield have, since Jan 2021 to date, made 6 safeguarding referrals into MASH. This is a significant reduction on previous years but due to the Covid-19 pandemic our Home Fire Safety Visit scheme was temporarily halted for some time reducing our interactions with the community and therefore our exposure to situations requiring a safeguarding referral to be made.

Pre Covid-19, engagement was made with Enfields Modern Slavery investigator with a view to providing input for all firefighters within the Borough in identifying and reporting modern slavery. This halted due to Covid-19 but planning is again is expected to resume soon.

Recent introductions have been made to Enfield Faith Forum with a view to improving commuity relations with traditionally hard to reach communities in Enfield.

Attended the Enfield White Ribbon Event and promotion of the White Ribbon Campaign.

Offer to Community MARAC to provide presentation to interested partners.

DONE_London Metropolitan Police, North Area BCU

## Safeguarding Enfield Annual Report information for 2021/22

### Safeguarding Adults:

**What have been the three key achievements for safeguarding adults partnerships work:**

- More integrated channels of communication with Adult Social Care and the police on the Haringey side of the partnership. Strong relationships and good co-ordination on the Enfield side.
- Joint Modern-Slavery Partnership Meeting established with Enfield Council.
- The police Mental Health team is performing well in developing and maintaing strategic and tactical relationships and reviewing and developing local practices and protocols to improve outcomes for service users.

**How effectively did partners collaborate during the pandemic?**

Collaboration during the pandemic was assessed to be good. There was an inevitable impact on the delivery of face-to-face frontline services, but this was mitigated via online meetings which has become embedded now as a hybrid model and enables greater efficiencies. There was no formal evaluation of this so metrics are difficult to identify so I have based this rating on feedback from internal and external partners.

**Emerging trends that have been identified with regards to adults safeguarding during the COVID-19 pandemic?**

1. Increase in s136 demand and mental health need
2. Increased DA due to covid pandemic.
3. The impact on elderly community - more vulnerable to exploitation and fraud including from family members.
4. Increase in cuckooing and exploitation offences.

**Actions taken to mitigate risks:**
(1) The BCU has introduced enhanced protocols in relation to the tracking and identification of cuckooing and exploitaiton. A report is created for each incident rather than recording on the Airspace database. This is overseen by the ANVA co-ordinator and trends/data shared with partners. This leads to better case management.
(2) Training frontline professionals in recognising financial abuse.
(3) Problem-solving with work BEH MHT and trigger plans/location based comments on CAD. Escalation of lack of s136 bed availability to NHS England Execs meeting through new procedure.

Safeguarding Childrens:

**See appendix A**

**Priorities for 2022/23**

Adults:
1. A roll out of training for police officers in relation to Vulnerable Adult cases.
2. An increase in publicity and referral Monthly meeting with CPIC Inspector ANVA more publicity and recognition of vulnerable adults.
3. Embedding an improved internal audit regime.
4. Review of Operation Boxter (Street Prostitution) safeguarding processes.

DONE_National Probation Service

**Safeguarding Enfield Annual Report information for 2021/22**

**Safeguarding Adults:**
**What have been the three key achievements for safeguarding adults partnerships work:**

- Partnership Working - Use of MAPPA to ensure effective Risk Management Planning and access to local services / resources
- Delivery of a transition programme for young adults transitioning from youth justice services to adult criminal justice services.
- Clear national guidance on the difference between referrals and checks. Supported by a video presentation and PowerPoint. All teams in Enfield briefed by Head of Service (HoS) and line managers

**How effectively did partners collaborate during the pandemic?**

DATA and anecdotal evidence supported emerging trend of abuse. Close liaison with Police to identify if any of our SUs were coming to their notice.

**Emerging trends that have been identified with regards to adults safeguarding during the COVID-19 pandemic?**

Identifying domestic abuse to family members and intimate partners where they may not have been identified before; increasing mental health concerns and working with staff to recognise signs; developing staff skills in working with suicidal ideation.

**Actions taken to mitigate risks:**
Increased briefings and reminders to staff. Use of data to bring the message home. Service Users seen regularly face to face, frequency based on risk but never less than once every four weeks for medium with supplementary phone call supervision and high risk seen face to face every week. Use of Doorstop visits.

## Safeguarding Childrens:

**Overview of work in 2021/22**

The National Probation Service and London Community rehabilitation Company amalgamated in June 2021 to form a new national organisation, the Probation Service. There have been ongoing checks in place to ensure that all staff are up to date with mandatory safeguarding children's training.

The London division has also completed a quality assurance exercise to ensure that not only is staff training up to date but that section 11s have been completed and that MARAC/MASH in each Local authority have been approached for feedback. Feedback received from Enfield indicated that whilst Probation attends CP conferences a report is not always provided. As a result of feedback staff have been provided with a report template and briefed to provide a report whether or not they attend in person. Quality development officers have completed audits on cases to ensure best practice. Specialist pan-London briefings on Safeguarding Children, Working with adults who offend against children (sexual and indecent images); youth transition to adulthood and SGO cohort. Safeguarding adults are part of the MAPPA core panel to advise on cases discussed in this multi-agency forum.

There has been a continued focus on operations during the Covid pandemic and how the Probation Service has adjusted and applied flexibility whilst maintaining public protection. During early 2022 we moved out of our exceptional delivery model with a view to moving closer to business as usual. The prioritising probation framework model was introduced which stipulates how the Enfield teams manage individuals subject to Community Orders and Licences following their release from prison.

Safeguarding remains a key a focus during the Covid recovery stage. During the initial lockdowns some people on probation received telephone or video appointments in order to reduce face to face

contact however, this is now being scaled back and increasingly where there are safeguarding concerns individuals are required to report to the Enfield Probation office for supervision. As always there is a focus on those who are assessed as high risk or where there are domestic abuse and Safeguarding concerns.

**Priorities for 2022/23**

Childrens:

Mandatory Child Safeguarding e-learning completion to be completed for all staff (including legacy CRC).

Child Safeguarding briefing to be formulated based on the questionnaire and above evidence (contextual safeguarding/SGO/younger siblings/non-disclosure) via L&D Task Force.

Adults:

Adhere to the London Adult Safeguarding ISA, Staff training commitment and attendance at partnership boards.

DONE _ NHS North Central London Clinical Commissioning Group, Enfield Directorate

## Safeguarding Enfield Annual Report information for 2021/22

### Safeguarding Adults:

**What have been the three key achievements for safeguarding adults partnerships work:**

- The Enfield Safeguarding Adult Board and its partners have demonstrated a system leadership in responding to Covid 19 and ensuring that there are systems and process in place to support local residents and provide support and advise to local colleagues.
- 
- Collaboration between the Enfield Safeguarding Adult Board and the Enfield Safeguarding Children Partnership has focussed on the development of a Transition Team with a focus on transitional safeguarding which aims to ensure that young adult in Enfield receive a service during the change from a child focussed service to an adult focussed service.
- 
- The designated professionals have continued to participate in the reviews of incidents that have led to a SAR and/or SI reviews, including rapid learning reviews and sessions and have ensured that learning from incidents has been shared, including the delivery of training to support teams deliver safe care in practice.

**How effectively did partners collaborate during the pandemic?**

Throughtout the pandemic, the CCG Safeguarding Lead was a core member of all relevant SAB sub groups and Task and Finish Groups.

**Emerging trends that have been identified with regards to adults safeguarding during the COVID-19 pandemic?**

The pandemic has seen the importance of education to support the delivery of safeguarding in primary care, in particular the understanding and use of the MCA in practice, issues relating to DNACPR agreements in care homes and commmunity environments, accessable information for professionals and the rapid access to multi-agency services has been a strength but can be the focus of development within safeguarding services (in LD services, care homes and residential services) and the develoment of more personalised care planning for the care of vulnerable people in the community and care homes has been highlighted as an area for improvement

**Actions taken to mitigate risks:**
We have raised the profile of the needs of people with Learning disabilities into the safeguarding arrangements and the new LEDER process has been implemented into the safeguarding processes. Feedback from LEDER reviews has been included as part of the feedback and learning systems. We continue to work with the providers and provider concerns process and have revisited reporting links within the services.

Safeguarding Childrens:

See Appendix A

DONE_ North Middlesex University Hospital NHS Trust

**Safeguarding Enfield Annual Report information for 2021/22**

**Safeguarding Adults:**
**What have been the three key achievements for safeguarding adults partnerships work:**

- The support of senior Trust leaders and the Trust Board throughout the Covid-19 pandemic.
- Regular communication between the Board and partners - highlighting the pressures being experienced at the Trust.
- Updates and information sharing re national plans particularly in regards to the Covid-19 pandemic.

## How effectively did partners collaborate during the pandemic?

Safeguarding strategies are discussed with partners and information shared. Multi-agency approach on complex safeguarding cases. Assurance sought from partners who are encouraged to share issues/barriers encountered. Update on progress/actions plans given by partners at meetings.

*Case studies (2) illustrating good partnership and safeguarding practice*

Young adult female patient, who presented to A&E with complex health and social needs, was admitted on the ward. The complexity of her needs required the safeguarding team to involve partner agencies, including cross borough agencies.

Patient had mental health problems; she was under treatment for chronic diabetes for which she was poorly complying.

High intensity drugs user.

Came from Gloucester to London where she was staying at some friends' house before she became homeless.

There were concerns that the patient was being exploited by the "friends" who were well older than her.

There was allegation of rape - patient being the victim.

Was known to children social care before she became an adult.

Financial concerns: her benefits were stopped.

Good input and collaboration of partners agencies led to effective service delivery:

The community mental health team provided support and follow up with her mental health problems, including drug misuse.

District nursing provided care and support for the management of diabetes.

Connected Community supported with GP registration.

Effective liaison between the two Local Authorities, patient is now settled in London and housing situation resolved.

Investigation of allegation of sexual assault/exploitation carried out by Police.

Services continue to engage the patient to ensure that she is well supported to function to her full potential.

## Emerging trends that have been identified with regards to adults safeguarding during the COVID-19 pandemic?

We have identified increased rates of patients presenting with self neglect, difficult discharges and pressure area damage.

**Actions taken to mitigate risks:**

Ongoing discussions with LA and safeguarding team to address the increase in patients presenting with self neglect. Audit completed to identify areas of improvement in relation to documentation of pressure area damage. Quality improvement projects ongoing to improve information sharing on discharge summaries. review of pathway work across a number of services at NMUH; The PU steering group has been strengthened including attendances from community partners.

## Safeguarding Childrens:

### Overview of work in 2021/22

- The Trust has had to work through significantly challenging times due to the COVID Pandemic. Throughout the lockdown period the Trust supported the safeguarding team to remain on site and staff were not relocated. This ensured the Trust continued to maintain its safeguarding responsibilities and was business as usual. During this period the Trust went through significant changes. North Middlesex University Hospital (NMUH) Paediatric Emergency Department (ED) remained opened throughout the pandemic and children requiring admission during the first wave were transferred to Great Ormond Street Hospital (GOSH). Children's inpatient services returned to NMUH in February 2021

- The Associate Director for Safeguarding (children and adults) commenced in post in January 2021. This has supported the 'Think Family approach in all the work that we do and on-going development.

- The adult safeguarding team which includes Learning Disability lead and Lead Nurse for mental health across the organisation and the children's safeguarding team are now co-located. This has supported joint working / support for staff and families.

- NMUH CAMHS Liaison team as part of the North Central London (NCL) CAMHS Network in post and co-located with safeguarding team to support young people with overdose / deliberate self-harm.

**Evidence of Impact:**

- Medical Clerking proforma in place signposting health care professionals to record what the child says. HEADDS assessment tool used for young people. Referrals for on-going support /social care identified as a result of tool being used.

- Patient experience trackers used by children and parents. Improvements to areas / communication with parents made. Development and design of new Paediatric ED involved voice form children and parents. Current re-furnishment of children's ward is including the voice of children / young people as to what would want if in hospital.

- Oversight on 16–19-year old's across the organisation by Paediatric team. Discussed at daily site meetings, play specialist team attend daily to wards / areas where admitted that is young person and parent focused. Safeguarding concerns raised to safeguarding team as required.

- Children's Board and Youth forum established and will seek to gain the voice of children / young people and parents in ongoing service development within the organisation.

**Priorities for 2022/23**

Childrens:

- CAMHS pathway improvement
- Pathway for young people presenting with challenging behaviours / training for staff

Adults:

- To ensure data is captured and analysed effectively through the safeguarding dashboard.
- To improve our understanding of less well reported categories of abuse.
- To ensure we continue to work collaboratively with partner agencies to streamline our approach to data collection, reporting and outcomes for patients.
- To continue to develop and improve systems to promote effective lessons learnt from reviews.
- To continue to promote a "Think Family" approach.
- To respond effectively to the increasing number of SARs and DHR's.
- To continue to ensure consistency of safeguarding practice across two boroughs with separate commissioning arrangements and different safeguarding pathways.
- To ensure the challenge of working across the two boroughs, safeguarding partnerships and their associated sub-groups is managed effectively within the safeguarding team.
- To respond effectively to the increasing and competing issues/demands across the safeguarding landscape.
- Re-adjustment of vulnerable clients when returning to business as usual post-Covid. Anticipation of possible further increases in safeguarding adults cases particularly due to domestic abuse. We continue to experience an increased number of referrals for vulnerable adults particularly due to domestic abuse.

DONE_One-to-One (Enfield)

# Safeguarding Enfield Annual Report information for 2020/21

We are have worked on the following:

- During the pandemic we offered support and training to our members/service useres to improve their understaning about risks of abuse on social media, using internet, emails and attending digital activities.
- We have organised a talk/presentation by the Hate Crime Forum Officer to come and talk to our members about Hate Crime and listen to their experience and views and how they can be supported to report incident.
- We work closely with Enfield Integrated Learning Disability Services when it comes to reporting any safeguarding concerns about our members.
- We ensure that we discuss safeguading matters at our weekly staff meeting and share relevant information with relevant people and organisations, so we can make improvements and prevent abuse and keep our members safe.
- Work with our members and carers to develop risk assessment to safeguard and reduce risks and abuse.
- Updated our DBS checks for our staff and volunteers, including the manangement committee/board members.

Awaiting feedback

DONE_ Royal Free London NHS Foundation Trust

## Safeguarding Enfield Annual Report information for 2021/22

### Safeguarding Adults:

**What have been the three key achievements for safeguarding adults partnerships work:**

- We have developed Safeguarding Student Placement for the final year students to make ‘safeguarding’ a key component of student nurses' learning needs.
- We have developed and rolled out Safeguarding Adults Level 3 Training in line with the Intercollegiate Guidance: Roles and Competencies for Health Care Staff (2018).
- We have developed Easy Read DNACPR leaflet for patients with Learning Disability.

**How effectively did partners collaborate during the pandemic?**

Due to the Pandemic a number of external partners could not carry out patients' assessment (hospital social workers-patient's with safeguarding concerns related to capacity assessment, patient's views and care needs) and hospital frontline staff acknowledged this limitations and work in partnership with Social Services to complete their assessment and safety discharge patients.

Although most partners worked remotely there were good links through using platforms

such as Microsoft Teams to ensure safeguarding meetings could go ahead; social workers/IDSVAs/IMCAs all available via telephone and face-to-face where necessary

**Emerging trends that have been identified with regards to adults safeguarding during the COVID-19 pandemic?**

RFL NHS foundation trust has noticed 'self-neglect' as one of the highest category of safeguarding referral during the pandemic. The quarter four recorded a significant drop in self-neglect which could be due to the fact that the Covid-19 restriction is easing.

**Actions taken to mitigate risks:** L3 safeguarding training rolled out during the pandemic. Self-neglect case discussion during this training, reflection on current practice, local service and resources promoted. Resources are available on staffnet.

### Safeguarding Children:

## Overview of work over 2021/22:

In October 2021 the Royal Free London NHS Foundation Trust introduced an electronic patient record (EPR) across the whole of its patient services. The safeguarding team has been developing the system to support early identification of risk. The national notification system Child Protection Information Sharing (CP-IS) is now embedded within the EPR which means that staff in the emergency department and Urgent Care Centres are immediately alerted if a child attends who is a child in care or subject to a protection plan.

We have appointed two maternity safeguarding advisors who work along side the named midwife and the vulnerable women's team. They have been raising awareness about the role of fathers in pregnancy and the neo natal period and have developed the EPR to capture social history and risk indicators for the father of the unborn as well as the mother. The teams have also focused training for staff around ICON coping with crying programme and safer sleeping with the emphasis on including the father in the training given to parents when they take their newborn baby home.

A priority area for the Trust has been improving how we get learning to the frontline staff and support them with service improvement during a very busy time in the health service. The paediatric liaison nurses had developed a monthly bulletin for the emergency departments about key issues and highlighting good practice, the safeguarding team have linked with the Trust communication team to help promote monthly themes, such as support for young carers, and the produce a quarterly newsletter.

The safeguarding children training is now a blend of virtual and face to face training which is flexible to national and local priorities. In the year we hosted training for staff about the new Domestic Abuse Act, unaccompanied minors, Child Sexual Exploitation where we invited Barnardo's to deliver their nightwatch training to staff such as porters, security who work mainly at night, trauma informed care and we continue to reflect the learning form case reviews into our training.

In April 2022 the Trust executive approved our bid to become a White Ribbon UK organisation.

## Evidence that demonstrates impact:

Parent's have provided some feedback to the staff who have delivered the ICON (coping with crying) training.

A mother of newborn twins told the midwife doing a home visit that she had been shown the ICON information and had a discussion with the staff on the ward before discharge and that it had really helped when she was at home and the babies were crying. She felt more confident to manage the crying.

A father said that he had told his male friends who were also new dads about ICON and what he had learnt from the midwife.

### Priorities for 2022/23

### Adults:

- Implemenation of LPS
- Accessible information & identifying Paitient With Learning Disability as service users to ensure equality off access
- Further development: Streamlining adult referral process to make more efficient and accurate

### Childrens:

- Improving the experience and outcome for people with a Learning Disability or Autism, Children (including the unborn), young people and adults at risk
- Effective communication to share learning
- Documentation and Information sharing
- Liberty Protection Safeguards
- Teaching and learning
- Domestic Abuse and Violence against Women & Girls/ Gender based violence

DONE_Waverley School

### Safeguarding Enfield Annual Report information for 2021/22

#### Overview of work in 2021/22

Completed who school trauma informed practice training
Completed PRICE training which is committed to restraint reduction - 3 trainers trained. All staff trained in theory and focused training for staff who may require practical training
All staff completed child protection training plus online training

## Priorities for 2022/23

Highlighting neglect , ensuring that pupils get the right support at the right time